SPSO decision report

Case: **201811056, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, a support and advocacy worker, complained on behalf of their client (B) about the care and treatment their child (A) received in the early months of their life. A was born prematurely, suffered a number of medical problems following their birth and died a few years later. A was initially cared for in Aberdeen Maternity Hospital's neonatal unit. A was transferred for treatment in the High Dependency Unit (HDU) at Royal Aberdeen Children's Hospital. C asked us to investigate the standard of care and treatment that A received at Royal Aberdeen Children's Hospital. B said that A suffered a number of desaturation episodes which caused A to turn blue. They attributed this to staff being slow to react. A's feeds were increased upon admission to Royal Aberdeen Children's Hospital. B said that A's health began to deteriorate from this point. B said that A should have remained in Aberdeen Maternity Hospital's neonatal unit given A's weight at five months was still below that of many neonates, or else transferred to another neonatal unit elsewhere in Scotland. They complained that, whilst A was in Royal Aberdeen Children's Hospital, the level of supervision was insufficient, particularly over weekends.

We took independent advice from a consultant paediatrician and a paediatric nurse. We found that, while A's condition was complex, there was nothing to suggest that moving A to the HDU at Royal Aberdeen Children's Hospital resulted in a drop in the level of care and support available. We also found that the overall approach to managing and monitoring A's weight was reasonable. We did not uphold these aspects of C's complaint.

In relation to nursing supervision, we found that nursing staff reasonably monitored A throughout their time in the HDU, maintaining detailed and thorough records and appropriately escalating any issues identified to the medical team. We did not uphold this aspect of C's complaint.

In relation to medical supervision, while the nursing staff appropriately monitored A's condition and escalated A's management to medical colleagues when changes were observed, we found that these were not acted upon within a reasonable time in every case. On one occasion no medical staff attended for four hours following escalation by nursing staff. We upheld this aspect of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A's parents for the unreasonable delay in fulfilling a request for a medical review of A.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:

- The board should have a system in place to alert a more senior member of the medical team to attend when requests for medical reviews cannot be fulfilled by the relevant medical staff within a reasonable timescale.

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.