SPSO decision report

Case: **202101258, Forth Valley NHS Board**
Sector: Health
Subject: Appointments / Admissions (delay / cancellation / waiting lists)
Decision: upheld, recommendations

Summary

A was diagnosed with severe heart valve stenosis (when a heart valve narrows and blood cannot flow normally) and was informed that they required heart valve replacement surgery. A referral was made to a specialist unit within another health board. However, A died whilst awaiting surgery, during the early months of the COVID-19 pandemic.

C complained that there was a delay in providing A with treatment, and that when A's condition appeared to deteriorate, they were prescribed only water tablets. C also felt that there was a lack of communication from the Cardiology Department. Additionally, C pointed to a Significant Adverse Event Review (SAER) carried out by the hospital to whom A had been referred, which had concluded that the referral had been, in their view, wrongly categorised as "routine" as opposed to "urgent". C felt that the care provided to A had been unreasonable.

We took independent advice from a consultant cardiologist. We found that it was unreasonable that A was not referred more urgently for surgical consideration, noting that even before the COVID-19 pandemic a routine referral could take up to 18 weeks. We were also critical of the lack of formal arrangements made to keep A under regular review. A was diagnosed with severe chronic obstructive pulmonary disease (COPD) and we found that this was a missed opportunity for A's management plan to be reviewed. Additionally, we found that we were unable to establish whether the risks of surgery were ever explained to A or whether they were given the choice of treating their symptoms with drug therapy alone. Given the importance of this, we would have expected to see evidence of this in A's case notes. Therefore, we upheld C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this decision. The apology should meet the standards set out 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:

- Patients with congestive heart failure should be appropriately assessed with consideration given to having an urgent echocardiography (a scan used to look at the heart and nearby blood vessels) and an in-patient cardiological review. Patients being referred for more specialist investigation or treatment should be appropriately categorised in terms of urgency in relation to their condition. Patients diagnosed with severe aortic and mitral stenosis should be kept under regular clinical review. The risks of surgery and choices of available treatment should be explained to a patient and any discussions about this should be recorded in the patient's records.

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.