SPSO decision report

Case: **201803526, Tayside NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Miss C complained about the care and treatment she received from Ninewells Hospital in relation to the birth of her child. Miss C highlighted that her child has brain related problems. Miss C also complained about the time it took for the board to respond to her complaint.

Following the birth of Miss C's child, the board conducted a Local Adverse Event Review (LAER) to detail the root causes and key learning from an adverse event. The LAER found that the root cause was that Miss C had hyponatremia (low sodium concentration in the blood - a rare complication in low-risk labouring women). The LAER identified a number of concerns in terms of the administration of intravenous (IV) fluids on the midwifery unit, timing of blood tests, confusion surrounding the need to transfer Miss C due to her behaviours and significantly altered conscious state, and the obstetric (pregnancy and childbirth) team not being informed of the transfer and associated concerns. As a result, the board took action to address these issues to ensure learning and improvements.

We took independent advice from a consultant obstetrician and a midwife. We noted that Miss C was a low-risk patient at the beginning of her labour in the midwifery unit. We found that the progress of the first stage of Miss C's labour was unreasonable and she was given excessive fluids orally and by IV infusion which was not recorded on a fluid balance chart or reviewed by medical staff prior to IV fluids being given, after which she became unresponsive.

We also found that, despite not having any sedating analgesia (pain relief), the deterioration in Miss C's condition was not recognised and assistance was not requested. There was an unreasonable delay in transferring her to the labour ward, with unfamiliar staff being involved in the transfer and key information not communicated effectively to the new team. However, we were unable to say what effect earlier detection and treatment would have had on the outcome for her child.

After Miss C's transfer to the labour ward, the medical staff recognised her poor condition promptly and delivered her child. Had Miss C been transferred when the delay in the first stage of labour was diagnosed, it was likely that blood tests would have been taken leading to an earlier diagnosis of the problem. We found that there was a delay in obtaining and acting on the blood results which we considered unreasonable, although this delay would not have affected Miss C's child's outcome. In view of these findings, we upheld this aspect of the complaint. The board has already taken some action in respect of their findings on this case. However, we made further recommendations to ensure learning.

In terms of the board's handling of Miss C's complaint, we found that there was evidence that the complaints department made attempts to arrange a meeting to discuss Miss C's concerns with her and provide the complaint response within good time. However, it appears that there was a delay in clinical staff responding to these attempts. While the update response sent to Miss C was factually correct, in the absence of any evidence from the board justifying the delay, we found that the time taken to deal with the complaint was unreasonable.

Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss C for failing to recognise her deterioration and for the delay in dealing with her complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/information-leaflets" www.spso.org.uk/information-leaflets .

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

- All relevant staff should be fully appraised and aware of key information.
- All relevant staff should be able to recognise and manage a deteriorating patient.
- Clinical staff should respond to the board's complaint investigations in a timely manner.
- Patients should be appropriately transferred to obstetric care.
- Communication of blood test results should be recorded in a structured and consistent way.
- All staff taking blood tests should take responsibility to obtain the results or communicate with the next shift about any outstanding results.

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.