SPSO decision report

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Case: **201911256, Forth Valley NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment that they received from the board during an in-patient stay at Forth Valley Royal Hospital. C was admitted to the hospital while in the early stages of labour. C gave birth a few days later and was discharged to their home the following day. After discharge, C's health began to deteriorate and were later admitted to a different hospital, where they received a blood transfusion and treatment for an infection.

C complained that the board had failed to inform them that they had a yeast infection and failed to provide them with any treatment for this. C also complained that a clinician knowingly recorded an inaccurate pulse rate on their records and that the board failed to appropriately treat their post-natal high blood pressure and/or blood loss.

We took independent advice from an obstetrician (a doctor who specialises in pregnancy and childbirth). We found that the board had failed to inform C that they had a yeast infection. Therefore, we upheld this aspect of their complaint.

We found insufficient evidence to establish that an inaccurate pulse rate had been recorded on C's records. We also found that C's blood pressure and/or blood loss were within normal limits when they were discharged from hospital. Therefore, we did not uphold these aspects of C's complaints.

However, we did find that clinicians failed to reasonably respond to C's high pulse rates at one point during their admission. While this issue was not raised by C in their complaint, we considered that it was reasonable to make recommendations to the board in relation to this matter.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to adequately monitor and respond to their condition. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Clinicians should closely monitor Modified Early Warning Scores (MEWS) and appropriate action should be taken in light of them.
- When a candida (yeast) infection is identified, patients on the ward should be informed.

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.