SPSO decision report

Case: **201004466, Grampian NHS Board**
Sector: health
Subject: clinical treatment; diagnosis
Outcome: not upheld, no recommendations

Summary

Mr C was admitted to hospital after suffering a significant stroke. He underwent physiotherapy at three different centres (Centre 1, 2 and 3) specialising in stroke rehabilitation, to progress his recovery and achieve his goals of independent mobility and returning to work. Mr C complained about the care and treatment he received at two of the centres.

Mr C complained that he sustained a serious chest and shoulder injury while on a ward at Centre 1 as a result of inappropriate handling by nursing staff and that it had been aggravated by a physiotherapist working there and at Centre 2. Mr C was unhappy with Centre 2, saying that they did not provide physiotherapy for his specific needs. He also said they blocked his request to return to Centre 3, and cancelled his appointments following his complaint.

In response to the complaint, the board said that on admission to Centre 1, Mr C's shoulder was partly dislocated. They provided a shoulder support but he was allergic to this, so pillow support was provided instead. The board told Mr C that he received appropriate physiotherapy at Centre 1 and Centre 2. They said that there was no clinical indication that Mr C needed to return to Centre 3 and that his appointments were cancelled as he no longer wanted to be treated at Centre 2.

After referrring Mr C's medical records to one of our medical advisers, we did not uphold any of Mr C's complaints. We found that while the records showed that it was difficult for him to position his arm on the pillow, which might have led to some of his pain and injury, there was insufficient evidence to support his concern that staff at Centre 1 caused damage to his shoulder through poor handling. We also established that although there was no specific record of an incident at Centre 1 that could have caused trauma to Mr C's shoulder, there were clear notes of his pain and the effect this was having on his mobility and participation in therapy. We concluded, however, that there was evidence to

show that Mr C had been assessed, with treatment plans, goals and physiotherapy interventions in line with national guidelines for the management of stroke patients.

We found that the physiotherapy sessions at Centre 2 were not as regular as planned. It also appeared that Mr C was not initially provided with a home exercise programme. However, we concluded that overall his treatment was reasonable and there was evidence to show that physiotherapists there carried out an appropriate assessment, with a problem list drawn up and treatment plans put in place.

There was also evidence to show that Centre 2 fully considered Mr C's request to return to Centre 3 and gave reasons why it would not be appropriate to do so. We agreed with this decision as Mr C's level of function did not require in-patient care, and it was important at that stage for him to be in a home environment as recommended in the national guidelines.

Finally, we identified from Mr C's clinical records that referral to community physiotherapy was discussed with him as an alternative to being treated at Centre 2, as he did not want to continue his sessions there. We did not consider that Centre 2 acted inappropriately in referring Mr C for community physiotherapy treatment, as he was clearly dissatisfied with the service they were providing.