**Scottish Parliament Region: Highlands and Islands**

**Case 201204498: Highland NHS Board**

**Summary of Investigation**

***Category***

Health: Hospital; general medical; clinical treatment/diagnosis

***Overview***

The complainant (Mrs C) raised a number of concerns on behalf of her husband (Mr C), who was admitted to Raigmore Hospital (the Hospital) on 4 January 2012 after suffering a seizure. She complains that during his stay, Mr C was not given appropriate care and treatment, nor was he properly assessed for rehabilitation prior to his discharge.

***Specific complaints and conclusions***

The complaints which have been investigated are that:

(a) staff at the Hospital failed to provide Mr C with appropriate care and treatment following admission on 4 January 2012 *(upheld);* and

(b) staff at the Hospital failed to assess properly whether Mr C would benefit from rehabilitation on discharge from hospital (*upheld*).

***Redress and recommendations***

| The Ombudsman recommends that the Board: | *Completion date* |
| --- | --- |
| (i) make a formal apology to Mr and Mrs C for their failures; | 23 September 2013 |
| (ii) ensure that the consultant physician (Doctor 2)'s next appraisal includes this case, together with reflection on the Adults with Incapacity legislation and the specific rights of patients with dementia; | 21 February 2014 |
| (iii) conduct an audit on Ward 6C, relating to compliance with Adults with Incapacity legislation for patients with dementia, and satisfy themselves that all staff are fully apprised of its implications; | 21 November 2013 |
| (iv) formally apologise to Mr and Mrs C for failing to assess Mr C properly prior to his discharge from hospital; and | 23 September 2013 |

| | | |
|---|---|---|
| (v) | (with Mrs C's agreement) assess Mr C thoroughly to establish whether he would benefit from further physiotherapy input and, if he would, the Board arrange this. | 21 November 2013 |

The Board have accepted the recommendations and will act on them accordingly.

## Main Investigation Report

### Introduction

1. Mr C, who was born in 1952, suffers amongst other things from early dementia. He also has hearing and sight problems. On 4 January 2012, he was admitted to Raigmore Hospital (the Hospital) after suffering a seizure. It was thought that this may have been as a consequence of encephalitis but because a lumbar puncture picture was not possible (because Mr C was unable to co-operate) this was not confirmed. Mrs C said that on 11 January 2012, she told nursing staff that she thought her husband had had a stroke. However, it was not until 13 January 2012, after a physiotherapist noted that he had left-sided weakness, that the matter was reported to medical staff. It would appear that no action was taken on this until 16 January 2012, when Mr C was referred for a scan. This confirmed a possible, recent stroke.

2. The view subsequently taken by medical and physiotherapy staff was that Mr C had 'poor rehabilitation potential' and instead of being discharged to another hospital for rehabilitation as planned, it was later decided to discharge him to a nursing home.

3. Mrs C complained that her husband was not seen by a doctor after suffering a stroke nor was he given appropriate physiotherapy treatment.

4. The complaints from Mrs C which I have investigated are that:

(a) staff at the Hospital failed to provide Mr C with appropriate care and treatment following admission on 4 January 2012; and

(b) staff at the Hospital failed to assess properly whether Mr C would benefit from rehabilitation on discharge from hospital.

### Investigation

5. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the correspondence between Mrs C and Highland NHS Board (the Board). My complaints reviewer has also has sight of the Board's complaints file and Mr C's relevant clinical records. Independent advice was obtained from consultants in geriatrics and general medicine (Adviser 1) and physiotherapy (Adviser 2).

6. While this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Mrs C and the Board have been given an opportunity to comment on a draft of this report.

**(a) Staff at the Hospital failed to provide Mr C with appropriate care and treatment following admission on 4 January 2012**

*Mrs C's complaint*

7. Mrs C said that on 4 January 2012 her husband was admitted to the Hospital after suffering a seizure. She said that he had two further seizures in quick succession and she was told that he had a virus on the brain, for which he received intra-venous antibiotics. Mrs C explained that Mr C suffered from dementia and had problems hearing and seeing but that nursing staff took 'a dim view' of his lack of cooperation when they tried to get him mobile and she said she was told constantly that he was not helping himself.

8. On 11 January, Mrs C told nursing staff that she thought Mr C had had a stroke because his left arm was swollen and he could not use his left leg. However, she said she was told that this was because of the way he had been lying. The next day, Mrs C said that his condition had not improved and she found her husband slumped in a chair on his left side with a swollen, discoloured left foot. She said she was told that this was due to bad circulation and his foot was elevated.

9. Mrs C said that Mr C had a scan on 17 January 2012 and also a lumbar puncture. The day after (18 January 2012), she was informed that Mr C had had a stroke but that there was no point in giving him intensive physiotherapy due to his lack of hearing and frontal lobe dementia. Mrs C alleged that during this time, staff made no efforts to communicate with her husband and staff failed to show any patience or compassion towards him. She said he was later admitted to a care home, rather than a rehabilitation centre where he would have received physiotherapy. She contended that he has been 'left to vegetate' and on 6 August 2012 she wrote to the Board complaining about his treatment.

*The Board's response*

10. The Chief Executive to the Board replied to Mrs C's complaint on 3 October 2012. She said that as a result of the complaint, Mr C's case had been reviewed. The Chief Executive outlined the circumstances of his admission to the Hospital. She said Mr C was initially admitted to Ward 6A and then, the next day, he was transferred to Ward 6C where he had a

computerised tomography (CT) scan and a lumbar puncture. She said that unfortunately the lumbar puncture had not been successful because of Mr C's inability to cooperate with the procedure. On 6 January 2012, he was reviewed by a consultant neurologist (Doctor 1).

11. Following his transfer to Ward 6C, the Board said that Mr C was assessed by physiotherapy and it was advised that he should use full hoist transfers to follow instructions. However, if that improved (his ability to follow instructions) he would progress to using a wheeled zimmer frame. Mr C was reviewed again on 9 January 2012 by both a physiotherapist and a consultant physician (Doctor 2) and his treatment remained unchanged.

12. The Board advised that, on 12 January 2012, a further physiotherapy review was requested by nursing staff as Mr C's left arm was swollen. The Chief Executive said that this was initially thought to be because of the way he had been lying in bed. The next day, Doctor 2 reviewed Mr C on her ward round and decided that he should be referred to another hospital for rehabilitation. At the same time, she noted that her examination had been difficult due to Mr C's communication problems and lack of cooperation. The Board said that an attempt was made to address the communication problems by arranging a hearing assessment.

13. Later on 13 January 2012, a physiotherapist reviewed Mr C. It was noted that he had a new left-sided weakness and this was reported to medical staff. The physiotherapists were asked to continue to review him. The Board noted that there was no further medical entry in Mr C's notes until 16 January 2012, when he was seen again by Doctor 2. Doctor 2 noted the physiotherapy assessment and confirmed the new left-sided weakness and referred Mr C for another CT scan.

14. The Board said that since reviewing Mr C's case as a result of Mrs C's complaint, Doctor 2 indicated that Mr C should have had a medical review on 13 January 2012 after it had been reported that he had a new left-sided weakness. Doctor 2 apologised that this had not happened. However, Doctor 2 said that even if a further review had been carried out on 13 January 2012, the result would have been the same. The CT scan indicated a possible recent stroke. The Board said the result of the scan and further care options were discussed with Mrs C by another doctor (Doctor 3) on 18 January 2012.

15. The Board's letter went on to say that Doctor 3, together with a Senior Charge Nurse, met with Mrs C again on 23 January 2012 to discuss Mr C's current treatment. They said that there was also discussion about his now poor rehabilitation potential and that his transfer to the rehabilitation hospital would be of no benefit. The Board further added that the Senior Charge Nurse had raised the high level of nursing input Mr C required and that it was his view that it would be unlikely that Mrs C would be able to manage at home. The Board said that it was left that Mrs C would discuss the situation with the social worker.

16. Another meeting was held with Mrs C on 27 January 2012. The Board said that the physiotherapist, together with nursing and medical staff, were in attendance as Mrs C was still keen to discuss Mr C's rehabilitation potential. However, Mrs C was told that this was limited due to his reduced comprehension; further, that Mr C was unable to cooperate and was actively resisting. The Board said it was agreed with Mrs C on 28 January 2012 that social work would make contact to discuss a nursing home placement for Mr C and he was subsequently transferred there (on 3 February 2012). The Board advised that there was no physiotherapy planned for Mr C as there was thought to be no potential for rehabilitation. However, the Board apologised that Mrs C thought that the nursing staff had a poor attitude towards Mr C and said that a high level of intervention had been made. It was confirmed that Mr C was 'very complex in terms of the level of support required as his behaviour was very challenging and a lot of the time he would not participate or cooperate in his care'. The Chief Executive said she believed that staff tried to be compassionate, understanding and sympathetic to Mr C's needs, particularly taking into account his multiple on-going health issues and his challenging behaviour. Nevertheless, she apologised if this had not been apparent.

*Independent clinical advice*

17. My complaints reviewer discussed Mr C's care with both a clinical and a physiotherapy adviser (Adviser 1 and Adviser 2 respectively).

18. Adviser 1's view was that the initial medical care given to Mr C concerning his seizures and infection was reasonable. He said there was a good medical assessment of Mr C's presenting issues on admission and a CT scan of his brain was performed promptly. The medical staff then performed appropriate investigations and initiated treatment in Accident and Emergency and there was a review by a neurologist in clinic. There was also an electroencephalogram

(EEG or brain wave test) to exclude ongoing seizures as the cause of his symptoms.

19. However, Adviser 1 went on to say that he did find omissions in Mr C's care and he gave a list of examples. For instance, he said, he found no consideration of the effect of Mr C's dementia on his presenting symptoms or subsequent treatment. Specifically, Adviser 1 said, there was no assessment of the severity of his dementia, or the cause of the deterioration of his symptoms; there was no assessment of his capacity to make decisions; no completion of Adults with Incapacity certificates; limited assessment of the role of his Welfare Power of Attorney (that is, Mrs C) to guide decisions about his treatment and care; no specialist psychiatric involvement in the care of his symptoms while Mr C was in hospital; sedation with sleeping tablets was seen as the only solution for his night-time symptoms (with a comment in the notes about how Mr C was disrupting the ward); and no adequate period of rehabilitation from his initial illness as Mr C was assessed while he still had evidence of infection in his blood tests. His C-Reactive Protein (CPR– a measure of infection response by the body) was still elevated at the time decisions about his future care were being made; and no consideration of Mr C's ongoing physical or psychiatric care needs after discharge were considered.

20. While Adviser 1 said that he would not expect to find all of these items referred to in Mr C's notes, he said that it would have been reasonable to see many of them considered and documented. They were not.

21. With regard to Mrs C's assertion that on 11 January 2012 she told nurses that she believed Mr C had had a stroke, Adviser 1 said that there was no evidence of this in the notes. However, it was noted that a further physiotherapy review was requested by nursing staff as Mr C's left arm was swollen (see paragraph 12). On 13 January 2012, physiotherapy reported that Mr C had a new left-sided weakness but Adviser 1 said a review did not take place until 16 January 2012. As a minimum, Adviser 1 said, he would have expected that Mr C would have received a medical assessment the same day his symptoms were reported (see paragraphs 12 and 13). He added that while it was unlikely that Mr C would have required immediate emergency treatment, Mr C's ongoing care may have been modified and it could have changed some of his assessments. Adviser 1 said that the CT scan's findings (which was subsequently carried out on 17 January 2012) were subtle and the stroke had not caused significant changes on his brain scan. However, Adviser 1

commented that if Mr C's symptoms had happened at home and NHS 24 had been contacted, the response would have been an urgent visit by a GP or an ambulance would have taken him to hospital. In Adviser 1's view, Mr C received less care in hospital than he would have at home. As this was a new problem he suffered in hospital, it should have been considered in more detail. Adviser 1 said that Mr C should have been reviewed by a stroke physician or another specialist after the CT scan's results were known.

22. Adviser 1 was of the opinion that there was no specialist care for Mr C during his admission. He was not seen by stroke, psychiatric or rehabilitation doctors. He commented that the doctors who did discuss his care and potential discharge to a nursing home were junior doctors in the second year of training. He said that he saw little evidence of detailed consultant involvement or oversight in the discharge process.

23. Adviser 1 added that there was a Charter of Rights for People with Dementia and their Carers in Scotland which said, amongst other things, that:

> 'People with dementia have the right to health and social care services provided by professionals and staff who have had the appropriate training on dementia and human rights to ensure the highest quality of service. People with dementia and their carers have the right to information, to participation in decision making and, where rights are not observed, the right to seek remedy through effective complaint and appeal procedures.'

24. In the circumstances, overall, Adviser 1 said that Mr C's care fell below the standard he would reasonably expect. He said that his care needs were not adequately assessed and there were no meaningful attempts at rehabilitation or to discharge him home. His dignity was not respected. Mr C was treated and discharged without appropriate specialist care of his dementia and without regard to Adults with Incapacity legislation.

*Independent physiotherapy advice*

25. Adviser 2 said that during Mr C's stay in the Hospital there were five direct physiotherapy contacts recorded with him (on 6, 9, 13, 18 and 23 January 2012). Prior to 11 January 2012, Adviser 2 said that attempts to assess and treat Mr C by physiotherapists appeared to be broadly consistent with established practice in the context of his presenting features. At this stage, Mr C was considered to have rehabilitation potential and was on the waiting list for the rehabilitation hospital.

26. However, Adviser 2 went on to comment that on 6 January 2012, at his first physiotherapy assessment, the decision to choose between transfers using a full hoisting technique (which would not require Mr C to weight bear on his feet) and the use of a wheeled zimmer frame was left for nurses to decide based on any 'obvious' change. Adviser 2 said that given the early stage and complex presenting features of Mr C's condition, this decision should have been made on the basis of an updated assessment by the physiotherapist and not delegated to nurses over what was the weekend.

27. Adviser 2 went on to say that after the CT scan on 17 January 2012, which indicated a possible recent stroke, there was no evidence that Mr C was referred for a stroke specialist physiotherapy assessment. Adviser 2 said that 'the rationale did not appear to change pre and post stroke'. Nevertheless, it was recorded on 18 January 2012 that Mr C did 'appear to have good functional ability but limited by [confusion and agitation]', although by 23 January 2012, it was recorded that he was deemed to have 'limited rehab potential' (but Adviser 2 said Mr C did appear to improve somewhat, as the same day it was noted that he transferred to a chair with the assistance of staff using a zimmer frame). Adviser 2 noted that the plan was then altered to 'no physiotherapy input at present', but that if the situation was to change physiotherapy would be happy to review.

28. Adviser 2 also noted that on 19 January 2012, Mr C had evidence of infection and a confirmed urinary tract infection on 26 January 2012. He said both of these events would have had a significant impact on both his stroke symptoms and general performance. Adviser 2 said that this was not acknowledged by physiotherapists in Mr C's record as having any significance in his symptomology.

29. Generally, Adviser 2 said that in his view, the written evidence in the record suggested a lack of consistent, good quality stroke specialist clinical reasoning relating to Mr C's physiotherapy care. His overall rehabilitation was not consistent with clinical guidelines, or the evidence base, for the care of both stroke and dementia. He went on to say that little consideration appeared to have been taken of Mr C's pre-admission situation and its implications for his subsequent management. In Adviser 2's opinion there were clear signs of 'victim blaming' and frustration about the difficulties assessing Mr C and his impact on the ward staff and other patients. Adviser 2 further said that there

was little recognition that Mr C may have been disorientated and afraid and that his behaviour may have reflected this. As a result, Adviser 2 believed, there seemed to be little attempt to console him or ameliorate his distress in a strategic way. Adviser 2 said that none of this was under Mr C's control and staff should have been aware of this.

*(a) Conclusion*

30. The advice I have received from both independent advisers was clear; there was little appreciation of the fact that Mr C suffered from dementia and that this was not a matter within his control, regardless of any disturbance he may have caused. Similarly, there was no recognition that he may have been afraid and disorientated. Little appeared to have been done to reassure him. Mr C was seen as an inconvenience and he seemed to be treated as such. Indeed, Adviser 1 said that after it was suspected by his wife that he had had a stroke, Mr C would likely have received better care if this had happened when he was at home, rather than in hospital. None of this can be acceptable and is concerning.

31. Although Mr C's care and treatment initially appeared to have been reasonable, once it was reported to staff that he appeared to have left-sided weakness, he should have been assessed immediately rather than waiting for at least three days for a consultant review and another day for a CT scan. This should not have happened. Similarly, his physiotherapy care was less than optimal and no change in approach was made after his stroke. Mr C received no specialist care as the Advisers would have expected and there was little evidence of detailed consultant involvement.

32. Given the detailed advice I have been given (and referred to above), I am satisfied that the Board failed to provide Mr C with appropriate care and treatment during his admission to the Hospital in January 2012. I uphold the complaint. The Board should now make a formal apology to Mr and Mrs C for their failures. They should also ensure that Doctor 2's next appraisal includes this case together with reflection on the Adults with Incapacity legislation and the specific rights of patients with dementia. (In commenting on a draft of this report, the Board confirmed their willingness to comply with the Ombudsman's recommendations. They also confirmed that they had completed this particular recommendation.) Further, the Board should conduct an audit on Ward 6C relating to compliance with Adults with Incapacity legislation for patients with

dementia and satisfy themselves that all staff are fully apprised of its implications.

*(a) Recommendations*

| 33. I recommend that the Board: | *Completion date* |
|---|---|
| (i) make a formal apology to Mr and Mrs C for their failures; | 23 September 2013 |
| (ii) ensure that Doctor 2's next appraisal includes this case, together with reflection on the Adults with Incapacity legislation and specific rights of patients with dementia; and | 21 February 2014 |
| (iii) conduct an audit on Ward 6C, relating to compliance with Adults with Incapacity legislation for patients with dementia, and satisfy themselves that all staff are fully apprised of its implications. | 21 November 2013 |

**(b) Staff at the Hospital failed to assess properly whether Mr C would benefit from rehabilitation on discharge from hospital**

*Mrs C's complaint*

34. Mrs C contended that Mr C was not properly assessed before he was discharged from hospital. Both Mr and Mrs C were keen for him to return home and thought that he was to go to a rehabilitation hospital. However, it was later decided that he be discharged to a care home. Mrs C was extremely unhappy with this as she said that Mr C had been admitted to residential care without any physiotherapy care. She said that he has been given no chance of a future and she has been deprived of his companionship.

*The Board's response*

35. After Doctor 2 reviewed Mr C on 13 January 2012 as part of her ward round, she decided that he would be referred to a rehabilitation hospital. After it was confirmed that Mr C had likely suffered a stroke, on 18 January 2012, the Board said that Doctor 3 discussed further care options with Mrs C. A further meeting was arranged with Doctor 3 and the Senior Charge Nurse on 23 January 2012 (see paragraph 15) and the Board said that, amongst other things, Mr C's 'now poor rehabilitation' was discussed and how a transfer to the rehabilitation hospital would not be of any help to him. Mrs C was told she would be unlikely to be able to look after Mr C at home and Mrs C was to discuss options with a social worker.

36. The Board acknowledged that Mrs C was keen to consider Mr C's rehabilitation potential at a meeting on 27 January 2012 but that the physiotherapist confirmed that this was limited due to his reduced comprehension. It was pointed out that Mr C was unable to cooperate and was 'actively resisting intervention'. The next day (28 January 2012), the Board said it was agreed that a social worker would contact Mrs C to discuss a nursing home placement which was where Mr C was discharged. There was to be no physiotherapy planned as the Board were of the view that there was no potential for rehabilitation.

*Independent clinical advice*

37. My complaints reviewer specifically asked both advisers to review the documentation with regard to Mr C's discharge. Adviser 1 told her that the Scottish Government had given specific advice to Health Boards about the care of patients with dementia in 'Caring for people with dementia in Acute Care settings', a resource pack for staff issued by the Scottish Government in 2009. Amongst other things this said:

> 'The person with dementia should be given every opportunity for support to facilitate a successful return to their home environment from hospital. This will involve a multi-disciplinary team working together to maximise the person's potential. This type of assessment therefore requires a thoughtful, non–threatening and creative approach from the practitioner involved.'

38. Adviser 1 acknowledged that the rehabilitation of patients with dementia was harder for staff than for people without this diagnosis. He said the ability of patients to remember instructions - for example, about walking - can hinder continuous improvement. Accordingly, it was his view that staff needed to be more flexible and creative when treating patients with dementia. However, he said that it was not true that attempts at rehabilitation were futile and that barriers to rehabilitation like behavioural symptoms, delirium and medication all needed to be considered before rehabilitation could be said to have been tried unsuccessfully. Adviser 1 said that there was no justification to abandon attempts at rehabilitation until significant, flexible efforts had been made.

39. Adviser 1's view was that Mr C received no specialist care during his admission, including by a stroke, psychiatric or rehabilitation doctor. The doctor discussing Mr C's potential discharge to a nursing home with Mrs C was a junior doctor in the second year of training. Adviser 1 commented that there was little

evidence of detailed consultant involvement or oversight of the discharge planning process. Adviser 1's opinion was that Mr C's care needs were not adequately assessed, nor was Scottish Government advice followed (Paragraph 37). There were no meaningful attempts at rehabilitation or discharge home.

*Independent physiotherapy advice*

40. Adviser 2 expressed a similar opinion and said that there was no evidence in the records to suggest that increasing the care package to support Mrs C had been explored, although there were several references in the notes that both Mr and Mrs C wished Mr C to return home. Adviser 2 went on to say that, given that stroke was a condition which generally underwent a degree of recovery over time, the decision by physiotherapists (in collaboration with colleagues) to judge Mr C as having limited rehabilitation potential was premature and unreasonable (see paragraph 16). He added that even if Mr C was not capable of great change in his own particular functional performance as a result of his preceding difficulties, there was no clear evidence of any attempts to realise his, and his family's, wish to go home.

41. Adviser 2 went on to explain that the concept that a patient was only fit for rehabilitation if they could tolerate and comply with therapy assessment and treatment was limiting in its approach and lacked 'person-centredness'. He said it was his view that there was confusion about whether 'rehabilitation' constituted physiotherapy for Mr C, or whether it should really be comprised of efforts to manage his long term condition in a way that satisfied both Mr C and his family. Adviser 2 said that there was evidence in the records that a physiotherapist was part of a discussion with Mrs C as late as 27 January 2012, when Mrs C expressed her unmet concerns about a lack of ongoing 'rehabilitation'. He added that, despite the challenges of Mr C's pre-admission situation (which were recorded), home might have been a possibility with appropriate reappraisal of Mr C's care and rehabilitation needs in that context. Adviser 2 acknowledged that this would have taken time and an extended hospital stay but this was not offered. He said that although Mr C was referred to a medical social worker, this was solely in the context of securing a nursing home place, as opposed to reviewing his package of care at home; there was no documented consideration of potential referral to a community rehabilitation service which would have provided ongoing rehabilitation to support Mr C's discharge home. Adviser 2 said that there was a strong evidence base (Scottish Intercollegiate Guidelines Network (SIGN) 2008 – Management of

patients with stroke or TIA: assessment, investigation, immediate management and secondary prevention; and, SIGN 2010 – Management of patients with stroke: rehabilitation, prevention and management of complications, and discharge planning) for providing such a service to people with a stroke. He said that where there was a desire to care for someone at home, particularly in a case like Mr C's, where his ongoing management may have been simplified by more settled behaviour in a familiar environment, this should at least have been considered if the right health and social care provision was available.

42. Adviser 2 said that the wishes of Mr and Mrs C should have been paramount in the decisions regarding his ongoing care. They were not. He added that the decision to send Mr C to a nursing home, in his opinion, may have been premature as he was unlikely to have realised his recovery potential prior to the transfer to the care home and his capacity to return home was never seriously considered.

43. Adviser 2 concluded by saying that challenging behaviour, particularly in the context of clear evidence of infection and a brain injury such as a stroke in the very early stages of recovery, should not in itself be a rationale for discontinuing rehabilitative care unless the potential vehicles for recovery had been fully explored. Adviser 2 said that this did not happen in Mr C's case.

*(b) Conclusion*

44. Both Mr and Mrs C were keen that Mr C go home but the advice I have received was that this was never properly and fully explored. Both advisers said that this was contrary to advice from the Scottish Government and SIGN guidelines. Nor was the situation with regard to rehabilitation explored once it had been determined that Mr C had had a stroke. Rather, the view appeared to have been taken that the combination of Mr C's symptoms excluded him from the possibilities offered by rehabilitation; this, notwithstanding the fact that Mr C had not fully recovered from infection. Mr C's care appears to me to have been decided on the basis of expediency. This can never be right and I uphold the complaint.

45. In the circumstances, I recommend that the Board formally apologise to Mr and Mrs C for failing to assess Mr C properly prior to his discharge from hospital. Mr C has now been in the care home for more than a year with little or no physiotherapy input. I recommend that (with Mrs C's agreement) he is

thoroughly assessed to establish whether he would benefit from further physiotherapy input and, if he would, the Board should arrange this.

*(b) Recommendations*

| 46. I recommend that the Board: | *Completion date* |
| --- | --- |
| (i) formally apologise to Mr and Mrs C for failing to assess Mr C properly prior to his discharge from hospital; and | 23 September 2013 |
| (ii) (with Mrs C's agreement) assess Mr C thoroughly to establish whether he would benefit from further physiotherapy input and, if he would, the Board arrange this. | 21 November 2013 |

47. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

**Annex 1**

**Explanation of abbreviations used**

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| Mr C | The complainant's husband |
| The Hospital | Raigmore Hospital |
| Mrs C | The complainant |
| The Board | Highland NHS Board |
| Adviser 1 | The clinical adviser |
| Adviser 2 | The physiotherapy adviser |
| Doctor 1 | A consultant neurologist |
| Doctor 2 | A consultant physician |
| Doctor 3 | A doctor in his second year of training |
| SIGN | Scottish Intercollegiate Guidelines Network |

**Annex 2**

## Glossary of terms

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| Computerised tomography scan (CT) scan | creates detailed images of inside the body |
| C-Reactive protein (CPR) | a protein within the blood, levels of which rise in response to inflammation/infection |
| Electroencephalogram (EEG) | records the brain's electrical activity |
| Encephalitis | ccute inflammation of the brain |
| Lumbar puncture | a procedure where a needle is inserted into the lower part of the spine |
| Transient Ischaemic Attack (TIA) | a mini stroke |