SPSO decision report

Case: **202005915, Golden Jubilee National Hospital**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained on behalf of their sibling (A) about the treatment A had received from the Golden Jubilee National Hospital. A had emergency surgery to repair a dissected aorta (a tear in the heart) and a pacemaker fitted. Following A's surgery, they suffered a ventricular fibrillation (abnormal heart rhythm) resulting in cardiac arrest. It was later established that A's ventricular fibrillation had been caused by an incorrectly programmed pacemaker. C complained to the hospital about how this could have occurred.

We took independent advice from a cardiologist (a doctor who can diagnose, assess and treat patients with diseases and defects of the heart and blood vessels). We found that A's external pacemaker had been incorrectly programmed and there was a failure to manage the resulting R on T event (when the temporary pacemaker delivers an electrical impulse to the heart at an inappropriate time causing an abnormal rhythm) leading to A's cardiac collapse. We found that the hospital had failed to provide A with a reasonable standard of treatment and upheld this aspect of C's complaint.

C also complained that following A's cardiac arrest, A was discharged too early from hospital and had not been provided with clear information regarding their cardiology rehabilitation and aftercare, resulting in a delay in A receiving appropriate follow-up appointments.

We found that A's post-surgical out-patient review had been delayed by seven weeks without explanation. We also found that the hospital's post discharge communication practice had contributed to the delay in A receiving appropriate cardiology follow-up and cardiac rehabilitation from their local health board. While we found that A's discharge was reasonable, the hospital had failed to provide A with appropriate cardiology aftercare. On balance, we upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A and A's family for contributing to the delay in A receiving appropriate cardiology follow-up and cardiac rehabilitation. The apology should meet the standards setout in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.
- Apologise to A and A's family for incorrectly programming A's external pacemaker and for failing to manage the resulting R on T event leading to A's cardiac collapse. The apology should meet the standards setout in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Ensure all junior medical staff rotating through ITU/HDU are trained in temporary pacemaker programming and troubleshooting.
- Ensure appropriate post discharge communication pathways are in place to ensure patients receive timely

follow-up from their local health board.

- Ensure post-surgical follow-ups are timely and in line with discharge summary.

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.