Scottish Parliament Region: Glasgow and Central Scotland

Cases 200502301 & 200600457: NHS24 and Lanarkshire NHS Board

Summary of Investigation

Category

Health: Clinical treatment; diagnosis
Health: Hospitals; general medical; clinical treatment; diagnosis

Overview

The complainant (Mrs C) raised a number of concerns that her husband (Mr C) had been wrongly diagnosed as having Bells Palsy by an NHS24 Nurse Adviser (the NHS24 Adviser) after he contacted NHS24 complaining of numbness in his face and index finger, slurred speech and a headache. Mrs C also complained that Mr C had been informed of the diagnosis inappropriately by the NHS24 Adviser and that he should have arranged for an ambulance for Mr C and treated him as a medical emergency. Instead, Mr C was advised by the NHS24 Adviser to attend the Primary Care Emergency Centre (PCEC) and an appointment made for him there.

Mr C drove to the PCEC himself and was seen by a GP (GP 1), who made a diagnosis of Transient Ischaemic Attack (TIA). After this consultation, he was allowed home and advised to see his own GP if he did not begin to feel better. Mr C then waited in the PCEC car park until Mrs C arrived. He re-attended the PCEC where, after a 30 minute wait, he was seen by a second GP (GP 2). Mr C was then admitted to hospital and found to have suffered a stroke. Mrs C complained about the consultation with GP 1 and the care offered to Mr C by the PCEC and Lanarkshire NHS Board (the Board).

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C was wrongly diagnosed and informed inappropriately of the diagnosis over the telephone by the NHS24 Adviser (*upheld*);
(b) the NHS24 Adviser failed to treat Mr C as a medical emergency and should have arranged an ambulance, instead of sending Mr C to an out-of-hours GP practice (*upheld*);
(c) GP 1 diagnosed Mr C wrongly and, therefore, treated him inappropriately *(upheld)*;

(d) GP 1 did not offer to admit Mr C to hospital *(no finding)*;
(e) GP 1 failed to record sufficient data about his consultation with Mr C *(upheld)*;
(f) GP 1 rushed his consultation with Mr C *(not upheld)* and;
(g) Mr C waited an unreasonably long time on re-attending the PCEC *(not upheld).*

Redress and recommendations

The Ombudsman had no recommendations to make in relation to NHS24.

The Ombudsman recommends that the Board:

(i) ensure that GP 1 shares this report with his appraiser at annual review and that he reflects on the comments made in this report regarding the diagnosis of a TIA;
(ii) review GP 1's record-keeping to ensure it meets the required standards of the regulatory bodies; and
(iii) write to Mr C with an apology for the failures which have been identified in this report.

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

Main Investigation Report

Introduction

1. On 6 December 2005 the Ombudsman received a complaint from Mrs C about the treatment and assistance received by her husband, Mr C, on 11 June 2005, after he phoned NHS24 complaining of numbness in his face and index finger, slurred speech and a headache. Mrs C complained that her husband had been wrongly and inappropriately diagnosed by the NHS24 Adviser that he was suffering from Bells Palsy. Mr C was advised to attend the local Primary Care Emergency Centre and an appointment was made for him there. Mrs C believed that, instead of allowing Mr C to drive himself to the PCEC, the NHS24 Adviser should have treated his case as a medical emergency and arranged for an ambulance for him. On attending the PCEC, Mr C was seen by GP 1, who diagnosed him as suffering from a Transient Ischaemic Attack (TIA). After the diagnosis he was allowed to return home and told to contact his own GP if he did not begin to feel better. Instead of returning home, Mr C stayed in his car at the PCEC car park until Mrs C arrived. They then re-attended the PCEC, where Mr C was seen by GP 2. He was then admitted to hospital and found to have suffered a stroke.

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

(a) Mr C was wrongly diagnosed and informed inappropriately of the diagnosis over the telephone by the NHS24 Adviser;
(b) the NHS24 Adviser failed to treat Mr C as a medical emergency and should have arranged an ambulance, instead of sending Mr C to an out-of-hours GP practice;
(c) GP 1 diagnosed Mr C wrongly and, therefore, treated him inappropriately;
(d) GP 1 did not offer to admit Mr C to hospital;
(e) GP 1 failed to record sufficient data about his consultation with Mr C;
(f) GP 1 rushed his consultation with Mr C; and
(g) Mr C waited an unreasonably long time on re-attending the PCEC.

Investigation

3. The investigation involved obtaining and considering the relevant documentation and correspondence from NHS24, relating to the complaints against them, and Lanarkshire NHS Board (the Board), in relation to the complaints against GP 1. This included correspondence relating to Mrs C's complaint and Mr C's clinical records. I also obtained from NHS24 a recording on CD of the telephone conversation between Mr C and the NHS24 Adviser on

11 June 2005 when he phoned NHS24. I sought advice on Mrs C's complaints from three of the Ombudsman's professional advisers. They were a nursing adviser (Adviser 1), an Accident and Emergency (A&E)/hospital adviser (Adviser 2) and a GP adviser (Adviser 3).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C, NHS24 and the Board were given an opportunity to comment on a draft of this report. On receipt of the draft report the Board commented that there is work ongoing by the Out of Hours National Strategy Group to establish a National Performance Indicator for Acute Stroke. They stated that in line with emerging Scottish Intermediate Guidelines Network guidance, and to identify potential stroke patients, out-of-hours PCECs, NHS24 and the Scottish Ambulance Service are seeking to incorporate the FAST (face arms speech test) into clinical practice with an aim to achieve treatment of stroke patients within three hours. The Board also commented that they have developed referral processes for routing A&E patients into the out-of-hours service and vice versa and that they believe this should assist in ensuring patients are seen by the most appropriate clinician.

(a) Mr C was wrongly diagnosed and informed inappropriately of the diagnosis over the telephone by the NHS24 Adviser

5. In response to Mrs C's letter of complaint to NHS24, NHS24's Nurse Director wrote on 5 August 2005, saying:

> 'I would confirm that [the NHS24 Adviser] informed your husband that he had symptoms that were suggestive of Bell's Palsy but that he required a medical assessment undertaken by a General Practitioner to determine the diagnosis.'

6. NHS24's internal complaint investigation form into Mrs C's complaint states the following, under the heading 'Investigator's Conclusions':

> '[The NHS24 Adviser] suggests to the patient that his symptoms were those of Bells Palsy and while some symptoms are similar to a stroke, the Nurse has not fully explored the presenting signs and symptoms.'

7. Adviser 1 stated, having reviewed the case, that the NHS 24 Adviser inappropriately and wrongly made a diagnosis for Mr C. She continued by stating that the symptoms of Bell's Palsy were not those described by Mr C when he phoned NHS24 in that Bell's Palsy, whilst consisting of facial

numbness, does not include tingling and numbness in a limb. Adviser 1 stated that the NHS24 Adviser inappropriately made a diagnosis for Mr C, and in doing so, made the incorrect diagnosis.

8. Having reviewed the recording of the conversation between Mr C and the NHS24 Adviser on 11 June 2005, Adviser 1 commented that, on the tape, the Call Handler was heard indicating to the NHS24 Adviser that Mr C was presenting with three symptoms: numbness on left side of face, tingling down the left arm and numbness in his left finger. During the consultation Mr C appeared to offer other clues, such as feeling drunk and having a pain in the back of his head. The sound was somewhat poor at times, due to the fact the Mr C was in his car and some of his responses were muffled, however, Adviser 1 noted that he did also say at one point that he felt that he was not 'speaking right'. The NHS24 Adviser concluded by saying that it was really only the face numbness that was affecting Mr C and that he didn't think Mr C was suffering a stroke and hence gave the possible diagnosis of Bells Palsy. In view of what Mr C had been describing, Adviser 1 stated that she would not have agreed with the NHS24 Adviser's diagnosis of Bell's Palsy.

9. An additional aspect of Mrs C's complaint was that, as well as the diagnosis being incorrect, it was wrongly conveyed to Mr C by the NHS24 Adviser over the telephone when they were not qualified to do so. NHS24's Nurse Director wrote to Mrs C on 5 August 2005 that:

> 'Whilst some presenting symptoms can enable the nurse adviser to make a differential diagnosis, the fundamental role of the nurse adviser in NHS24 is to assess and identify each patient's clinical need and to decide who is the right person to treat the symptoms, when the treatment is required and where this will be met. It was inappropriate of [the NHS24 Adviser], however, to suggest that your husband might be suffering from a Bell's Palsy and I would offer you my sincere apologies that this occurred.'

10. Adviser 1 indicated in her advice that it was not the primary role of a nurse adviser to make a diagnosis over the telephone even though clinical decision making, by its very nature, must include consideration of potential clinical diagnoses. Their key role was to ensure the most appropriate access to healthcare for the caller, whether this be self-help advice, access to an out-of-hours GP service or direct transfer via ambulance to the nearest A&E Department. Adviser 1 wrote that it is clear that the NHS24 Adviser both

inappropriately and wrongly made a diagnosis for Mr C, which did not result in the optimum level of care that that he deserved.

(a) Conclusion

11. Having reviewed the recording of the telephone conversation between Mr C and the NHS24 Adviser, and from Mr C subsequently being found to have suffered a stroke, it is clear that Mr C was wrongly diagnosed as possibly suffering from Bell's Palsy by the NHS24 Adviser. Adviser 1 has stated that the symptoms described by Mr C would not have led her to believe that he was suffering from Bell's Palsy.

12. In terms of the diagnosis being conveyed over the telephone, NHS24 accept that their adviser's actions in diagnosing Mr C over the telephone were inappropriate. This view is backed up by Adviser 1. I accept the view of Adviser 1 regarding the wrong diagnosis; the appropriateness of the NHS24 Adviser making the diagnosis in the first place; and informing Mr C of his view over the telephone. In all the circumstances, therefore, I uphold this complaint.

13. In their formal response to Mrs C's letter of complaint, NHS24 apologised to Mrs C and stated that it was inappropriate for the NHS24 Adviser to state that Mr C might have been suffering from Bell's Palsy. As a result of their investigation, they have told me that they reviewed a number of the NHS24 Adviser's calls and found them to be clinically appropriate. Additionally, the Team Leader (Senior Nurse) with responsibility for the NHS24 Adviser implemented a development plan, focusing on vascular disease. NHS24 have also advised me that all their nurse advisers are subject to a review of their calls on a monthly basis. Adviser 1 has indicated that the decision to implement the development plan was an appropriate action and she is satisfied with the remedial action taken by NHS24. I accept the view of Adviser 1 and, consequently, have no recommendations to make regarding this aspect of Mrs C's complaint.

(b) The NHS24 Adviser failed to treat Mr C as a medical emergency and should have arranged an ambulance, instead of sending Mr C to an out-of-hours GP practice

14. Mrs C complained that her husband Mr C drove himself to his appointment at the PCEC rather than an ambulance being arranged to take him there. Mr C did manage to drive himself to the PCEC centre but there is an additional point

to this aspect of Mrs C's complaint. Part of Mrs C's complaint related to the care that Mr C received from GP 1 when presenting to the PCEC. Had an ambulance been arranged to transport him from the roadside, where he phoned NHS24 with his symptoms, he would have gone straight to the A&E department rather than be sent to the PCEC.

15. During the call from Mr C to NHS24, the NHS24 Adviser ascertained Mr C's location in case he became more unwell while speaking to him and the NHS24 Adviser did encourage him to be taken to the PCEC by a family member rather than drive himself (see paragraph 20).

16. Mrs C also alleged that NHS24 failed to treat her husband's symptoms as a medical emergency, taking fifteen minutes to return his telephone call and arranging an appointment with a GP for over an hour later.

17. NHS24's response to Mrs C's letter of complaint on 5 August 2005 detailed the timing of the events that occurred on 11 June 2005. It showed that the NHS24 Adviser commenced the conversation with Mr C at 13:01. The call lasted seven and a half minutes and ended at approximately 13:09. The NHS24 Adviser phoned the NHS Lanarkshire Out-of-Hours Service at 13:09 to arrange an appointment at the PCEC. An appointment was arranged for 14:09 and at 13:10 the NHS24 Adviser phoned Mr C back to inform him of the appointment.

18. From NHS24's records, it was clear that the time taken between first speaking to Mr C and phoning back with the appointment was taken up with making arrangements for the appointment at the PCEC. There was no delay in the NHS24 Adviser phoning Mr C back with the details of the appointment.

19. In their letter of 5 August 2005 responding to Mrs C's letter of complaint, NHS24 accepted that the NHS24 Adviser should have arranged for an ambulance to transport Mr C rather than to simply offer it. They made reference to the fact, evidenced in the recording of the telephone conversation, that Mr C indicated during the conversation that he refused an ambulance and indicated that he was able to drive himself. NHS24 accepted, however, that the NHS24 Adviser should have insisted that Mr C accept ambulance transport. NHS24 apologised for this and stated that the call was reviewed by the NHS24 Adviser along with their Team Leader (Senior Nurse); that learning

outcomes have been determined; and incorporated into the NHS24 Adviser's personal development plan.

20. NHS24's internal complaint investigation form into Mrs C's complaint stated the following, under the heading 'Investigator's Conclusions':

> '[The NHS24 Adviser] should not have left the decision to attend the PCEC to the patient as this involves Clinical Risk. The patient may have deteriorated and may not have been able to contact a relative or friend to drive his car as was suggested by Nurse. The patient also states he has no credit on his mobile phone.'

21. When receiving calls, NHS24 Nurse Advisers use triage algorithms to offer support to the adviser in their clinical decision making. Adviser 1 questioned in her initial advice whether the algorithm used by the NHS24 Adviser, 'Facial Pain', was appropriate to the symptoms being described by Mr C during his telephone call. NHS24 maintain that 'Facial Pain' was appropriate given Mr C's main presenting symptom although they accept that other algorithms could also have been used, including 'Weakness' and 'Headache'. This was, however, contradicted in the findings of their internal Complaints Investigator, who wrote in the internal Complaints Investigation Form that 'The Algorithm used was not appropriate but outcome was 999 which the Nurse changes to GP 4 hours'.

22. NHS24 stated in their letter that, no matter which algorithm was used, they would all have resulted in the same outcome, namely that an ambulance be arranged for Mr C.

(b) Conclusion

23. Mrs C alleged that the NHS24 Adviser failed to treat her husband as a medical emergency by taking fifteen minutes to return his call and arranging a GP's appointment for over an hour later. I am satisfied that there was no delay in returning the call to Mr C and the time in between was taken up with the NHS24 Adviser arranging the appointment at the PCEC. However, NHS24 accepted that the NHS24 Adviser was wrong not to insist that Mr C accept an ambulance to transport him. Had that happened, Mr C would have been transferred straight to the A&E Department (see paragraph 14). Nevertheless, NHS24 took appropriate steps to review the call with the NHS24 Adviser, to ensure that he did not repeat the incident. There is no doubt that the triage algorithm used, and others which NHS24 maintained would have been appropriate to use, should all have resulted in an ambulance being arranged for

Mr C but that the NHS24 Adviser changed this to 'GP 4 hours' and allowed Mr C to drive himself. I, therefore, uphold this aspect of Mrs C's complaint.

24. I accept the view of Adviser 1 that she is satisfied with the remedial action taken by NHS24 and I am content that NHS24 have formally apologised to Mrs C in their letter of 5 August 2005. I, therefore, have no recommendations to make in regard to this aspect of Mrs C's complaint.

(c) GP 1 diagnosed Mr C wrongly and, therefore, treated him inappropriately

25. Mr C drove himself to the PCEC, arriving at 14:10. At 14:51 he saw GP 1. The consultation lasted 12 minutes and ended at 15:03. Mrs C alleged that GP 1 diagnosed her husband incorrectly and, therefore, he was treated inappropriately. Adviser 3 stated in his advice to the Ombudsman that the computer records for the consultation showed that GP 1 diagnosed (TIA) because he found that Mr C had a raised blood pressure of 169/110; with a numbness of the hand (which was improving); no carotid bruit (a noise heard when listening with a stethoscope over the carotid (neck) artery which would indicate a narrowing of the artery - usually due to atherosclerosis - and the possible need for admission to hospital for surgery) (in parentheses the absence of a bruit does not rule out the possibility of the carotid artery being the source of emboli causing the TIA/stroke); with normal pulse rate; normal pupil size; and no signs of meningism.

26. Adviser 2 stated that TIA is, by definition, transient and cannot, therefore, be diagnosed unless the symptoms have completely resolved. This may take minutes or hours but should always be within 24 hours. In this case the patient was discharged by GP 1 still with residual symptoms.

27. Adviser 3 went on to state that, again, if the symptoms are still there after 24 hours then the diagnosis would not be TIA but, rather, a stroke. Mr C's symptoms did last for more than 24 hours and he did suffer from a stroke.

28. Adviser 3 also maintained that a diagnosis of TIA could not have been made at the time Mr C presented to GP 1. A possible diagnosis might have been TIA should the symptoms have ceased within 24 hours of them first appearing. In Adviser 3's view, GP 1 did not diagnose Mr C correctly.

(c) Conclusion

29. Adviser 2 and Adviser 3 both indicate their belief that it is not possible to diagnose a TIA until 24 hours after the symptoms first become apparent. This is because a TIA, by definition, cannot be determined until the patient has recovered. A TIA that is not transient is an ischaemic attack, ie, a stroke. Having wrongly diagnosed Mr C, GP 1 then prescribed Mr C aspirin and bendrofluazide and allowed him home. It may have been acceptable to diagnose a possible TIA but to diagnose a TIA was incorrect. As can be seen in paragraph 33, Mr C should have been admitted to hospital. Consequently, the decision to prescribe medication and then allow Mr C home was incorrect. I, therefore, uphold the complaint.

(c) Recommendation

30. The Ombudsman recommends that the Board ensure that GP 1 shares this report with his appraiser at annual review and that he reflects on the comments made in this report regarding the diagnosis of a TIA.

(d) GP 1 did not offer to admit Mr C to hospital

31. The Board's response to Mrs C's letter of complaint stated that GP 1 considered Mr C was improving but that GP 1 had advised that he did give Mr C the option of being admitted to hospital. The Board noted that this is different to Mrs C's understanding that this option was not offered.

32. Adviser 3, reviewed the clinical records from the consultation (see paragraph 25) and, having done so, it was his view that the records did not show any evidence that GP 1 offered Mr C the option of hospital admission.

33. It was the view of Adviser 2 that Mr C should have been admitted to hospital. Adviser 2 wrote that even if admission were offered, and there was no evidence of this, failure to document this was poor practice and the follow-up advised was inadequate. Adviser 2 expressed the opinion that a young man like Mr C with these unresolved symptoms should have been admitted or, failing that, very definitely arranged early follow-up and not just 'return to GP if not resolving'.

(d) Conclusion

34. The Board, in their response to Mrs C, stated that GP 1 informed them that he did offer to admit Mr C to hospital. This is different from Mrs C's understanding of the course of events. There is no evidence recorded to

determine whether GP 1 did or did not offer to admit Mr C to hospital. GP 1 stated that he did offer admission and Mrs C contended that this was not the case. In the absence of evidence, I cannot reach a conclusion on whether or not Mr C was offered admission during his consultation with GP 1 to hospital and, therefore, make no finding on this aspect of the complaint.

(d) Recommendation

35. Although I have not made a finding this is largely a result of the decision to, or not to, offer admission not being recorded in GP 1's clinical record of the consultation. Had GP 1 offered admission and the offer been refused, then the advice I have received is that it would have been appropriate for this to be recorded on the clinical record of the consultation. The Ombudsman, therefore, recommends that the Board review GP 1's record-keeping to ensure that it meets the required standards of the regulatory bodies.

(e) GP 1 failed to record sufficient data about his consultation with Mr C

36. Mrs C, in making her complaint to the Board, alleged that when Mr C was subsequently seen by GP 2 she referred to the computer to access the notes from Mr C's consultation with GP 1 but that insufficient data had been recorded. Mrs C contended that nothing had been entered or documented from the consultation, other than it being written that Mr C had been given a prescription and that his blood pressure was very high.

37. The Board wrote to Mrs C on 5 September 2005 and, in answer to her question, 'Why when [GP 2] went to review [GP 1]'s consultation was there minimal data on the screen' they responded that '[GP 2] accessed all the data that was placed on the computer by [GP 1]. [GP 2] noted that there was little data of information on the computer for her to establish the severity of the symptoms and signs present on examination at the time of [GP 1]'s consultation. Regardless of the information available to [GP 2], she based her decision to admit [Mr C] based on her own assessment'.

38. Adviser 3 considered the clinical data recorded by GP 1. Adviser 3's expressed view was that GP 1's entry did not evidence the extent of the numbness and loss of power of Mr C's left arm; nor did it make mention of any paralysis of the face. These symptoms were mentioned in the telephone call between Mr C and the NHS24 Adviser, recorded by the reception staff at the PCEC and also by GP 2 during her consultation. As such, Adviser 3 offered the view that the records were not those he would expect of a GP.

(e) Conclusion

39. The Board, in addressing the question of why little information appeared to have been entered in the clinical records about the consultation between GP 1 and Mr C, indicated that GP 2 had reached her decision about how best to treat Mr C with the information available but noted that there was little information regarding the severity of Mr C's symptoms and signs entered during the time Mr C saw GP 1. On reviewing the clinical notes, Adviser 3 advised that the notes were not as he would have expected. Additionally, it is apparent from paragraph 35 that if GP 1 had offered Mr C admission to hospital and Mr C had refused this, GP 1 should have recorded this in the clinical notes. This did not happen and for that and the other reasons outlined, I uphold this aspect of Mrs C's complaint.

(e) Recommendation

40. As in paragraph 35, the Ombudsman recommends that the Board review GP 1's record-keeping to ensure that it meets the required standards of the regulatory bodies.

(f) GP 1 rushed his consultation with Mr C

41. The record of Mr C's consultation with GP 1 showed that the consultation lasted for 12 minutes between 14:51 and 15:03, including the time taken by GP 1 to write the clinical records on the computer. Mrs C stated her belief that the consultation was rushed and that GP 1 was in a rush as he was due to go off duty. The Board responded to this complaint stating that GP 1 finished his work at the appropriate time and was then replaced by GP 2.

42. Adviser 3 considered this aspect of Mrs C's complaint and, in doing so, reviewed the clinical records from GP 1's consultation. Adviser 3 stated that there was no evidence from the records that the consultation was rushed and that 12 minutes was above the 10 minute average for GP consultations.

(f) Conclusion

43. Mrs C stated to the Board, in making her complaint, her view that Mr C's consultation with GP 1 was rushed. I accept, however, the view of Adviser 3, that there is no evidence to show that it was rushed and note the comment that the 12 minute consultation was above average in terms of length. I, therefore, do not uphold this aspect of Mrs C's complaint.

(g) Mr C waited an unreasonably long time on re-attending the PCEC

44. On finishing the consultation with GP 1, Mr C was discharged with aspirin and bendrofluazide to treat high blood pressure and blood thinning for the TIA. Mr C was met outside the PCEC by Mrs C and another relative, who were unhappy with his condition. They took him back to the PCEC, where Mrs C complained that he waited for approximately 30 minutes before being seen by GP 2.

45. The Board, in response to Mrs C's letter of complaint, wrote to her on 5 September 2005. They indicated that 30 minutes was the then current running time GP 2 had with patients arriving in the department. The Board also stated that, if Mr C's condition had been causing significant concern, he would have been transferred to the nearby A&E resuscitation room.

46. In assessing this aspect of Mrs C's complaint, I sought advice from the Adviser 3. Adviser 3 indicated that on re-attending the PCEC Mr C would have treated as a new patient and that, in such circumstances, a wait of 30 minutes was reasonable when arriving in a PCEC.

(g) Conclusion

47. Adviser 3 has indicated that a wait of thirty minutes is reasonable for a new patient attending the PCEC. Although Mr C had previously been seen by GP 1, he had been allowed home. On coming on duty, GP 2 would have had other patients waiting to see him before Mr C. I, therefore, accept Adviser 3's view that a 30 minute wait was not unreasonable and the Board's contention that had Mr C's condition deteriorated he would have been moved to the A&E resuscitation room. I, therefore, do not uphold this aspect of Mrs C's complaint.

General Recommendation

48. The Ombudsman recommends that the Board write to Mr C with an apology for the failures which have been identified in this report.

49. The Ombudsman had no recommendations to make in relation to NHS24.

50. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been accepted.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	The aggrieved
The NHS24 Adviser	NHS24 Nursing Adviser
PCEC	Primary Care Emergency Centre
GP 1	GP at PCEC
TIA	Transient Ischaemic Attack
The Board	Lanarkshire NHS Board
Adviser 1	The Ombudsman's Nursing Adviser
A&E	Accident and Emergency
Adviser 2	The Ombudsman's A&E/Hospital Adviser
Adviser 3	The Ombudsman's GP Adviser
GP 2	GP at PCEC

Annex 2

Glossary of terms

Bells Palsy	A condition in which there is paralysis of the muscles of the face, typically on one side
Bendrofluazide	A drug prescribed following TIA or stroke to reduce a patient's blood pressure
Carotid Bruit	A noise heard when listening with a stethoscope over the carotid (neck) artery which indicates a narrowing of the artery
Emboli	Something that travels through the bloodstream, lodges in a blood vessel and blocks it
FAST Test	An assessment of the three main symptoms of stroke – facial weakness, arm weakness and speech problems
Meningism	A condition of meningeal (system of membranes which envelope the central nervous system) irritation in which the symptoms mimic those of meningitis but in which no inflammation is present
Stroke	A brain injury caused by a sudden interruption of blood flow. Differentiated from a TIA if symptoms last for more than 24 hours
TIA	Transient Ischaemic Attack. A condition caused by a temporary reduction in blood and oxygen supply to part of the brain. All symptoms must disappear within 24 hours