SPSO decision report

Case: **201404012, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C complained about the care and treatment she received during the birth of her son. In particular, she complained that there was a delay in the decision being taken to deliver her baby by caesarean section, that midwives took too long to react to complications, and that she had been left without staff being present for long periods of time. Ms C was also unhappy with the level of information given to her during the birth of her son and complained that the board failed to communicate effectively with her.

We took independent medical advice from one of our advisers. Our investigation found that overall the care and treatment given to Ms C was unreasonable. The advice we received was that her observations should have been taken more frequently, especially following Ms C's raised temperature. We also found that there was a lack of close monitoring of her vital signs and that an obstetric early warning system chart should have been used to record Ms C's vital observations. The advice we received was that these observations are important signs that may suggest serious illness and warrant immediate medical referral. In the circumstances, we upheld the complaint that the board had failed to provide appropriate care and treatment to Ms C during labour.

Our investigation also found that, while the midwife had communicated with Ms C on some issues, there was no evidence that some of the examinations carried out were explained, or that concerns about her raised temperature or transfer to another ward was discussed with Ms C or that Ms C's ongoing treatment plan was discussed with her. We found that the board had failed to communicate effectively with Ms C and we upheld the complaint.

Recommendations

We recommended that the board:

- apologise to Ms C for the failings we identified;
- provide us with an action plan which addresses the failings identified in the assessment, monitoring and evaluation of vital signs, which should include the use of the obstetric early warning system chart and the triggers for referral to an obstetrician; and
- provide us with an action plan which addresses the communication issues identified in this investigation, which should include involving women and their partners in the ongoing plan of care and any concerns about labour and recording information /communication.