SPSO decision report

Case: **201608873, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mr C complained about the care provided to his wife (Mrs A) during out-patient appointments at the cardiology department at Ninewells Hospital. Mrs A was referred to the cardiology department by her GP because of drop attacks (sudden episodes of collapse). Over the following 18 months, Mrs A attended consultations in the department and a number of investigations into her symptoms were carried out. During the period that Mrs A was waiting to be fitted with a cardiac event monitor device (a device to measure the heart's activity), she sustained a stroke and was admitted to hospital for treatment. Tests carried out during this admission indicated that Mrs A was in atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). Mr C complained that the board had failed to provide Mrs A with a appropriate treatment in view of her presenting symptoms and medical history.

We took independent advice from a consultant cardiologist. We found that the board managed Mrs A's condition appropriately, with the exception of the way they handled a referral from her GP approximately five months prior to the date of the stroke. We found that this referral described a change in Mrs A's symptoms and their pattern and the adviser said that the referral should have been considered more promptly and carefully by the cardiologist. The adviser said that further tests could have been considered and that, had these been carried out promptly, atrial fibrillation might have been diagnosed sooner. The adviser said that if atrial fibrillation was diagnosed, then medication would have been started and the likelihood of the subsequent stroke would have reduced. We were unable to conclude that better management would have changed the eventual outcome in this case. However, we upheld the complaint and made recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and Mrs A for the failings to handle the GP referral five months before the stroke in an appropriate manner. The apology should meet the standards set out in the SPSO guidelines on apology available at: https://www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Staff should carefully assess whether a referral highlights a change in symptoms and their pattern, before promptly considering whether further investigations or actions are indicated.
- Waiting times for routine investigations, such as a patient being fitted with a cardiac event monitor device, should be minimised as far as possible.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.