



Staffordshire and
Stoke on Trent Partnership

NHS Trust



North Staffordshire Rehabilitation Centre

Haywood Hospital
High Lane
Burslem
Stoke on Trent
ST6 7AG

Tel: 01782 673694
Fax: 01782 673912

Our ref: OS/LIJ/JJ
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Dr. H Van Der Linden
Trent Vale Med Practice
876 London Rd, Trent Vale
Stoke On Trent
ST4 5NX

HEAD INJURY
BROADFIELD
26/09/2015
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Dear Dr. Van Der Linden

Re: **David Wozny, DOB: 10/10/1969 Unit No.: D87050 NHS No.: 606 488 1291**
8 Eleanor Crescent Newcastle Stoke on Trent ST5 3SA

CLINICAL PSYCHOLOGY ASSESSMENT SUMMARY

Background

David suffered a head on collision with a car whilst cycling on his bicycle on 31/07/2015. He was admitted to the Royal Stoke University Hospital, where he received emergency neurosurgery. David was subsequently admitted to the Broadfield Ward on 25/09/2015 for a period of assessment and rehabilitation.

Reason for assessment

David was admitted to Broadfield as a polytrauma patient, having a severe traumatic head injury (extradural haematoma right side, focal contusions, base of skull fractures).

Considering the extent of his head injury, a request was made by the multidisciplinary team for a cognitive assessment to be carried out to assess David's cognitive functioning and neuropsychological status. Baseline screening measures of cognitive function indicated mild cognitive impairments.

With David's consent, the following assessments were carried out.

- Neurocognitive testing:
 - o Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
 - o Test of Premorbid Functioning (ToPF)
 - o Neurobehavioural Functioning Inventory (NFI)
 - o Frontal Systems Behaviour Scale (FrSBSe)

- Hospital Anxiety and Depression Scale (HADS)

Chief Executive: Stuart Poynor

Chair: Professor Nigel Ratcliffe

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- Clinical interviews with David and his partner
- Observations of David with physiotherapy and occupational therapy

Presentation during assessment

During the assessment period David has displayed a high level of engagement with staff from all disciplines. David is able to understand and comply well with task instructions and has maintained a good level of effort during all the assessments.

David has shown a high degree of self-motivation and appears to enjoy challenges presented to him. During these he would verbalise sound problem-solving strategies used which reflected good deductive reasoning. This solution-focused and determined approach appears consistent with his premorbid personality. David is self-employed as an IT consultant and achieved a first in his degree in Engineering. David's partner, Ruth, confirmed that she has observed no noticeable personality changes in David. Both David and his partner reported that a relative area of difficulty for David is his short-term memory, which has been present since before the injury. This has been evident in David using a range of compensatory strategies to carry out domestic and work-related activities – examples include frequently depending on notes recorded on his phone and ipad to remember information.

Frontal Systems Behaviour Scale (FrsSBE)

Given the extent of David's injury to the frontal lobe of the brain, the Frontal Systems Behaviour Scale (FrsSBE) was administered to both himself and his partner. This assesses behavioural functioning specifically related to the frontal lobes and systems of the brain – namely, executive functioning, disinhibition and apathy.

Both David's and Ruth's assessment revealed no significant impairments in relation to David's functioning in these areas.

Cognition

Initial screening of David's cognitive functioning, using the Montreal Cognitive Assessment (MoCA), revealed some mild cognitive impairment, particularly in relation to memory processing. A more comprehensive neuropsychological assessment was therefore carried out alongside an estimation of David's pre-morbid intellectual ability. This provides an estimated level of David's cognitive functioning prior to the injury, which enables comparisons to be made with his current performance.

Estimates of Pre-Morbid Intellectual Ability

An estimation of David's pre-morbid intellectual abilities was based on results gathered from the Test of Premorbid Functioning (ToPF) and also his educational history. The findings estimate that David previously functioned within the high average range of cognitive functioning.

Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)

The RBANS measures cognitive functioning across the following domains:

- Immediate memory (measures initial encoding and learning of verbal information)
- Delayed memory (measures delayed recall and recognition for verbal and visual information, including retrieving information from long-term memory)
- Language (measures expressive language, fluent use of language)
- Attention (measures the ability to register simple auditory information, visual scanning and processing speed)
- Visuo-spatial/Constructional (measures ability to perceive and process visuo-spatial information)

David's scores for this assessment are recorded in Table 1 below:

| | Immediate Memory | Delayed Memory | Language | Attention | Visuo-spatial |
|------------------------|-------------------------|-----------------------|-----------------|------------------|----------------------|
| Index Score | 76 | 64 | 80 | 94 | 112 |
| Classification | Borderline | Extremely low | Borderline | Average | High average |
| Percentile rank | 5 | 1 | 6 | 34 | 79 |

Scores on the RBANS fall within seven progressive categories as follows: *extremely low, borderline, low average, average, high average, superior, and very superior.*

The percentile rank refers to comparisons to a normative sample – that is how others of David's age, without a brain injury, would be expected to perform in these areas.

As depicted in the table above, David's scores for this assessment indicated that his current cognitive functioning for visuo-spatial/constructional and attention falls within *high average* and *average* ranges respectively. David scored within the *borderline* range for immediate memory and language whilst his scores for delayed memory fall with the *extremely low* range.

This suggests that David's brain injury has likely affected his cognitive functioning, particularly in relation to these latter three areas and especially for delayed memory. Whilst David has reported that he has always had a poor memory, even prior to the injury, the estimation of his premorbid functioning would predict higher levels than that which are recorded above - for both delayed and immediate memory as well as language and attention.

Further analysis of the subtests for the delayed memory domain suggest that David has a particular difficulty with long-term verbal memory encoding and retrieval – that is a high rate of forgetting information he has heard but a better chance of recalling information that is presented visually.

David's visuo-spatial/constructional abilities appear to remain a significant area of strength for him. It bodes well that David has these relative areas of strength, which can be drawn on in his rehabilitation. It is also important to note that David is very early in his journey of recovery and has shown remarkable improvements during his stay here on the ward. It is likely that he will continue to improve with time, more specifically over the coming months.

Neuro-behavioural Functioning Inventory (NFI)

In addition to this cognitive assessment, the Neuro-behavioural Functioning Inventory (NFI) was administered separately to both David and his partner.

This measure screens for a wide range of neurological disability related behaviours and symptoms within six key domains as follows:

- Depression (low mood, hopelessness, and social isolation)
- Somatic (headaches, sleep disturbances)
- Memory/attention (forgetfulness, distractibility, confusion and disorientation)
- Communication (speech, writing and reading difficulties)
- Aggression (being argumentative, verbal or physical abusive)
- Motor (physically slow, weak or problems with balance or coordination)

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For this measure, scores within the lower ranges depict a lower level of difficulty in these areas of functioning. Higher scores would suggest greater impairment in functioning.

David's self-reported scores for the NFI and those completed by his partner are summarised respectively in the tables below.

| | Depression | Somatic | Memory/ Attention | Communication | Aggression | Motor |
|------------------------|------------|----------|----------------------|---------------|------------|-------|
| T Score | 37 | 34 | 42 | 45 | 41 | 43 |
| Classification | Low | Very low | Low | Average | Low | Low |
| Percentile rank | 10 | 5 | 21 | 42 | 18 | 24 |

| | Depression | Somatic | Memory/ Attention | Communication | Aggression | Motor |
|------------------------|------------|---------|----------------------|---------------|------------|-------|
| T Score | 39 | 46 | 41 | 39 | 41 | 43 |
| Classification | Low | Average | Low | Low | Low | Low |
| Percentile rank | 14 | 34 | 18 | 14 | 18 | 24 |

The scores show David is perceived to fall within the low range for most domains, which suggests a low level of impairment in these areas.

It is perhaps surprising that no impairment has been noted in the Memory/Attention domain, given the RBANS score suggests significant deficits in delayed memory. However on the NFI, memory and attention is assessed as a single domain. Further analysis of the individual items that constitute this domain suggest that David's scores for attention-related competencies (a relative strength noted in both the RBANS and the NFI) may have elevated his scores in this domain on the NFI.

Furthermore it is possible that David has limited awareness of possible deficits in certain areas of cognitive functioning as he is currently not in a position to have these tested in real-life settings. He may tend to minimise these because of past patterns of attributing related difficulties to a relatively poor memory. Nevertheless it is encouraging that both David and his partner have observed a low level of impairment across all these domains, which could reflect the immense progress David has made in his rehabilitation whilst being on the ward. When David returns to his home environment and in time starts a process of returning to work, he will be able to test out these different areas of functioning in real-life situations.

Mood

In addition to the cognitive assessments completed, a mood assessment was carried out using the Hospital Anxiety and Depression Scale (HADS). David reported no clinically significant problems with anxiety or low mood. This is consistent with the cheery mood with which he has presented whilst remaining on the ward.

Recommendations

Feedback sessions were carried out with David and his partner to provide relevant psycho-education regarding the psychological assessments carried out and the interpretation thereof. This included reviewing

the recommendations below as a means of providing advice and guidance regarding David's continued rehabilitation following discharge from Broadfield Ward.

In particular it was recommended that David do the following:

1. Use a diary/calendar to note down important dates and times (such as appointments).
2. Keep a diary or a small notepad with you (such as on your phone or ipad) when you are out to make a note of something important that needs to be recorded or remembered later.
3. Identify a single area in the house that is visible and easily accessible to keep relevant items together (such as your keys, ipad, etc).
4. Establish a structured routine for upcoming weeks which includes specific time for rest.
5. For each activity, do not get tempted to keep going until you become fatigued. Instead pace yourself with rest periods and slowly grade up your activity levels (functional, vocational and social).
6. Create a filing system for all correspondence, content of appointments, bills and letters. Use separate compartments or trays and label these clearly.
7. Simplify environmental demands when completing tasks and/or processing information; ensure that the environment is as uncluttered and distraction-free as possible.
8. When completing new, prolonged or more complex tasks:
 - 8.1. Allocate time beforehand to consider the task in detail, read carefully any relevant material and to plan a procedure.
 - 8.2. Try to structure the task and section it into manageable steps.
 - 8.3. Keep a record of these activities – write out clear goals you have set with each step clearly defined. Make a note next to each one regarding whether or not this was achieved, and record the time you were able spend on each activity before tiring.
 - 8.4. After completing the activity, take time to consider the successes of the process and, if relevant, how you might complete the task differently if repeated.

David's partner and others who support him are advised to support David with the above recommendations as well as the following:

9. When conversing with David, do not overload him with too much information at once; instead break information down into manageable chunks.
10. Be receptive to when David may not have remembered something and be prepared to repeat the information.
11. Encourage David to write down and record key points of the relevant information.
12. Give David multiple opportunities to learn new information; talk things through with him to ensure he understands the information and encourage him to repeat it back to support successful encoding.
13. Try to help David to recall information by providing some cues/prompts to see if he can then remember it. For example, give him some choices to choose from, provide David with the first letter of the word or provide a cue to the context of the answer. Also, try directing David to any of the recording systems (e.g. calendar/note pad) he may be using which may have the information on it.
14. It is possible that David may experience frustration if he is not able to freely recall information. Support can be offered by validating these feelings and reassure David at these times.

Finally, a referral has been made by the MDT at Broadfield to the Bennett Centre, Neuropsychological service as well as North Staffordshire Community Healthcare Community Rehabilitation Team for them to consider seeing David in the community regarding his on-going goals as necessary.

Conclusion

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David has fully engaged in his rehabilitation and has shown a real commitment to remaining goal focused whilst transitioning through his post brain injury recovery. The progress David has made during his stay here on the ward is remarkable and it has been a privilege and a pleasure to witness this.

David is looking forward to continuing his progress in his home environment. He is highly motivated towards resuming domestic, leisure and work-related activities, which reflects his determination and resilience. David has a wide range of strengths to draw on, including the extensive support from his partner. It is not possible to predict the pace or extent of David's progress in his rehabilitation; however David and Ruth are encouraged to continue building on these strengths whilst prioritising periods of rest and allowing for the time needed in this continuing journey.

We wish David all the best for the future.

Please see the included recommendations which highlight strategies to help David, and those who support him, as he continues on his rehabilitation journey. If you require any further information please do not hesitate to contact myself or the team.

Yours Sincerely

Louise Joy-Johnson
Trainee Clinical Psychologist

Dr Oliver Sefton B.Sc.(Hons), PgCert (PCMHP), Dip.CBT, DClinPsych, CPsychol
Senior Clinical Psychologist (Neurorehabilitation)