Nelson Marlborough District Health Board

A Report by the

Health and Disability Commissioner

(Case 09HDC01408)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary 1

Complaint and investigation 2

Information gathered during investigation 2

Responses to provisional opinion 11

Opinion: Breach — Nelson Marlborough District Health Board 13

Recommendations 16

Appendix 1: Independent expert psychogeriatric advice 18

Appendix 2: Quantity of fluphenazine administered 28

Executive summary

1. Mr A, aged 64 years, was admitted to Nelson Marlborough DHB's Mental Health Acute Care Unit (the Unit) under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).

2. Mr A was floridly psychotic and was considered a risk to himself and others. Various types of medication were trialled but were unsuccessful in controlling his delusions.

3. Mr A began refusing all oral medications so it was decided to give him the drug fluphenazine decanoate (fluphenazine) by injection.

4. The records contain conflicting information, but Mr A was administered between 162.5mg and 225mg of fluphenazine in a period of up to 40 days.

5. The manufacturer's recommended dose for people aged over 60 years is 6.25mg for a test dose and subsequently ¼–⅓ the normal adult dose, which equates to 22–75mg every three weeks.

6. Mr A's physical functioning declined, he had increasing body stiffness, stooping posture and a Parkinsonian gait, decreasing mobility, a mask-like face, slow thinking and speech, and a lack of attention to physical cleanliness.

7. Mr A was often unshowered and left wearing dirty clothes.

8. The opinion finds that Nelson Marlborough DHB gave Mr A more than the recommended quantity of medication for a man of his age with dementia.

9. As Nelson Marlborough DHB failed to provide fluphenazine with reasonable care and skill it breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

10. Nelson Marlborough DHB breached Right 4(2)[2] of the Code for failing to clearly record the administration of fluphenazine.

11. Nelson Marlborough DHB breached Right 4(1) of the Code for failing to have a clearly defined plan and strategy to manage Mr A's behaviour and hygiene needs.

---

[1] Right 4(1): Every consumer has the right to have services provided with reasonable care and skill.
[2] Right 4(2): Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaint and investigation

12. On 30 June 2009 the Commissioner received a complaint from Mr B about the services provided to his father, Mr A, at Nelson Marlborough District Health Board's (NMDHB) Acute Mental Health Unit. The family complained that their father was neglected and given an excessive level of medication, which was not appropriate, resulting in his deterioration and loss of most motor skills. The complaint is about the poor standard of care their father received.

13. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mr A by NMDHB from January to September 2008 and from July to August 2009.*

14. An investigation was commenced on 4 March 2010.

15. Information was obtained from the parties directly involved in the investigation:

Mr B	Consumer's son/Complainant
Mr C	Consumer's son
Mr D	Consumer's son
Nelson Marlborough DHB	Provider
Dr E	Chief medical advisor
Dr F	Psychiatrist

Also mentioned in this report:

Dr G	Admitting officer
Dr H	Medical officer mental health
Dr I	Acting chief medical advisor
Dr J	House surgeon
Dr K	Psychiatrist/Geriatrician
Dr L	Locum medical officer

16. Independent expert advice was obtained from psychogeriatrician Dr Christine Perkins and is attached as **Appendix 1**.

Information gathered during investigation

Background

17. On 18 January 2008, Mr A, aged 64, was admitted to NMDHB's Mental Health Acute Care Unit under the Mental Health (Compulsory Assessment and Treatment) Act 1992.[3] Mr A had previously been a physically fit man with no history of mental

[3] Sections 11, 13 and 14 of the Mental Health Act enabled NMDHB to detain Mr A for observation and assessment. On 20 February an order detaining Mr A until 19 August 2008 was granted. On 21 August 2008 Mr A was released from compulsory treatment.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

illness. He was generally well and did not have a regular general practitioner. He had been a builder all of his working life.

18. Mr A's sons, Mr B and Mr D, advised the admitting officer, Dr G, that Mr A's delusions may have begun before his wife's death nine years previously.

19. At the time of admission Mr A was floridly psychotic and, according to his records, was considered a risk to himself and others. The records note that the day before admission he had handed his daughter-in-law a gun and ammunition. He had said he was frightened and could accidentally shoot someone. Invisible creatures (referred to by him as spirits or "gits") were attacking him and he needed to defend himself. Mr A's conversation was bizarre with a strong religious orientation.

20. Early in Mr A's admission he was co-operative but anxious and wanting to go home. He often had his bags packed waiting for one of his sons to collect him.

21. Mr A's care was co-ordinated by a multi-disciplinary care team (the team) who met regularly with the family, usually after a team meeting. A team meeting on 21 January 2008 described Mr A as a socially isolated man who was experiencing visual and auditory hallucinations, believing he was God and his sons were descendants of God. The team referred Mr A for a physical assessment and CT scan of the brain. However, on 3 March 2008 Mr A refused to have the CT scan because he thought it would disrupt his spiritual powers.

22. Mr A's sons found the explanations they were given about their father's diagnosis and treatment confusing. They said that the doctors could not agree on a diagnosis and at various times discussed the possibility of frontal lobe dementia, Lewy body dementia, some form of psychosis, or a brain tumour.

23. Various types of medication were trialled to control Mr A's delusions. Initially, oral medications were used (olanzapine, Epilim, risperidone and haloperidol). Each drug was given a trial of about a month, by which time, if he had been compliant, he would have been expected to have shown some response.

24. According to Mr A's records, he thought that the medication was having no effect. By the end of January 2008 his family advised the staff that he was spitting out his medication. However, he denied spitting out the medication.

25. Over a period of time Mr A became less co-operative, refusing to take oral medication, and refusing to change his clothing, wash his clothing or shower. NMDHB's Chief Medical Advisor, Dr E, advised HDC that the failure to attend to Mr A's personal cares was not due to a lack of care or neglect, but because "this was a dilemma for staff trying to care for this big man who was frail and unsteady, aggressive and a risk to shower in our facilities. This was done with large staff groups but verged on a restraint-type scenario with a wet, aggressive, large man at risk of further injury." However, subsequently, on 15 April 2010 Dr E advised HDC, "Being an active man who had worked in the building industry he was physically fit, strong, muscular and weighed just under 80kg. Thus, as opposed to having the appearance of

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

a frail, elderly man, he was a strong, fit male who fell short of the age and diminished physical health criteria typically required for the provision of specialist psychogeriatric services."

26. In contrast, the family state that they were concerned that their father was dishevelled and smelly. They believe that he was wearing the same clothes for weeks at a time but, when they brought up the subject with staff, they were told that Mr A would not let the staff wash his clothes. When staff were asked to wash Mr A's clothes at night when he was asleep, they responded that they could not because it would be an invasion of his privacy and would be seen as "bullying". The family agree that Mr A was not a frail man at the time he was admitted, although during the time he was in the unit he became less robust. They state that he was not aggressive, and the staff constantly told them that he was a perfect gentleman, always polite and friendly and they wished other patients were like him. Mr A's family point out that the nursing records do not record any physical aggressiveness but note instances of irritability and agitation, usually when Mr A was pressed about taking his medication.

27. These matters were discussed again by the team on 25 February, 11 March and 15 April, but no comprehensive plan to address the issues was developed.

28. On 8 April 2008 Mr A agreed to have a CT scan. The CT scan results were reported as "suggestive of dementing process". There was no brain tumour but there was "atrophy evident". The type of dementia was not identified.

29. By 16 April Mr A was refusing all oral medications. It was decided to give him his medication by injection. If he refused to take it orally, the drug fluphenazine decanoate (fluphenazine)[4] was to be given by injection.

Quantity of fluphenazine administered

30. Mr A's fluphenazine injections are recorded in several places in his clinical notes. The information provided to HDC as to the amount administered varies. The table in **Appendix 2** documents the doses of fluphenazine from three sources — Mr A's progress notes, Dr E's letter to HDC, and a medication summary prepared by the DHB for Mr A's family. These differing accounts impaired HDC's ability to determine the treatment Mr A actually received. The various accounts follow.

31. Dr E advised HDC that Mr A received six doses of fluphenazine. Dr E said that "the initial two stat doses of 12.5mg and 25mg charted on his medication record were subsequently crossed out and not actually administered by the nursing staff" and Mr A's first "test" dose of 12.5mg was administered on 21 April 2008 after he refused oral medication. The records show that Mr A was angry and abusive and had to be restrained in order for the injection to be administered.

32. The medical record for 18 April states: "fluphenazine decanoate 12.5mg today then repeat Monday — 25mg". However, the drug record for 18 April, which states "fluphenazine decanoate 12.5" and a following entry with an illegible date for 25mg

[4] Also referred to as Modecate.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

have lines through them. As the first two entries are initialled by the doctor but not by the nurses it appears likely that they were not administered. In that case the first dose would have been given on 21 April 2008.

33. Dr E stated that Mr A received 25mg on 24 April 2008, 50mg on 30 April 2008, and a further 50mg two weeks later on 14 May 2008. The dose was reduced to 25mg on 28 May 2008 because of the emergence of side effects, and then the medication was stopped.

34. Dr E said that the reference in Mr A's clinical notes made on 8 May 2008 to his having received intramuscular Modecate that day was a summary from the multi-disciplinary meeting held that day, and referred to Mr A having received this medication previously.

35. The clinical record for 8 May 2008 states: "Modecate 50mg given with w/restraints." The same record notes "tremor v. evident".

36. The dose Dr E said was given on 24 April appears from the records to have actually been given on 23 April.

37. In a letter to the intake team at the public hospital dated 18 August 2008, the Medical Officer Mental Health, Dr H, stated:

> "Between 21.4.08 to 28.5.08 [Mr A] received four fluphenazine depot injections which almost completely stopped his psychotic symptoms but caused severe extra pyramidal side effects [EPSE]. This was treated with benztropine [Cogentin] which helped his EPSE but caused severe confusion."

38. The pharmacist at the public hospital noted that Mr A commenced fluphenazine on 21 April 2008, was given an increasing dosage up to 50mg weekly, and it was stopped on 21 May owing to side effects.

Determination of appropriate dosage

39. Dr E said that fluphenazine can be prescribed in accordance with the manufacturer's guidelines, but they had found "expert opinion is more helpful" and it is not uncommon for prescribed doses of psychotropic medication (such as fluphenazine) to exceed the recommended guidelines.[5]

40. Dr E advised that each dose is prescribed as a single (stat) dose and the patient is closely monitored in between times for side effects. He said that Dr F, who first prescribed the fluphenazine and oversaw its administration, is a psychiatrist with many years' experience working with the elderly and cognitively impaired patients at the public hospital.

[5] Medsafe data sheet 2007: "For most patients a dose of 12.5 to 25mg may be given to initiate therapy … antipsychotic medication should be used with care in elderly patients (>60 years old), as these patients have a greater potential for adverse events. Doses in the lower range (¼ to ⅓ of those in younger adults) should be sufficient for most elderly patients. Response should be monitored and dose adjusted. If an increase is necessary doses should be gradually increased."

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

41. Dr F advised HDC that by the time he saw Mr A in February 2008 he had had over 25 years' experience in dealing with psychogeriatric clients as a consultant psychiatrist, and he had had experience in prescribing fluphenazine for over 30 years. He advised that the fluphenazine he prescribed was:

- 21 April 2008 — 12.5mg test dose
- 23 April 2008 — 25mg top-up dose
- 30 April 2008 — 50mg.

42. Dr F said that subsequent injections were given under the supervision of a colleague. When asked the rationale for the quantity and frequency of the medication, Dr F stated:

> "[Fluphenazine] is an injection that can be given weekly during the acute stages. Although the recommended dose in young adults is 100mg per [month], in clinical practice higher doses are sometimes needed and prescribed, depending on the acuity of the symptoms and the ability of the patient to handle the dosage. Once a steady state is reached, 100mg or more can be given as a single dose.
>
> In elderly, much smaller doses are recommended largely due to the common side effect of sedation, and the inherent risk of falls. Also the elderly are more prone to developing tardive dyskinesia.[6] The side effects that [Mr A] subsequently showed were that of Parkinsonism, which is a reversible side effect, commonly seen in relation to most of the antipsychotics."

43. In contrast, my expert, geriatrician Dr Perkins, stated:

> "The doses of fluphenazine decanoate were large for an older man known to have brain damage. The manufacturer's recommended dose for people over 60 is 6.25mg for a test dose and subsequently ¼–⅓ the normal adult dose which is 22–75mg every three weeks ... A more cautious approach (… the geriatric adage: 'start low and go slow') may have prevented this serious outcome, although even low doses can cause problems in a person who is sensitive."

Ongoing care

44. On 19 May 2008, Mr A agreed to shower once a week and it was noted that he had been changing his clothing and bedding more frequently.

45. By 28 May, Mr A had developed significant side effects from the fluphenazine and it was stopped. He had been having Cogentin up to three times a day to relieve the side effects of the fluphenazine.

46. On 11 June, Dr H assessed Mr A. At that time Mr A had no insight into his illness and believed there was nothing wrong with him. He said that he did not need any

[6] Tardive dyskinesia is involuntary movements of the tongue, lips, face, trunk and extremities that occur in patients treated with long-term dopaminergic antagonist medications.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

medication, and the medication they had given him had nearly killed him. He had not showered for some time and had body odour and, it appears, poor dental hygiene.

47. On 13 June, Dr I assessed Mr A. Mr A wanted to know what was wrong with him. Dr I explained that his stiffness and difficulty initiating movements were caused by the fluphenazine injections, but the Cogentin pills were meant to counteract these effects. Dr I noted that Mr A was physically unwell. She stopped the Cogentin, and ordered a complete physical investigation with blood and urine tests, an electrocardiograph and chest X-rays.

48. Mr A was also assessed by house surgeon Dr J. All Mr A's tests and investigations were normal, and there was nothing to explain his presentation. Dr J concluded, "[delirium] ?cause no cause found on physical examination … most likely [secondary] to Cogentin [benzatropine]".

49. Mr D visited his father on the evening of 13 June and reported to the family that their father was back to normal. When Mr C visited his father on 15 June, Mr A was excited about going home, and his notes confirm that staff were preparing him for discharge.

50. However, on 16 June, Mr A suffered what his family refer to as his "crash". On the afternoon of 16 June while Mr A was out with the occupational therapist, his movements suddenly became more wooden, his speech was delayed, and his facial expressions became blank. When Mr D came to see him later that evening he found his father sitting in a chair in a "vegetative state". Mr A did not recognise his son.

51. The following morning Mr A had wet the bed because his limbs were too stiff during the night to enable him to get out of bed to go to the toilet. He asked the staff to wake him every three hours to go to the toilet. After 17 June, Mr A was never again able to recognise his sons.

52. Mr A's side effects continued to cause him problems. Dr H reviewed him on 19 June and noted his decline in physical functioning, increasing body stiffness, stooping posture and Parkinsonian gait, decreasing mobility, mask-like face, slow thinking in speech, and lack of attention to physical cleanliness. Dr H was unable to complete tests for frontal lobe functioning because of Mr A's slow responses. He referred Mr A for an MRI scan.

53. On 30 June, Drs I, H and J assessed Mr A. He remained very impaired physically, needing assistance to get out of bed, walk, talk and chew. He told them he felt better than the day before, but was having difficulties with speaking and getting out of bed. It was decided that until these symptoms improved he would have no further antipsychotic medication.

54. Mr A's delusions appeared more controlled. For example, he was no longer troubled by "gits" but told the doctors he still had healing powers. He said he could not heal himself but he was going to heal someone today and he would have to go outside to do so.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

55. At the team meeting on 1 July, Mr A's diagnosis was discussed. It was noted that the severity of his side effects from fluphenazine was unexpected and they questioned whether he had an underlying dementia. The team awaited the results of the MRI scan which had been ordered on 19 June.

56. Mr A's MRI scan, taken on Monday 9 July, revealed generalised atrophy (shrinkage) of the frontal lobe of the brain and no evidence of a major bleed or stroke.[7]

57. Over the following weeks Mr A's improvement was slow. He began having a shower in the morning without prompting and required little assistance. However, he was unable to get out of bed unaided and had difficulties getting to the toilet in time. His speech deteriorated further with minimal and delayed responses. At times he was mute.

58. On 22 July, Dr I referred Mr A to the assessment, treatment and rehabilitation (AT&R) team at the public hospital for assessment and suitability for placement. The record states "MRI shows ↑ atrophy than expected for his age. But he was OK before meds."

59. On 29 July, Dr K from the public hospital attempted to assess Mr A but was not able to communicate with him. Dr K talked with Mr A's son, Mr D, to clarify Mr A's history. Mr D was concerned that the doses of antipsychotic medication could have exacerbated his father's mental deterioration. At that stage it was thought that Mr A's diagnosis was most likely Lewy body dementia (LBD). In Dr K's opinion, Mr A's psychosis would return when the effects of the fluphenazine wore off. He concluded that it was not appropriate to transfer Mr A to AT&R until a new specialist psychiatrist arrived in about a month.

60. Dr K advised HDC that, in his opinion, it was reasonable to trial Mr A on antipsychotic medication as he was suffering a major psychotic event. Dr K does not consider that antipsychotic medication accelerates the deterioration of patients with LBD, but considers that they are much more prone to develop Parkinsonian side effects, and these effects tend to be much more severe and occur at lower doses than in patients with other illnesses. He noted that a definitive diagnosis of LBD can only be made on autopsy, but even then the diagnosis may not be clear cut. He said that the symptoms of LBD and frontal lobe dementia are similar and often overlap. Dr K considers that it is impossible to know for sure if the side effects were the result of a progression of Mr A's disease, or the medications prescribed, or a combination of the two.

61. My expert, Dr Perkins, considered that the diagnosis was likely to have been front temporal dementia (FTD). She considered that the antipsychotic medication unmasked or precipitated a latent Parkinsonian syndrome, possibly related to an underlying FTD and/or cerebrovascular disease.

[7] Mr A's family advise that the post mortem concluded there was no atrophy of the frontal lobe.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The Public Hospital

62. Mr A was transferred to the public hospital on 4 September 2008 for further assessment and treatment. On 6 September, Mr A was noted to have tinea on his feet and antifungal powder was applied. Mr A's family said that the nurses told them that Mr A had the worst tinea they had ever seen.

63. Early in 2009, Mr A's mental state began to deteriorate further. On 30 July 2009 his unpredictable aggressive behaviour meant that he could no longer be controlled and managed safely at the public hospital. He was transferred back to the unit. Mr A remained in the unit until 13 August 2009 when he was considered stable enough to return to the public hospital.

64. Mr A was transferred to the public hospital on 13 August 2009. Mr A's family were told that upon his return to the public hospital he had no paperwork, was accompanied by a bag full of dirty clothes, and had a red, raw, groin from sitting in his own urine. His notes record "testicles and anal area very excoriated". He was wearing incontinence pads.

65. The public hospital staff sent hospital management an incident report about Mr A's poor condition. The report states:

> "It was reported to me (as Primary Nurse on night duty) that [Mr A] was transferred back to [Hospital] without any written transfer sheet, or no/limited verbal handover when he arrived back @ 1530hrs … He was unshaven on return, wearing a pull-up, had an excoriated anal area, and testicles, and his laundry required a wash. … Due to this I found it difficult to complete his care plan accurately — potentially placing himself, staff, clients and visitors at risk of harm. There was no record of his last bowel motion, shower, excoriation, diet or last contact with relatives from nursing staff, or risk management, precedents or management plan."

66. The incident plan noted that in the future, if one of the public hospital's patients were transferred to the mental health service, the public hospital would offer support and assistance with personal cares with their own staff for a time.

67. Dr I, the Acting Chief Medical Advisor of the DHB, advised HDC that Mr A's excoriated anal area and testicles was caused by recurrent faecal incontinence that had started four days prior to his transfer to the unit on 30 July, and continued on that admission, perhaps exacerbated by treatment of antibiotics for a presumed chest infection. She stated that Mr A's variable and at times lack of co-operation with showering would have aggravated matters. She said:

> "Room entry proved difficult on a number of occasions due to [Mr A's] aggressive stance and tendency to lunge towards staff in an effort to leave the room. Use of sedative medication to reduce his level of agitation was of course precluded in view of his previous reaction to psychotropic medication."

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

68. Dr I advised that the decision to transfer Mr A back to the public hospital on 13 August was made that day following his review by a visiting psychogeriatric registrar from a main centre, who was providing medical oversight for the public hospital to cover absence due to leave. The transfer was not confirmed until that time and therefore there was insufficient time for staff to attend to Mr A's laundry which accompanied him to the public hospital. She stated that sending the laundry would be standard practice to mitigate against the risk of client property being lost. She said that the unit records went with Mr A, along with [the public hospital] file, and there was a verbal handover between medical and nursing staff at the time of the review by the psychogeriatric registrar. Three nursing staff accompanied Mr A to the public hospital and provided the nursing handover.

69. Mr A continued to deteriorate and died in 2010.

Subsequent developments

70. Dr I said that positive action has been taken to improve the pathway of care for patients at the public hospital requiring periods of in-patient treatment at the unit. On occasion, this involves nursing staff from the public hospital coming to the unit to assist and provide advice regarding the physical cares for the public hospital patients, and monitoring of changes in the patient's behavioural presentation in conjunction with the unit's staff. When the patient is transferred back to [the public hospital], nursing staff from the unit may remain at the public hospital until the staff there feel able to manage without their assistance. Dr I advised that "similar co-operative care plans continue to be formulated for others on an individualised basis".

Clinical advice

71. Psychogeriatrician Dr Christine Perkins advised me on the standard of care provided to Mr A. With regard to the three primary issues raised by the family she said:

> 1. [Mr A] was known to have some degree of brain damage (resulting from dementia) before he began intramuscular fluphenazine, and this indicated that some degree of caution was needed. Even if he was not given as many injections as the clinical records suggest, and [Dr E's] information is accepted, Dr Perkins believes that 50mg per fortnight was a large dose for someone known to have dementia. She would view this as a moderate deviation from professional standards.
>
> 2. As a rule she would cautiously interpret the manufacturer's instructions and give less than recommended and slowly increase the dosage and frequency. Nevertheless she could not say whether the side effects [Mr A] experienced were idiosyncratic or dose-related.
>
> 3. In relation to [Mr A's] personal care, Dr Perkins said that this is an issue in all mental health facilities, and a comprehensive care plan should be developed to cope with the problem. Much could be learned by nurses working in acute mental health from those in the rehabilitation unit.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Responses to provisional opinion

Nelson Marlborough District Health Board

72. The DHB acknowledged that the amount of fluphenazine prescribed to Mr A exceeded the recommended dosage for elderly patients with dementia, but did not accept that that fact alone meant it did not exercise reasonable care and skill. It stated that this view was supported by Mr A's improvement before his abrupt decline.

73. The DHB stated that:

- Mr A presented initially with florid psychosis and his initial cognitive assessment found no impairment. So while the brain atrophy seen on the CT scan some months later suggested a dementing process, on its own with no evidence of cognitive impairment, that is not conclusive proof that Mr A had dementia;

- Mr A did not manifest cognitive impairment until August 2008;

- As Mr A's decline was most likely the result of "motor neurone plus syndrome" which was established at post mortem, the prescription of fluphenazine outside the manufacturer's guidelines did not actually impact on the ultimate outcome;

- 162.5mg of fluphenazine was administered to Mr A.

74. The DHB accepted that it cannot rely on experience to overcome shortfalls in policy and that it should provide clear guidelines for practitioners when prescribing medication outside of recommended dosages.

75. The DHB advised it has recently adopted the national medical chart which should avoid confusion over the amount of medication administered.

76. Since 2008, the DHB has had a psychogeriatrician, which has resulted in an improvement in the provision of services to older persons with dementia.

77. The DHB accepts that the separation of the psychogeriatric service from the Mental Health Services contributed to the absence of clear strategies for the two services to work together to meet Mr A's needs. In addition, the approach in the adult inpatient unit is to encourage independence and avoid being intrusive or directive, whereas the strategies used by dementia unit staff are different and much more intrusive and directive.

78. The adult inpatient staff lacked the skill and experience to deal with Mr A's condition.

79. Further improvements are anticipated when the psychogeriatric service comes under the management of the mental health directorate from 1 July 2011.

The family

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

80. The family noted that the nurses and staff were often more attuned to what was happening with the patients as they spent more time with them than did the doctors. They submitted that there needs to be a culture where those involved in the day-to-day care of patients are able and encouraged to speak up freely, and question orders given by "higher authorities" with regard to medication prescriptions and dosage levels.

81. They asked the staff to provide cares such as washing Mr A's clothes and person but they would not do it because they considered it "bullying" and that Mr A had a "right to refuse" that kind of care. The family feel that in a situation where people are incapable of caring for themselves and are committed to a mental health facility, common sense should prevail and the staff should provide necessary cares.

82. They believe compassionate staff would try to interact with patients, treat them with respect and help them retain their personal dignity so they are not left dirty or sitting in their own urine. Staff should also ensure that proper medical care is received, such as making sure patients take their medications, and looking after their wounds.

83. The acute unit had a high staff turnover and no one seemed to be in charge of Mr A's care. They consider that each patient should have one or two dedicated caregivers who fully understand the situation to make sure proper, consistent care is received, and adequate communication with family members is achieved.

84. The family believe that patients being treated for drug and alcohol addiction should be in a separate facility from patients with dementia and other mental health problems. If a separate facility cannot be developed, staff should receive training to cope with the differences between drug/alcohol patients and those with other psychological problems.

85. Staff at the hospital had a completely different mindset to those at the acute unit. They showed great compassion and wanted to do everything they could to help their residents.

86. As the area has a high number of elderly people there should be a full-time geriatric specialist.

87. They believe a drug overdose killed Mr A or at least contributed to his near-vegetative state and subsequent death. They consider that if they had not requested an investigation into his care, no one would have been alerted to the problems at the facility.

88. They believe it is important that Mr A's story is told so others, both the general public and the medical profession, may learn from it.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Opinion: Breach — Nelson Marlborough District Health Board

Introduction

89. Mr A was suffering a major psychotic illness when he was admitted to the unit under the Mental Health Act in January 2008. He was a danger to himself and others, and his psychosis had to be treated.

90. NMDHB submitted that it is unclear whether the fluphenazine administered to Mr A was the cause of his decline. That of course is not the issue. As a health care provider, NMDHB is subject to the Code and had a duty to provide Mr A with services of an appropriate standard.

Medication

91. My expert, Dr Perkins, said that the early attempts to treat Mr A with oral antipsychotics were "thwarted by lack of efficacy", either having no effect or causing unacceptable side effects. She explained that each drug was trialled for a month, and one would have expected to see a response if Mr A was taking the medication.

92. Mr A frequently began to refuse oral medication, and so he was given intramuscular fluphenazine, which apparently caused severe and limiting side effects. To control these symptoms Mr A was given another drug, Cogentin, which caused mental confusion and disorientation. Despite reducing the dose of fluphenazine and then stopping the medication, his symptoms remained.

93. In Dr Perkins' opinion, Mr A's psychosis had to be controlled, but the dosage used was too large for someone with dementia. Dr E explained that Mr A was a well built, physically mature adult, and it was their practice to prescribe doses of psychotropic medication in excess of the recommended guidelines.

94. Dr F advised HDC that fluphenazine is an injection that can be given weekly during acute stages and, although the recommended dose in young adults is 100mg per month, in clinical practice higher doses are at times needed and prescribed and "once a steady state is reached 100mg or more can be given as a single dose".[8] He considered that "much smaller" doses are recommended for elderly patients largely due to the common side effect of sedation, the inherent risk of falls, and because the elderly are more prone to developing tardive dyskinesia. He considered that the side effects that Mr A subsequently showed were of Parkinsonism, which is reversible.

95. Dr E stated that Mr A received less fluphenazine than appears from the records. Information from Dr H and the pharmacist at the public hospital also suggests that the records were inaccurate.

---

[8] The Medsafe Data sheet 2007 states: "The optimal amount of fluphenazine decanoate and the frequency of administration must be determined for each patient, since dosage requirements have been found to vary with clinical circumstances as well as with individual response to the drug ... Dosage should not exceed 100mg. If doses greater than 50mg are deemed necessary, the next dose and succeeding doses should be increased cautiously in increments of 12.5mg."

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

96. The recommended dose of fluphenazine for people over 60 years is 6.25mg as a test dose and subsequently ¼–⅓ the normal adult dose, which is 22–75mg every three weeks.[9] Even low doses can cause problems for people who are sensitive to the drug, and a person with dementia (whether Lewy body or some other type) could be sensitive to psychotropic drugs such as fluphenazine.

97. The records indicate that Mr A was administered between 162.5mg and 225mg of fluphenazine within a period of up to 40 days (see **Appendix 2**). My expert, Dr Perkins, is of the opinion that the doses of fluphenazine given to Mr A, even at the lower amounts indicated by Dr E, were larger and more frequent than acceptable. Dr Perkins said that she would err on the side of caution when medicating a person known to have a degenerative brain condition. She considered that 50mg every two weeks was a large dose for a person with any type of dementia.

98. Dr Perkins does not consider that Mr A's history supports a diagnosis of Lewy body dementia but, as a person with dementia of any type is likely to be sensitive to neuroleptics, considers that caution in dose size and frequency was warranted. She doubts that Mr A's severe side effects could have been predicted but believes the geriatric adage "start low and go slow" might have prevented this outcome. I agree.

99. Despite the varying information provided as to the amount of fluphenazine administered to Mr A, which is in itself unacceptable, the amount as determined by the DHB was 162.5mg administered between 21 April and 28 May.

100. I accept Dr Perkins' advice that this quantity and frequency of fluphenazine administered to Mr A was above the acceptable level for a man aged over 60 years with a degenerative brain condition. Given his circumstances, a more cautious approach would have been appropriate. In my opinion NMDHB failed to provide fluphenazine with reasonable care and skill and breached Right 4(1) of the Code.

Quality of care

101. Mr A's family believed that by leaving their father dirty and unkempt, the nurses failed to treat him with respect. Dr E defended the actions of the nursing staff, saying that when Mr A was unco-operative or aggressive it would have been unsafe to try to shower him under restraint.

102. The acting unit manager told Mr A's family that they left him dirty and unkempt because it would upset him if they attempted to intervene and, if they took his clothes at night while he was sleeping and laundered them, this would invade his privacy and amount to bullying. Mr A's family say that he was a sound sleeper and his laundry could easily have been handled while he was sleeping.

103. My expert, Dr Perkins, said that Mr A lacked insight into his poor hygiene, and the staff knew this. It was discussed at several multi-disciplinary team meetings, but no specific plan to deal with it was recorded. Dr Perkins acknowledged that staff in acute psychiatric units attempt to encourage independence and avoid being intrusive or

[9] Medsafe datasheet June 2007.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

directive, but the strategies used by dementia unit staff would have been helpful with Mr A. For example, they could have returned later when he was less irritable or sought help from his family.

104. I accept that Mr A would not have been easy to care for, but it is not uncommon in mental health or dementia units for there to be issues with hygiene and/or personal care. Organisations must have strategies for dealing with this. It is important to care for physical as well as mental health needs.

105. I do not accept that it would have been a breach of privacy or bullying to have laundered Mr A's clothes while he was asleep. I agree with Dr Perkins' view that there was insufficient attention paid to issues of personal care in an overall treatment plan, to ensure a consistent and effective approach to maintaining reasonable standards. It would have been appropriate to have had such a plan.

106. In a previous opinion,[10] the Commissioner found that a DHB breached Right 4(1) of the Code because the clinical staff did not have a clearly defined and structured management plan for a patient recognised by the clinical staff as challenging. Knowing the patient was "at the difficult end of a really difficult spectrum", it was even more important to have such a plan.

107. In another opinion about rest home care,[11] the Deputy Commissioner highlighted the responsibility of staff to explore different strategies, and work with families to manage difficult behaviour and poor personal hygiene in dementia patients.

108. In my view, this is another case where staff should have done more to manage the situation. Accordingly, it is my opinion that NMDHB breached Right 4(1) of the Code for failing to have a clearly defined plan and strategy to manage Mr A's behaviour and hygiene needs.

Tinea treatment

109. Mr A's family were concerned about the condition of Mr A's feet and his development of tinea. There is very little information in Mr A's records about the condition of his feet. However, he was referred to a podiatrist twice before his transfer to the public hospital, and the podiatrist arranged to see him there when he arrived. Tinea was first recorded on 3 September and treated on 6 September. I do not consider that the delay in treating Mr A's tinea amounted to a breach of the Code.

Record-keeping

110. I am concerned that accurate records were not kept of the amount of fluphenazine administered to Mr A. This has resulted in this Office receiving conflicting information and has impacted on the investigation of this complaint.

111. I am mindful of the following comments made by the Commissioner in relation to documentation of medication:[12]

[10] Opinion 05HDC09043, March 2006.
[11] Opinion 08HDC17105, August 2009.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"In her response to the provisional opinion, Ms A accepted that the record was 'not always completed accurately', but that 'it cannot be assumed that, because a medication is not recorded as having been given, it was not actually given'. However, Baragwanath J stated in his decision in *Patient A v Nelson Marlborough District Health Board*[13] that it is through the medical record that health care providers have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). In my view this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted. Furthermore, the failure to record medications given is poor practice, affects continuity of care, and puts patients at real risk of harm."

112. I note that the Medical Council of New Zealand publication *The Maintenance and Retention of Patient Records*[14] states: "Records form an integral part of any medical practice; they help to ensure good care for patients and also become critical in any future dispute or investigation." It requires a doctor to keep clear and accurate patient records.

113. In this case I have been informed that some medication recorded as having been given was not actually administered, and medication was administered on different dates to those shown in the records. In my view, an adequate medical record was not maintained. Accordingly, it is my opinion that NMDHB breached Right 4(2) of the Code for failing to clearly and accurately record the administration of fluphenazine.

Recommendations

114. I recommend that Nelson Marlborough DHB:

- apologise to Mr A's family for their breaches of the Code. The apology is to be sent to this Office by **4 July 2011** for forwarding to the family.

- prepare a policy regarding the pathway of care and communication with regard to geriatric patients with psychiatric problems, and provide the policy, together with details of implementation and training to this Office, by **5 August 2011**.

- advise this Office of steps being taken to ensure that accurate records of drugs administered are maintained, by **5 August 2011**.

---

[12] Opinion 08HDC10236, 28 November 2008, page 11.
[13] *Patient A v Nelson Marlborough District Health Board* (HC BLE CIV–2003–204–14, 15 March 2005).
[14] October 2005 and August 2008.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- develop a policy regarding the administration of drugs in excess of manufacturers' guidelines and provide a copy of that policy to HDC, by **5 August 2011**.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of the final report with details identifying the parties removed, but naming the DHB and the experts who advised on this case, will be sent to all district health boards and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 1: Independent expert psychogeriatric advice

The following expert advice was obtained from psychogeriatrician Dr Christine Perkins:

"**Report on [Mr A] 09HDC01408**

My information comes from a review of the inpatient notes 18.01.08 to 08.09.08, laboratory, X-ray and other clinical reports, reports from the family, HDC and [Dr E's] and [Dr K's] reports.

Initial comment
This is a very distressing case for all concerned, seeing a previously healthy man deteriorate so severely physically and functionally. Diagnosis was difficult to make and treatment complicated by side effects and non compliance. It appears that the family was kept well-informed and involved especially via [Mr D] as the main contact.

The issues to be commented upon include:

- making a definitive diagnosis and management of his medications
- the lack of personal care and treatment of tinea while in the mental health unit
- the apparent lack of qualified medical practitioners.

Diagnosis and treatment

Diagnosis
[Mr A] presented with his first mental illness at the age of 64. He appears to have been developing symptoms for the previous six years, although there was an abrupt deterioration two weeks prior to admission on 18.01.08.

On admission under the Mental Health Act he was suffering from religious delusions (believed he was God, or the son of God, and could heal people) and that invisible spirits were around him. He had auditory hallucinations including command hallucinations and had had visual hallucinations of his deceased wife.

Early on, his mood was thought to be elevated. Probably as a result of these symptoms he had stopped caring for himself and was dangerous when driving and possibly when in possession of a gun.

The preliminary differential diagnosis ([Dr G] 30.01.08) was late onset schizophrenia, bipolar disorder, mental disorder secondary to a medical illness.

<u>Schizophrenia</u>
The diagnosis of late-onset schizophrenia (paraphrenia) was supported by the presence of bizarre beliefs and prominent auditory hallucinations.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Bipolar disorder

The diagnosis of bipolar disorder was suggested by possibly elevated mood, the grandiose and religious nature of his delusions and increased activity. He is reported as 'over familiar, disinhibited' (28.01.08).

Mental disorder secondary to medical condition

There were no current medical problems or a known past history of significant illness (admission note 18.01.08). He had not seen his GP for ten years (OT assessment 27.02.08) and was taking no treatment for his physical health.

Possible medical conditions that may have affected his mental state include

Hypothyroidism

Initial laboratory testing indicated hypothyroidism (under-active thyroid). Apart from dry skin there were no physical symptoms of hypothyroidism. Hypothyroidism causes psychosis in 5–15% of cases (Heinrich & Graham 2003) but symptoms usually remit rapidly with replacement of thyroid hormone. On admission he did not have other mental symptoms suggestive of hypothyroidism, eg depression, fatigue, mental slowing, inattention, forgetfulness, emotional liability.

Parkinson's disease/symptoms

He did not have a prior diagnosis of Parkinson's disease and no symptoms suggestive of this were recorded when he arrived at the hospital. His son [Mr D] (30.08.08 by phone to [Dr K]) reported that there had been no physical slowing prior to admission. The physical examination done on 22 [January] did not indicate Parkinsonian symptoms (despite the fact that he was then taking 3mg/day of risperidone) or other neurological disorder. That is, on admission there was no evidence of Parkinson's disease.

Lewy body dementia (LBD)

The criteria for diagnosing probable Lewy body dementia are:

- progressive cognitive decline plus two of the following
- fluctuating cognition with variations in alertness and attention
- recurrent visual hallucinations that are usually well formed and detailed spontaneous motor symptoms of Parkinsonism.

Other criteria symptoms (minor) that further indicate LBD are:

- repeated falls
- syncope (fainting)
- transient loss of consciousness neuroleptic sensitivity*
- systematized delusions*
- hallucinations in modalities other than visual* (Norris & Haines 2003)

NB. These latter symptoms can occur in other forms of dementia. It is often difficult to accurately diagnose LBD.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In [Mr A's] case:
There was no clear history of progressive cognitive decline. Although his self-cares had deteriorated, this was initially (reasonably) assumed to be the result of his psychosis and preoccupation with religious matters. [Mr A] acknowledged being a poor housekeeper (OT report 27.02.08), something he attributed to his wife previously having done this.

On 05.04.08 he was reviewed by [Dr L], locum medical officer (Older Persons' Mental Health). [Dr L] noted a history of slow deterioration of mental state and activities of daily living (ADLs) over the previous six years (compatible with dementia). However, [Mr A] scored well on MMSE (29/30) a test of cognitive function (generally, dementia <24/30) despite still being grossly psychotic. Of interest, he gained full marks on the attention and construction parts of the MMSE. It is often these two areas that are first affected in LBD. [Dr L] could not make a diagnosis of dementia at that point and that his ADLs could improve with improvement of his psychosis.

On 07.04.08 the Dementia Rating Scale (DRS.2 was administered by [a] clinical psychologist) reflected 'moderate impairment'. While this is a useful screening test of a person's level of cognitive function, it does not necessarily explain why function is impaired. Results may have been affected by the ongoing psychosis and the large doses of haloperidol he was then prescribed (10mg daily reduced on 11.04.08 to 8mg daily because of shakiness). The result of any cognitive test has to be taken in conjunction with the history and clinical presentation and should be repeated when the person is optimally treated, if possible. It is very difficult to assess cognitive function when a person is actively psychotic.

There is no evidence of fluctuating cognition with variations in level of alertness or attention at admission. This is not mentioned in the history or reported in the initial inpatient notes.

Although there is a report that he had visual hallucinations of his wife (normal after bereavement), saw a 'bright light', smoke coming from his abdomen and that he may have 'seen' other people, this was not a prominent aspect of his presentation and seemed to have occurred earlier in his illness. The 'gits' that bothered him were invisible. People with LBD have well-formed hallucinations, often of people or landscapes and often they recognise these as hallucinations. Thus his visual hallucinations do not seem to be recurrent; well formed or detailed or otherwise characteristic of Lewy body disease.

He did not have spontaneous motor symptoms of Parkinsonism on admission (as noted above).

[Mr A] had three of the minor criteria for LBD systematised delusions and hallucinations in other modalities (auditory) on admission. As these symptoms occur commonly in a variety of psychiatric conditions they are not particularly useful in making a diagnosis of LBD. He clearly developed (or had) neuroleptic

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[drug] sensitivity but this was not something that could be recognised without first using neuroleptics.

In summary, the evidence early in his inpatient stay did not support a diagnosis of LBD.

Frontotemporal dementia (FTD)
The age of onset of FTD is typically in the 50s and the course is usually insidious with a slow progression. There is often a family history of FTDs. FTD is often mistaken for psychiatric disturbance because it commonly affects people in midlife and the first symptoms are often in the domains of personality and behaviour (Norris & Haines 2003 p.129).

The core diagnostic features are:

- behavioural disturbances, personality changes*
- affective symptoms (usually depression, though symptoms may overlap with mania)*
- speech disturbance
- intact spatial orientation and praxis (being able to do things)*
- physical signs, laboratory tests and imaging supporting diagnosis*
- typical changes on neuropsychological testing*.

Common cognitive impairments are:

- Progressive speech changes, starting with word finding difficulties, progressing through slow verbal production, stereotyped responses, eventually to mutism. Receptive language skills (i.e. understanding what is being said) remain intact.
- Impaired executive function, i.e. poor organisation, planning, sequencing and ability to shift set.*
- Cognitive and motor slowing and mental rigidity.
- Visuospatial, orientation, memory and reasoning abilities may be retained for longer.*
- Mood and behaviour disturbances. Mood problems typically include apathy, emotional aloofness, lack of empathy and lability (variable and rapidly changing mood).

Personality and behaviour changes
Include impersistence without purpose or directed goals, impaired judgement*, self-centredness, socially inappropriate behaviour*, neglect of personal hygiene*, poor insight and awareness*, inflexible and rigid routines*, perseverative (stuck on one thing) responses, excess oral stimulation and consumption and elaborate rituals.

Patients may be impulsive*, irritable*, aggressive, easily provoked and sexually inappropriate. Delusions are rare in FTD but may occur, occasionally. Visual hallucinations are very rare; late-life psychosis has been associated with frontal lobe infarction (poor blood supply).

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

As highlighted by asterisks (above) on admission [Mr A] had symptoms and signs more suggestive of FTD than LBD. This clinical diagnosis is strengthened by the CT and MRI findings and also the psychological testing (DRS.2 done 07.04.08) with poor performance on initiation perseveration and conceptualisation. A near normal MMSE test is compatible with FTD as the MMSE does not really test frontal lobe function.

[Mr A] developed severe speech disturbance eg perseverative speech (13.08.08) and mutism and cognitive and motor slowing later in his hospital stay.

Comment
The diagnosis is more likely to be front temporal dementia. Both LBD and FTD cause executive dysfunction. Patients with FTD can later develop Parkinsonism and hallucinations (Norris & Haines 2003).

Other
During [Mr A's] stay he developed delirium, secondary to a chest infection and to benztropine [Cogentin]. Delirium produces cognitive decline which is fluctuating in nature and this further confused the picture. I wonder if a depressive episode was considered when he developed mutism and withdrawal. Depression is commonly associated with FTD, post-psychosis and with fluphenazine.

Treatment
Regardless of diagnosis, the first goal of treatment was to get his psychosis under control. Treatment was difficult in that he was floridly psychotic, had no insight and could not see the need to take medication and was thus not compliant (including with thyroxine for hypothyroidism).

Medication: from drug charts
1. Thyroxine: 175mcg daily: this was sufficient, when taken to return thyroid function to normal.

Psychotropic medication

19.01.08 Risperidone up to 6mg daily until 7.03.08. Stopped because ineffective. He may not have been compliant. No mention of Parkinsonian side-effects (EPSE).

29.01.08 Sodium valproate (Epilim) added (to treat mood elevation) and increased to maximum of 1700mg per day before stopping on 20.01.08 because of apparent ineffectiveness.

12.02.08 Olanzapine 20mg nocte began and increased to maximum of 40mg daily after risperidone stopped. He was apparently compliant with this. There are intermittent reports that he improved, but this improvement was not dramatic and olanzapine was stopped. There is a mention that he may have been over-sedated, but this was not a persistent issue. Stopped on 25.03.09.

20.03.08 Started on haloperidol and increased to a maximum dose of 10mg daily. Problems with compliance (spitting out, holding in mouth)

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

with deterioration in mental state, bouts of 'shakiness' noted on 11.04.08 ? EPSE related to haloperidol. Haloperidol stopped 16.04.08.

14.04.08 Changed back to risperidone 2mg daily in form of quicklets to ensure compliance but continued to refuse. Stopped 6.5.08.

18.04.08 Fluphenazine [decanoate] 12.5mg test dose given and further 12.5mg dose on 21.04.08. No side effects noted on 23.04.08, so 25mg dose given on 23.04.08. He continued to refuse risperidone regularly and thyroxine often. He had a further dose of 50mg fluphenazine [decanoate] 30.04.08, i.e. the total given over 12 days was 100mg as well as being prescribed risperidone which he mostly appears to have refused. Psychotic symptoms persisted. No mention of EPSE.

Further doses of fluphenazine given: 50mg ? 8.5.08, tremor noted 8.5.08. Further 50mg given 14.05.08, on about 28.5.08, and given reduced dose 25mg because of emerging side effects. Slow gait tremor and restricted affect noted 17.05.08. On 19.05.08 [Mr A] said by social worker to be 'slightly confused'. Side effects required benztropine on 22.05.88. He was noted then to be 'a little vague'. Significant side effects noted from fluphenazine by 4.6.08 with some evidence of fluctuation in his presentation, cognitive impairment, wooden posture, difficulty getting out of bed because of leg stiffness. By 5.6.08 the decision was made to withhold fluphenazine.

These symptoms had not resolved by Sep 2008. The period of effect of fluphenazine [decanoate] is up to six weeks in adults, and probably longer in older people.

Comment

Psychotic symptoms affected [Mr A's] ability to care for himself and placed him and others at some risk. They masked possible underlying cognitive problems; the psychotic symptoms had to be treated.

Early attempts to treat him with oral antipsychotics were thwarted by the lack of efficacy. Each drug was given for about a one month trial, by which time, if compliant, one could expect some response in the absence of much in the way of side effects, even on quite large doses, one would assume that he was not compliant. Hence it seems reasonable to use depot medication after exhausting oral options.

After about three weeks on fluphenazine [decanoate] he developed Parkinsonian symptoms and fluctuating levels of cognition that despite reduction and then discontinuation of medication remained relatively permanent; hence the suggestion of LBD. However, a recent report suggests that sensitivity to neuroleptics can occur in people with FTD (Czarnecki, Kurnar & Josephs 2008) and in others without underlying dementia (Aronsen 1985).

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

My hypothesis is that the antipsychotic unmasked or precipitated a latent Parkinsonian syndrome, possibly related to an underlying FTD and/or cerebrovascular disease. It would have been difficult to predict such an outcome.

My concern, however, is that the doses of fluphenazine [decanoate] were large for an older man known to have brain damage. The manufacturer's recommended dose for people over 60 is 6.25mg for a test dose and subsequent 1/4–1/3 the normal adult dose which is 22–75mg every three weeks (Medsafe Data Sheet June 2009). A more cautious approach (... the geriatric adage: 'start low and go slow') may have prevented this serious outcome, although even low doses can cause problems in a person who is sensitive.

Other oral medication such as clozapine and quetiapine (which have fewer EPSE) were considered, but the issues with compliance would have remained. I note an alternate plan was to use risperidone depot if the psychotic symptoms recurred. This may have been less prone to cause side effects.

In relation to the large doses of fluphenazine (Modecate), [this] would meet with moderate disapproval of peers.

Lack of personal care

[Mr A] lacked insight into his poor hygiene and resisted attempts by staff to assist. His self-care seemed to deteriorate when he was mentally or physically unwell. It had also been poor prior to admission (?related to FTD or psychosis).

Staff were aware of his lack of personal care. This was noted in multidisciplinary team (MDT) meeting minutes. However, a specific plan to address this issue has not been recorded. It is a pity that the family did not know about this issue as they may have been able to help in some way. Nevertheless, some individual staff members appear to have been able to persuade him to look after his personal hygiene at times, and to take his clothes and wash them.

The usual approach in a dementia unit, if a person refuses care, is to go back later and offer to help when the person is less irritable. In an acute psychiatric unit staff usually try to encourage independence and avoid being too intrusive or directive. It could have been difficult to decide how to manage [Mr A], but this is not too uncommon a dilemma in Mental Health Units and it is important to look after patients' physical as well as mental health needs.

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Re tinea
[A house surgeon] examined [Mr A's] feet on 27.08.08 and no tinea was reported. On 20.08.08 a referral was faxed to a podiatrist (re toenails). A repeat referral was sent on 26.08.08 as he still had not been seen. On 03.09.08 the nursing note records: 'feet odorous/offensive' and suggested the use of an antifungal cream. This was not actioned as he was transferred to [the public hospital] the next day.

Either the house surgeon did not recognise that [Mr A] had tinea or the condition developed very quickly and the MHU did not have time to treat it.

Comment
While some individual staff managed [Mr A's] personal care well, there was insufficient attention paid to this in the overall treatment plan to ensure a consistent and effective approach to maintaining reasonable standards.

In relation to failure to provide appropriate planning to meet [Mr A's] personal hygiene needs [this] would meet with a mild to moderate departure from standards. He wasn't in a dementia unit (as per your note below) but an acute psychiatric unit. I can understand the philosophy of encouraging independence and avoiding intrusion, but this was probably not appropriate in [Mr A's] case.

Apparent lack of qualified medical practitioners
It would have been helpful if an old-age psychiatrist had been involved to get a good history (from family) regarding his cognitive state (to aid diagnosis) and to advise on treatment approaches. [Mr A] is a complicated case and would be very difficult for a general adult psychiatrist to diagnose and manage.

I am not sure whether [Dr L] was suitably qualified in old age psychiatry. Dr […] is suitably qualified but arrived late in the course of treatment.

I note that there was a wait for a geriatric opinion as [Dr K] was on leave (emails 22, 23, 25 July between [Dr I] and Dr […]).

A neurologist's opinion might also have been helpful if available.

[Mr A] was seen by several psychiatrists:
- [Dr G] (18.01.08 and 23.01.08)
- [Dr I]
- Dr […].

This may have reduced the continuity of care, though communication between [Dr I] and the others seems reasonable. [Dr H] (MO) seems to have been offered consistent support and [Dr F] and Dr […] were also involved.

Comment
It can be difficult to get staff for provincial hospitals, especially tertiary specialists like old-age psychiatrists. Mental health units are often staffed with

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

locums and it is challenging to maintain consistent cover when each stays only for a few months. As [Mr A] spent over seven months in the ward, there was bound to be some turnover.

When there is no local old-age psychiatrist available in [the region], perhaps the DHB could arrange for consultation with old-age psychiatrists from another DHB, by phone, telemedicine or the occasional visit, eg from Wellington or Christchurch.

In relation to their failure to consult a psychogeriatrician: [Mr A] was under 65 years old (the usual age cut-off is 65) and there were no psychogeriatricians readily available. Getting a psychogeriatric opinion is a bit of a luxury in many areas of NZ. Their failure to consult an old-age physician early would be a less than mild departure from standards.

Further expert advice from Dr Christine Perkins

"Thank you for the further information regarding [Mr A].

1. I accept that [Mr A] was a fit active 64-year-old man, who was not at all physically frail.

2. I also agree that his difficult and, at times, dangerous behaviour, along with non compliance with oral medication, warranted treatment with intramuscular antipsychotic medication.

3. He was found to have some degree of brain damage before he began on intramuscular fluphenazine. This would indicate that caution was needed. If the dose was 87.5mg over nine days (21.04.08 to 30.04.08) this was clearly better than I originally thought. However, I would still consider that and the 50mg per fortnight dose rather large for someone known to have dementia.

4. As a rule, I would cautiously interpret the manufacturer's dosage instructions in people with brain damage giving less than the recommended dose and working slowly upward from there. Nevertheless, I do not know whether his adverse reaction to fluphenazine was idiosyncratic or dose-related.

5. I cannot really comment on the expertise of any of the doctors involved. However, in a complex case like this (although [Mr A] did not meet the usual criteria) it may have been useful to seek the opinion of a psychogeriatrician.

6. To reiterate, I do not think the history supports a diagnosis of Lewy body dementia. However, anyone with a dementia of any type is likely to be sensitive to neuroleptics, hence caution in dose size and frequency is warranted.

I hope this adequately addresses [Dr E's] concerns."

In relation to a question put to Dr Perkins about the use of Cogentin she said:

"Cogentin can make people delirious, i.e. more confused but that isn't a very high dose [given to Mr A] and probably justified in attempting to treat symptoms. And they recognised it was a bit of risk and reduced then stopped it. So I don't have any major concerns."

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 2: Quantity of fluphenazine administered (as recorded in the clinical records, advised by [Dr E], and advised to the family)

Date	[Mr A's] clinical notes	Letter dated 15/4/10 from [Dr E]	Medication summary given to the family
18/4	12.5mg	nil	
21/4	12.5mg	12.5mg	12.5mg
23/4	25mg	nil	25mg
24/4	nil	25mg	
30/4	50mg	50mg	50mg
8/5	50mg	nil	
14/5	50mg	50mg	50mg
28/5	25mg	25mg	25mg
Total	225mg	162.5mg	162.5mg

Names have been removed (except NMDHB and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.