SPSO decision report

Case: **201406499, Orkney NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mr C complained about the care and treatment of his wife (Mrs C). Mr C was particularly concerned that the clinical notes showed Mrs C had symptoms of a stroke late on the evening of her admission to the Balfour Hospital (and doctors were told about this), but her stroke was not diagnosed until the doctor reviewed her early the next morning. Mr C was concerned that the delay meant that Mrs C was not able to receive thrombolysis treatment (a kind of treatment that can only be used within 4.5 hours after the onset of a stroke), and this may have impacted on her subsequent condition.

The board explained that thrombolysis treatment was not suitable for Mrs C, because it was not clear at the time that Mrs C's condition was due to an acute stroke and in any case the 4.5 hour window for treatment had already passed by the time of admission. The board also explained that doctors are cautious in offering thrombolysis to patients with diabetes (which Mrs C had) because there is a higher risk of complications, and because low blood sugars can sometimes 'mimic' the effect of a stroke.

After taking independent medical advice, we upheld Mr C's complaints. We agreed that thrombolysis would not have been suitable for Mrs C, because there was no clear time of onset for her stroke and by the time her symptoms were clear it was over 4.5 hours from when she was last known to be well. However, we found that staff should have considered the possibility of a stroke when Mrs C was admitted, and this should have been diagnosed that evening when the symptoms became clearer. This would have enabled staff to explain the decision about thrombolysis to Mr and Mrs C at the time, and put in place appropriate monitoring and assessment of her deterioration overnight, as well as better managing her diabetes the next day.

Recommendations

We recommended that the board:

- issue a written apology to Mr C for the delay in diagnosing Mrs C's stroke; and
- ensure that staff involved reflect on Mrs C's care and discuss our findings, with reference to the specific points raised by the adviser.