Obstetric Anaesthesia
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Complaints Analysis in Obstetric Anaesthesia – can we learn from Scottish Ombudsman enquiries?

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Introduction

The Scottish Public Services Ombudsman (SPSO) is the final stage for complaints about public services in Scotland. Complaints are considered only after they have been through the complaints procedure of the organisation concerned. The aim of the complaints review is not only to provide justice for the individual, but also to share the learning points in order to improve the delivery of public services in Scotland. Obstetric Anaesthesia is generally perceived as a high-risk specialty for attracting complaints and litigation. We were interested to see how many complaints enquires relating to Obstetric Anaesthesia are processed by SPSO and what the common themes were.

Methods

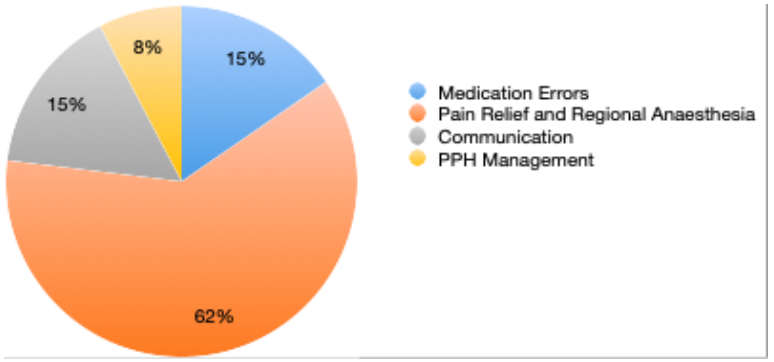
We performed search in the Scottish Ombudsman NHS Decisions and Investigation Reports Database [1] using key words "anaesthesia", "anaesthetist", "spinal", "epidural", “GA". All cases relating to Obstetric Anaesthesia were included over 11 years period (2008-2019)

Results

We identified 51 cases relating to anaesthesia and/or pain management out of 4700 NHS decisions and investigation reports, 13 of which were related to Obstetric Anaesthesia, constituting 25% of anaesthesia complaints and 0.27% of all NHS complaints. The breakdown in case content is highlighted in the chart opposite.

Ombudsman reports often noted poor documentation and unreasonable delays in providing pain relief, lack of follow up and debrief. Some reports analysed appropriateness of seniority of the clinicians involved and some suggested that communication with relatives can be improved.

Common themes



Discussion

Reassuringly overall number of Ombudsman complaints related to Obstetric Anaesthesia was low, common trends being labour analgesia provision, communication and avoidable drug errors. Although complaints analysis does not provide full picture of potential litigation points, it gives good guidance on how services can be improved. We suggest learning from complaints should be included in Clinical Governance process in all units to minimise future litigation risks.

References

1. Scottish Public Services Ombudsman Findings https://www.spso.org.uk/our-findings