SPSO decision report

Case: **201606972, Fife NHS Board**
Sector: health
Subject: nurses / nursing care
Decision: not upheld, recommendations

Summary

Mrs C complained about the support provided to her following the birth of her daughter at the Victoria Hospital. She raised concerns about both her hospital care and her care in the community following her discharge. In particular, she complained about a lack of breastfeeding support, which she considered contributed to her subsequent development of postnatal depression.

We took independent advice from a midwifery adviser, who reviewed the records and concluded that appropriate support was provided to Mrs C by both the hospital and community midwives, and by the breastfeeding support worker who visited her the day after discharge. It was noted that an apparent breakdown in communication within the breastfeeding support team meant that they did not follow up with Mrs C as planned. The board had already acknowledged this oversight and undertook to discuss how they can better document requests for follow-up. The adviser also observed that the community midwives documented Mrs C's tearfulness and low mood but that they did not pass this information on to the health visiting team, as they should have. It was noted that the board had asked the community midwives to carry out a piece of work in relation to women's emotional states. On balance, we did not uphold the complaint but we made some recommendations.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the breastfeeding support team's failure to contact her to arrange a follow-up appointment; and for the community midwives' failure to pass on details of her low mood to the health visitor. The apology should meet the standards set out in the SPSO guidelines on apology available at: https://www.spso.org.uk/leaflets-and-guidance.

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

- The breastfeeding support team should review their follow-up referral process and implement measures to ensure follow-up appointments are not missed in future.

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.