SPSO decision report

Case: **201607810, Shetland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr and Mrs C complained that midwives at Gilbert Bain Hospital failed to recognise that Mrs C had hyponatraemia (low blood sodium levels). Mrs C was given advice to drink more fluids, which made her condition more severe. Mr and Mrs C also complained that the board failed to handle their complaint and the review into Mrs C's care appropriately. In particular, they considered the review wrongly concluded Mrs C had a condition called syndrome of inappropriate antidiuretic hormone production (SIADH - the excessive secretion of antidiuretic hormone resulting in, among other things, water retention and dilution of the blood) when she actually had hyponatraemia. Mr and Mrs C considered the board failed to identify appropriate learning from the review and share it with them.

The board accepted that Mrs C was given inappropriate advice to drink fluids by midwives. However, they said it was unreasonable to expect midwives to have recognised she had SIADH, as it is very rare. The board considered they had undertaken a thorough review of Mr and Mrs C's care and complaint. They explained they had taken learning from it forward by training staff on recognising SIADH.

During our investigation we took independent medical advice from a midwife and from a consultant in general medicine.

The midwife adviser considered that the midwives carried out appropriate observations and tests in light of Mrs C's symptoms. They considered the advice given to Mrs C to drink more fluids was reasonable in light of those symptoms. Therefore, we did not uphold this aspect of the complaint.

The midwife adviser considered that the board undertook an appropriate review into Mrs C's care. However, there was a delay in sharing the action plan with Mr and Mrs C. The general medicine adviser considered it was reasonable that the board diagnosed Mrs C with SIADH following the review. They explained that Mrs C had hyponatraemia, which can have many causes, one of which is SIADH. However, given hyponatraemia is much more common than SIADH, the general medicine adviser considered the board should have trained staff on recognising and treating hyponatraemia as well as SIADH. In light of the failings we found in identifying learning from the review and in sharing it with Mr and Mrs C, we upheld this aspect of the complaint. We made recommendations in light of our findings.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr and Mrs C for failing to appropriately identify the learning from their case and share it with them at the time. 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:

- Reviews should be transparent and any learning should be shared with all those involved in the adverse event, including patients.
- The board should provide a reasonable standard of care to patients with hyponatraemia, whatever its underlying cause, with adequate staff training in place to support this.

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.