

‘Coughlan Compliance’ in Decisions on NHS Continuing Healthcare

Paragraph 90 of The Department of Health’s National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (2012) guidance, whilst cautioning against drawing generalisations about eligibility for NHS continuing healthcare, advises that *“CCGs should be aware of cases that have indicated circumstances in which eligibility for NHS Continuing Healthcare should have been determined, and where such an outcome would be expected if the same facts were considered in an assessment for NHS Continuing Healthcare under the National Framework (e.g. Coughlan...)”*.

In addition paragraph 40 of the NHS Continuing Healthcare Practice Guidance states that *“The DST [Decision Support Tool] supports practitioners in identifying the individual’s needs, which, combined with the practitioner skills, knowledge and professional judgement, should enable them to apply the primary health need test in practice, in a way that is consistent with the limits on what can lawfully be provided by an LA, in accordance with the Coughlan and Grogan judgements.”*

These refer to the Coughlan judgement¹. Pamela Coughlan is a C5/6 (complete) tetraplegic with no significant additional health needs. In 1999 the NHS tried to transfer responsibility for her care from themselves to the Local Authority (Social Services). Miss Coughlan took the NHS to court to stop them and the Court of Appeal found that she *“needed services of a wholly different category”* to those which social services can lawfully provide. She therefore was, and remains eligible for NHS Continuing Healthcare.

In order to assist assessors to follow the National Framework and Practice Guidance when deciding whether an individual has health care needs at least equivalent to those of Pamela Coughlan (which would make them eligible for NHS Continuing Healthcare) the Spinal Injuries Association has, in consultation with Pamela Coughlan, prepared a summary of her care needs in line with the Decision Support Tool.

This summary of Pamela Coughlan's Care Needs based on ‘Commentary and Advice for Local Authorities on The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care by ADASS & LGA October 2007: Additional Annex F1’ and Interview of Pamela Coughlan April 2012.

This summary can be read in conjunction with the BASCIS MASCIP Statement on Tetraplegia.

A short video of Pamela Coughlan can be seen at <http://www.youtube.com/watch?v=YaMXowPWxis>²

¹ R v. North and East Devon health authority ex p Coughlan (1999)

² SIA played no part in producing this video and the views expressed therein are those of Pamela Coughlan. SIA brings it to your attention as it enables you to have an insight into the level of disability and capabilities of Ms Coughlan and the consequent implications for her health care needs.

Background:

Injured in a road accident in 1971 (aged 28 yrs) and as a result became tetraplegic (C5/6 complete spinal cord injury resulting in both sensory and motor paralysis at this neurological level) and wheelchair-dependent.

Pamela Coughlan is dependent on others for all aspects of her personal care and daily living activities. However, her health care needs and her need for registered nursing care are neither complex nor unpredictable. Clinically and from a nursing perspective she is stable with predictable needs some of which present with medium risks e.g. regarding fainting if air flow was inhibited (managed by corset), spasm provoked by heat (e.g. touching a hot cup).

Behaviour	No behaviour that could be described as challenging.
Cognition	No cognitive impairment that had a significant effect on awareness of risk and delivery of care. She remained completely mentally aware.
Psychological and emotional needs	No evidence of psychological or emotional needs that impacted on her health and well-being.
Communication	She retains some (very limited) use of her hands with which she can write (with a pen strapped to her hand). She remains completely mentally aware, can access the Internet, converse freely and represent her views articulately.
Mobility	Paralysed in the lower part of her body with no movement in her legs, and limited movement in her upper torso. No triceps function in her arms. Requires hoisting (by 2 people) for all transfers and to be turned when in bed; However, once transferred into a wheelchair she has a reasonable amount of independence as she has retains some (very limited) use of her hands with which she can manoeuvre her electric wheelchair.
Nutrition – food and drink	Can eat independently using a spoon strapped to her hand provided that the food is cut up for her. Someone needs to hold a cup whilst she is drinking as her hand would spasm if she touched a hot cup.
Continence	She is doubly incontinent. Needing intermittent catheterization, every 3 hours (performed by nursing auxiliaries) as this proves the most effective way of keeping dry. Fluid intake is carefully managed. She wears incontinence pads in case of leakage, but rarely gets wet. <i>(Thus a well-managed need thereby minimizing risk of skin problems.)</i> Able to travel and stay dry when going out and about (visiting friends etc); she is accompanied only by a driver/handyman & manages her bladder by restricting fluid intake and using incontinence pads. Required insertion of docusate suppositories and digital removal of faeces ('manual evacuation') of her bowels every second night.

<p>Skin (including tissue viability)</p>	<p>Has no skin sensation or perception of skin damage on large areas of her body due to sensory paralysis and has high vulnerability to skin breakdown as is unable to change her position on bed or wheelchair without assistance. She required repositioning approximately 8 times per day to maintain skin integrity. Able to tolerate up to 12 hours sitting in wheelchair so long as pressure-relief is afforded. Uses silicon-foam cushion in wheelchair, but tolerates standard mattress as is turned (side-to-side) 3-times at night (at 0200, 0600 and 0900h).</p> <p>Returning to bed for intermittent catheterization every 3 hours (typically for a 10 min duration) affords pressure relief.</p> <p>Despite pressure-relief strategies, she has had pressure ulcers on her bottom, which although healed have high vulnerability to skin breakdown. Only once did pressure ulcer become infected, necessitating an extended period of bed rest.</p>
<p>Breathing</p>	<p>Wears a corset during the daytime to keep her chest upright without which she would have had breathing difficulties (shortness of breath as breathing is diaphragmatic only).</p> <p>There were no night care issues regarding her breathing.</p> <p>She was susceptible to chest infections (as paralysis of respiratory muscles prevents coughing to clear pulmonary secretions), which were relatively infrequent and not usually severe.</p>
<p>Drug therapies and medication: symptom control</p>	<p>All medication is routinely prescribed and administered by mouth; Senokot, Calcium, Iron.</p> <p>Once her condition (tetraplegia) stabilised she did not require an allocated consultant nor require any interventions from 'specialist' healthcare professionals.</p> <p>Requires insertion of docusate suppositories for bowel management every second day.</p> <p>She has constant neurogenic root pain in her left foot which does not respond to and is not amenable to control by analgesics.</p> <p>Does not require a regular programme of active or passive physiotherapy or exercise, although being assisted to stand twice per week helps with maintaining appropriate organ positions and strengthening her bones.</p>
<p>Altered states of consciousness</p>	<p>A medium risk of fainting if air flow was inhibited (managed by wearing a 'corset' – abdominal binder).</p>
<p>Other significant care needs</p>	<p>Autonomic Dysreflexia (very high blood pressure associated with sweating and pounding headache) as a result of pain or injury below the spinal injury site (C5/6). Autonomic dysreflexia first manifested ~20 years post-injury. Episodes of AD were very unpredictable – sometimes once per month, at</p>

other times several times in a week. There were usually triggered by overfull bowel/manual bowel evacuations or overfull bladder and were controlled by emptying the bladder by intermittent catheterization or by pausing the manual evacuation procedure and elevating her head (to lower blood pressure). On all but one occasion this management prevented the need for vasodilators (nifedipine).

Poikilothermia: Because of her injury she was unable to maintain her core body temperature, which was unstable and variable, and consequentially, because of excessive perspiration, she required changes of clothes and the corset up to three times a day. Pamela was able to tell when she was too hot or too cold and therefore proactive monitoring was not required regarding this aspect of her care.

Peripheral oedema: (swollen feet) due to immobility.