SPSO decision report

Case: **201508158, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Miss C raised her concern about the care she received from Forth Valley Royal Hospital during her pregnancy, labour and postnatal period.

During our investigation, we took independent advice from a consultant in reproductive medicine and surgery, a consultant obstetrician and a midwife. We also received advice on general nursing issues from a nursing adviser.

The board accepted that there had been errors in relation to the initial ultrasound scans Miss C received and, as a result, she had been incorrectly advised that she had suffered a miscarriage. The board had apologised for those errors and had taken action. The advice we received and accepted from the consultant in reproductive medicine and surgery was that it had been too early to diagnose a miscarriage and that there was no evidence consultant advice had been obtained. The adviser also said that there was a failure to record / obtain a complete menstrual history at the time of the scans.

The advice we received from the midwife was that carrying out an ultrasound scan before six weeks gestation would not normally happen. The midwifery adviser also said that it happened in this case in an attempt to meet Miss C's needs, given that she had recently undergone surgery. The adviser said that this was not clinically appropriate.

In the circumstances, we considered that the board had failed to provide Miss C with appropriate care and treatment and we upheld this aspect of the complaint.

We were satisfied that an appropriate assessment had been carried out when Miss C first attended the hospital when she believed her labour had started. However, while the advice we received and accepted from the consultant obstetrician and the midwife was that aspects of her care and treatment were reasonable when she returned to the hospital (in particular, that the obstetrician adviser did not consider that there was an unreasonable delay before the decision was taken to proceed with a caesarean section), we were concerned about a number of communication failings and a failure in record-keeping. We made recommendations to address these failings.

The board had apologised for Miss C's concerns in relation to her postnatal care and had taken action. The advice we received and accepted from the nursing adviser was that the action taken had been reasonable.

Recommendations

We recommended that the board:

- remind staff of the need to record/obtain a complete menstrual history at the time of ultrasound scans;
- bring to the attention of relevant staff the findings of this investigation, in particular the need for experienced medical involvement in a similar situation and the need for further scans;
- consider the suggestion received from the midwifery adviser that additional training in relation to dealing

with bereavement surrounding early pregnancies should be provided for midwives who regularly work in this area; and

- remind midwifery staff of the need to maintain full and accurate nursing records in line with Nursing and Midwifery Council guidance.