Scottish Parliament Region: Highlands and Islands

Case 200502319: Highland NHS Board

Introduction

1. On 22 November 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) that Highland NHS Board (referred to in this report as the Board) had failed in their care of her grandmother (referred to in this report as Mrs A) while a patient in Portree Hospital (the Hospital), Portree from 23 December 2004 until her death on 1 March 2005.

2. The complaints from Mrs C which I have investigated *(and my conclusions)* are that the Hospital failed to:

(a) have adequate security policies and procedures in place to protect patients' personal property and pass on personal effects appropriately *(upheld, see paragraphs 10 to 11)*;

(b) ensure staff respected patients' dignity in allowing Mrs A to be referred to by a nickname *(not upheld, see paragraph 15);*

(c) maintain appropriate levels of cleanliness on the ward *(not upheld, see paragraph 19)*.

3. The Ombudsman commends the action being taken by the Board to address the issues raised in (a) and has no recommendation to make.

Investigation

4. The investigation of this complaint involved obtaining and reading all the relevant documentation, policies and procedures, and complaint files. I have made written enquiries of the Board. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board have been given an opportunity to comment on a draft of this report.

5. A number of the issues giving rise to Mrs C's complaint concerned the exact nature of what was said or done by staff. In some instances there is evidence to support one view over the other, but this is not always the case and I have

indicated this in the report.

(a) Adequate security policies and procedures were not in place to protect patients' personal property and pass on personal effects appropriately.

6. Following the death of her grandmother on 1 March 2005, Mrs C contacted the Hospital on 5 March 2005 and asked for Mrs A's wedding ring. Mrs C told me that she was advised by a staff nurse that there was no record of a wedding ring but that a check would be made. Mrs C told me she was further advised the following day that the undertakers had noted Mrs A was wearing a ring, but that it later emerged that the undertaker did not make such a record and nor was it their practice to do so. Mrs C complained to the Hospital in April 2005 that no further action had been taken on the matter and there was no process for recording a patient's valuables.

7. In response the Board wrote to Mrs C on 6 July 2005 that staff had not removed Mrs A's ring and there was no standard policy in place in NHS Highland to record patient's property, except where a specific request was received from a patient. The Board acknowledged that this had caused distress to Mrs A's family and apologised for this. The Board advised Mrs C that they would take action to prevent any recurrence of this problem and a policy document would be drawn up.

8. Mrs C remained unhappy as she considered a more thorough investigation should have occurred and the matter should have been reported to the police at the time. Mrs C brought her complaint to the Ombudsman and told me that it had been particularly distressing for the family to be handed Mrs A's possessions in the bags used by the Hospital for the disposal of contaminated products and without being asked to sign for the belongings or there being any record of these belongings. Mrs C remained concerned at the lack of any policy on safeguarding patient's property.

9. In response to my enquiries the Board provided me with a copy of the January 2006 draft of the *Care and Custody of Patients Property* for NHS Highland and the protocol now used by the Hospital for handling of valuables. These policy documents are a direct result of Mrs C's complaint. I have reviewed these documents and am satisfied that both should greatly assist in avoiding a recurrence of the problem experienced by Mrs A's family. I have provided a copy

of these to Mrs C for her information. The policy does not make specific reference to the type of container used for delivery of patient's property, but I have discussed this with the Board and they have told me they will make an amendment to the draft policy to reflect the need for patient's property to be handed to relatives in an appropriate container and to specifically avoid using contamination bags for this purpose.

(a) Adequate security policies and procedures were not in place to protect patients' personal property and pass on personal effects appropriately: Conclusion

10. The Board did not have a policy or protocol in place to safeguard patients' property. I, therefore, uphold this aspect of the complaint.

11. The Ombudsman acknowledges and commends the work done by the Board to address the problem identified by Mrs C and their willingness to amend the draft policy to reflect Mrs C's ongoing concerns about the use of contamination bags. In light of the new policy the Ombudsman has no recommendation to make.

(b) Staff did not respect Mrs A's dignity in addressing her by a nickname

12. Mrs C complained that on a number of occasions the family heard a staff nurse refer to Mrs A by her nickname and they felt this was unprofessional conduct. In response to this the Board replied that the nickname was used only after a discussion with Mrs A and that staff would not have continued to use this name if Mrs A had been unhappy at any time.

13. Mrs C remained unhappy with this explanation and did not accept that her grandmother had permitted staff to use this name.

14. In response to my enquiries, the Board provided me with a copy of a statement from the staff nurse concerned, advising that she had asked Mrs A which name she preferred to be called and Mrs A had responded that either name could be used. The staff nurse had been accompanied by another staff member at this point. The Board also advised me that several other staff members recalled referring to Mrs A by her nickname and that she had not expressed any concern about this.

(b) Staff did not respect Mrs A's dignity in addressing her by a nickname: Conclusion

15. I acknowledge the distress felt by Mrs C at the use of her grandmother's nickname. I cannot determine whether or not Mrs A gave permission for this, but as it is the view of several staff members that Mrs A had not objected to being called by her nickname I conclude, on the balance of the evidence, that Mrs A had no objection to this. I do not uphold this aspect of the complaint.

(c) Appropriate levels of cleanliness were not maintained on the ward.

16. Mrs C complained that her grandmother's personal locker was not cleaned after the previous occupant had left the bed and that the screens around the bed were blood stained.

17. In their response the Board advised Mrs C that they had investigated her concerns and confirmed that the locker had been cleaned and that the screens had been stained by hibiscrub, an anti-bacterial cleaning agent. The Board advised that replacement screens had been ordered but had not arrived at the point Mrs A was admitted. Mrs C remained unsatisfied with this response and maintained that the locker had not been cleaned and she disputed the nature of the stain on the screen.

18. In response to my enquiry, the Board provided me with information, specifically the cleaning schedule and a statement from the cleaning supervisor, taken from the Board's own internal investigation of the complaint. The schedule indicates an appropriate routine for cleaning the rooms. The Board's response to Mrs C suggested that the previous patient had inadvertently returned items to the locker after it had been cleaned pending Mrs A's arrival and advised that had staff been aware of this they would have removed the items. The statement from the cleaning supervisor indicated that the screens had been washed as directed and had now been replaced.

(c) Appropriate levels of cleanliness were not maintained on the ward: Conclusion

19. There is a difference of view about the cleanliness of the locker and the cause of the stain on the screens. The Board took steps to investigate the matter at the time the complaint was raised and provided an appropriate response. I do not consider it is possible to obtain any further information or evidence on this point. I

do not uphold this aspect of the complaint.

27 June 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mrs A	The aggrieved, Mrs C's grandmother
The Board	Highland NHS Board
The Hospital	Portree Hospital