SPSO decision report

Case: **202104574, Greater Glasgow and Clyde NHS Board - Acute Services Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that they received during their labour and delivery of their baby (A). In particular, C complained that the standard of care and treatment they received had been unsafe, that there had been a lack of communication in relation to their requested position during labour, the use of forceps and the provision of pain relief. C also complained that they had been unable to give their informed consent for the use of forceps.

The board, when responding to C's complaint, accepted that some aspects of C's care did not meet the standard that they would expect in terms of communication and C's requested positioning throughout the labour and delivery of A. As a result of C's complaint, the board had shared the complaint with the midwifery staff responsible for C's care. The board asked them to reflect on C's experience and consider ways of improving care for the purpose of providing person centred care. The board also accepted that they had failed to arrange C's postnatal review clinical appointment. The board said they had taken action to review and amend the process for appointing consultant led postnatal follow-up. The board indicated that, while the event had not been recorded as an adverse incident and a Datix (an incident/risk management reporting system to collect and manage data on adverse events) had not been submitted, a review had been carried out and action had been taken as a result of that review.

We took independent advice from a consultant obstetrician (a doctor who specialises in care during pregnancy, labour and after birth). We found that during C's labour there were significant periods of loss of contact (LOC) during the recording of the foetal heart rate. However, we also found that, while labour would have been complicated by the LOC there was no evidence that C or A were put at risk. We also found that the actions of staff during this period were reasonable and proportionate to the needs of C and the clinical circumstances which occurred at the time. We found that safe care and delivery had been provided to C. However, we also found that there had been a material change in C's birth plan and that there had been a failure to communicate these changes with C.

The board accepted that there was no documentation in the medical records of a discussion with C in line with Royal College of Obstetricians and Gynaecologists guidance on obtaining verbal consent on assisted vaginal births. We found that obtaining consent is an important aspect when providing care and treatment to a patient, and completing the appropriate documentation is a professional standard. The event should have been recorded as an adverse incident and a Datix should have been submitted. We upheld the complaint and provided feedback to the board in relation to the use of the adverse event process and the submission of a Datix.

Recommendations

What we asked the organisation to do in this case
Apologise to C for the failings identified in this complaint. 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:

- Patients should receive clear explanations and appropriate information where there are changes to their birth plan. Where discussions have taken place with a patient, this should be documented.
- Staff should be aware of the relevant Royal College of Obstetricians and Gynaecologists (RCOG) guidance on documenting consent.

In relation to complaints handling, we recommended:

- Complaint responses should be informed and accurate and address all aspects of the complaint.

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.