SPSO decision report

Case: **201702066, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained on behalf of his wife (Mrs A) about the care and treatment she received at the Royal Alexandra Hospital. Mrs A experienced a traumatic birth when problems with the fetal heart occurred and an emergency caesarean section was required. Mr C complained that both the obstetrics (the field of medicine concerned with pregnancy, childbrith and the post-birth period) and midwifery care was unreasonable.

We took independent advice from a consultant obstetrician and from a midwife. We found that consideration could have been given by the obstetric staff to the possibility that the drug terbutaline (medication to stop uterine contractions) could have resulted in improvement in the fetal heart rate. We also noted that there was insufficient evidence to show that a thorough debrief of the birth took place with Mrs A. However, we found that the overall obstetric care during Mrs A's admission was appropriate and that the problems with the fetal heart rate were promptly recognised, with timely action being taken to deliver the baby in line with national guidance. We did not uphold this aspect of Mr C's complaint but made recommendations to the board in light of the failings identified.

In relation to the midwifery care Mrs A received, we found that there was a lack of evidence to show what action had been taken when it was recorded that she was in discomfort when being triaged around the time of admission to hospital. There were also insufficient records to show that Mrs A had been kept informed about the baby's progress while in the special care baby unit; however, we noted that the board had apologised for this failing. We also found that there was poor record-keeping to demonstrate what information had been shared with Mrs A when she was discharged from hospital, particularly in relation to advice regarding self-administration of blood thinning medication and advice regarding breastfeeding given she had experienced problems during her admission. We were also critical of the lack of evidence to show what information had been shared with the community midwifery team at the time of discharge. Finally, we considered that there was no evidence of assessment or support of Mrs A's psychological needs during her admission. Therefore, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise for the failings in addressing Mrs A’s discomfort and psychological needs, the lack of information given to her, and the community midwives, on discharge and for the failings in record-keeping. 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:

- Where appropriate for patients in labour, consideration could be given to the administration of terbutaline, in accordance with national guidance.
- In a similar situation patients should be adequately debriefed and this should be properly recorded in the medical notes.

- Patients should be properly advised on any discharge medication and this should be properly documented in the medical notes.
- Midwifery patients should receive appropriate assessment of their needs, including any psychological needs, during admission which should be appropriately planned and documented.
- Midwifery patients should have their pain/discomfort suitably assessed and acted on when in triage.
- In a similar situation midwifery patients should receive detailed information in relation to the care and treatment of their baby and this should be properly recorded in the midwifery notes.
- Midwifery patients and community midwives (on handover) should receive adequate information on their care and treatment on discharge. This should include the discharge plan for women and babies leaving hospital, that each woman has received a copy of Ready Steady Baby, that there has been an effective handover between the hospital and community midwifery staff, and the guidance and support given to women having difficulties breastfeeding.

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.