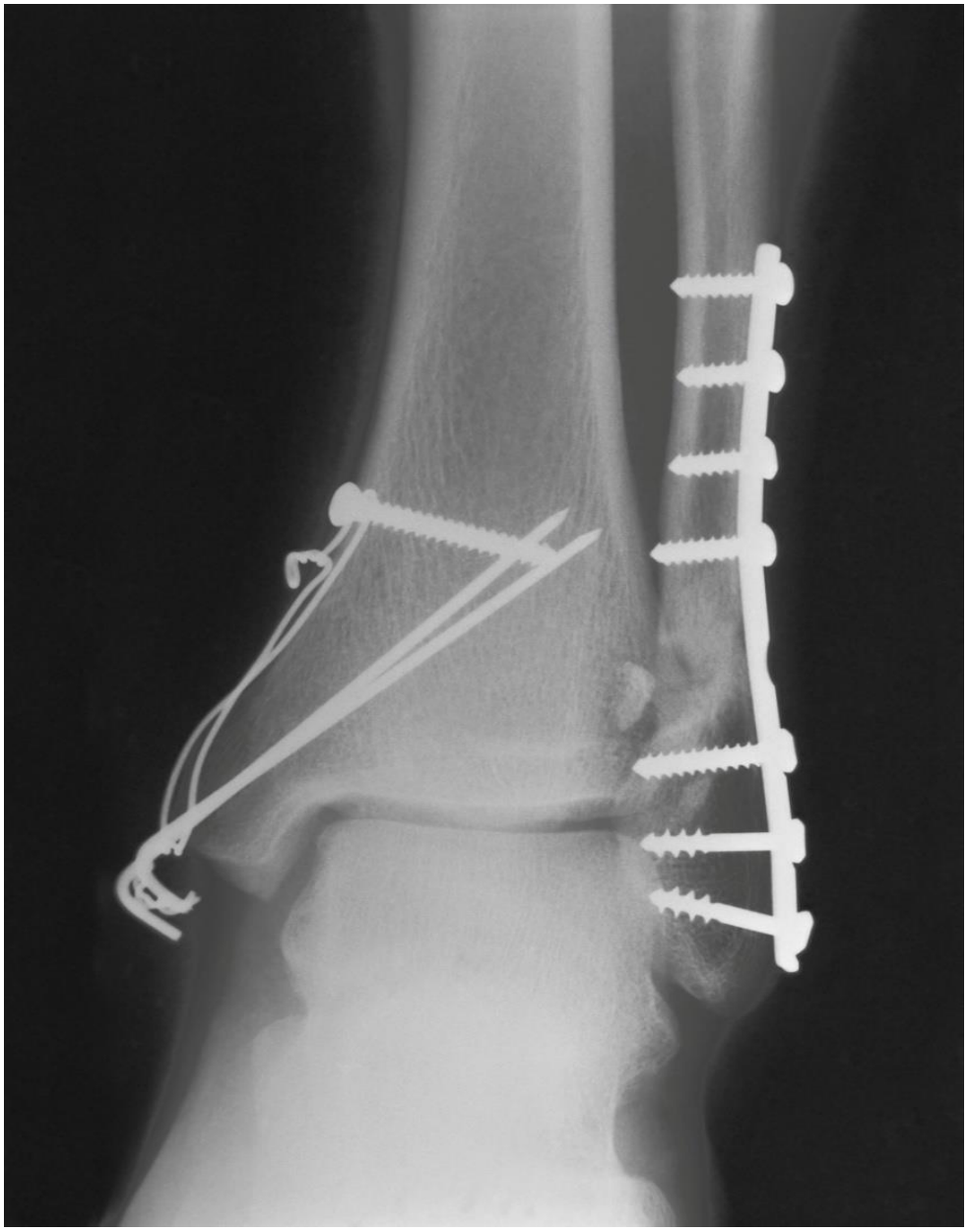

*One elderly adult's journey through Dundee's Health and Social Care System explained; and the questions*

This patient journey represents the context.

The more pressing matter is; what scrutiny mechanism exists to independently investigate our public services when things go wrong?


A list of some of the incidents and injuries sustained is listed on a separate page of this website.

This journey represents a frightening prospect for anyone growing old, especially on their own. With the appalling standard of public service provision described in this report, how do our leaders imagine people can ever trust them to serve and protect our elderly?

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## 1. Our Introduction to Social Care

Surely a needs assessment should be focussed, informative and holistic?
Was social care culpable for her injury?

Four years ago, the family recognised that mum was starting to need support. I moved into her home to provide general support and act as her advocate. We contacted Dundee Adult Social Care Services for assistance supporting her personal needs.

It is important to illustrate aspects of the approach taken by social work, to our care arrangements. It forms the nucleus of this matter and was an integral part of this journey. The reason the following matters are highlighted will become clearer later into this report.

### Needs assessment

Social Care visited mum at home to conduct a needs assessment. At mum's request, I attended to provide moral support and represent her.

We assumed we were going to become active participants in the process, at least that's what the policy tells us. The reality is that we immediately became passive recipients with little or no control over our lives.

Little, if any information was offered about what her expectations should be. Her human rights were not explained or subsequently respected. However, there was a heavy emphasis on the collection of personal information, much of it unwarranted.

### Financial assessment

The assessor offered to 'conduct a financial assessment to identify if there are any benefits you may be entitled to'. Mum didn't wish to apply and wouldn't qualify for

benefits. Personal care is free in Scotland. She didn't wish to disclose personal financial information unless it was relevant and necessary. It was a personal matter she didn't even share with her late husband. Her life was adequately managed. Her finances were in order. All she required was free basic personal care i.e. helping with showering. The same response applied to questions about legal arrangements.

To us, social care didn't appear to appreciate the concept of demarcations and privacy. The department seems to consider it has a right to access information about every area of your life, whether justified or not. Gathering rather than imparting information was the focus of the meeting. Despite our categorical refusals, the assessor persisted.

Later, another assessor visited, followed by another. This theme of 'conducting a financial assessment to identify if there are any benefits you may be entitled to' continued. It seemed to be a euphemism for snooping over your finances and personal life.

I was subject to similar financial probes. It wasn't that the assessors asked these questions; the problem was that the assessors ignored our answers and persisted.

## Probing

All Health and Social Care services are linked, even to your sheltered housing facility if you live in one. Probing is rife. Innocuous and irrelevant details shared with someone in one quarter quickly find their way around the system. The result is the development of an intrusive personal profile.

There was no lack of probing questioners and little respect for privacy. After various assessors failed to obtain my financial details I was visited by community nursing. Many carers repeatedly probed in what was a very obvious manner. People wanted to know anything and everything. If health care discovered a snippet of information, it reached social care and vice versa.

One weekend, two paramedics arrived to examine her. While they were going about their jobs, I was roaming the house gathering information and medication. We were immediately called on the intercom, demanding to know what was happening. In fact, whereas people might have wanted to know, it wasn't their right to know. As things turned out, mum required only minor medical intervention and there was little to share. But then the phone started ringing. Relatives heard through the grapevine that the paramedics had visited and wanted to know if she was alright.

When social care was tackled about this intrusion, the response was that they 'have a duty of care towards all clients'. That may be, and seeing further evidence of that would have certainly been welcomed. But a duty of care doesn't give them a right to persistently probe into deeply personal matters.

We would have appreciated the same level of commitment in delivering high-quality care and ensuring that robust safety measures were in place. We weren't ever pressurised by demands to know if she was being treated safely and with dignity.

This apparent sense of entitlement continued. On another occasion, a relative received a call requesting information. It represented a breach of confidentiality. It was then necessary to formally notify social care that unsolicited interference would not be tolerated.

The effect of this situation is that you begin to feel you have no right to privacy or control over your circumstances. Adapting to this level of interference in our lives required a period of adjustment. It really set the scene for our future relationship.

I am told this is one of the reasons many service users resort to advocacy arrangements.

## Institutionalised care

It was made abundantly clear from the first meeting that mum should always be accompanied to any discussions, particularly where decisions were being made.

If mum was asked if she would consider a care home, her response was always a resounding no. When there were subsequent problems delivering quality care, instead of tackling the causes, health and social care proposed consigning mum to an institution. This would alleviate service pressures in the community for health and social care. While she was in hospital social care made an impromptu visit to her bedside. She was woken and asked if she'd consider entering a care facility. Again she emphatically declined. It would appear that this approach was taken to circumvent my presence in the process. During a multi-agency meeting her rights and views were reinforced.

## Service user's rights ignored

These behaviours might indicate why a negative public perception of social work exists. Understandably, our relations became strained.

All health and social care service users have Human Rights. All services are duty-bound to make you aware of and to respect those rights. A vulnerable adult should not be attending any meeting alone with a Government agency. Service users have a right to be accompanied and represented.

Service users are not obliged to answer any questions they don't wish to. They are not obliged to share any personal information they don't want to share. Health and social care are obliged to respect and accept responses without challenge.

It seems to bother people across the system if you are aware of and try to assert your rights. The thought of a vulnerable elderly adult in mum's position, having no access to advocacy support is a matter that bothers me.

## Occupational therapy needs assessment

The next home visit we received was to assess the home for safety. I highlighted that the bed was a significant risk. Mum had tumbled from bed while sleeping, more than once. A family member attached a grab rail but some unspecified health and social care visitor removed it. I asked if she could have a profiling bed with cot sides to keep

her safe. The response was, ‘that’s not something we would do’. Surely a needs assessment should be holistic. What is the point of ensuring a toilet seat is high enough if your safety in bed can’t be guaranteed?

## Injury

The following month, she tumbled in the night and fractured her neck. To us, this was a preventable injury caused by the absence of active listening skills and a disregard for voiced concerns about her personal safety.

Instead of focussing on their own agenda, it would have been more constructive to have focussed on meeting her health and welfare needs. Then perhaps quality care and safety might have been provided. This incident could have been prevented, and our relations might have flourished. Instead, we spent four years on the defensive and constantly attempting to assert our rights.

This injury resulted in unnecessary pain and trauma and a lengthy hospital stay. Was social care culpable for her injury?

When the elderly sustain serious injuries of this nature, many never regain the level of functionality and confidence they enjoyed before falling. Sadly, this was true of mum. That preventable incident placed her prematurely onto a spectrum of decline.

During that first admission, there were some concerns about her stay at Ninewells. However, during her stay at the Royal Victoria Hospital, she received a high standard of nursing care and rehabilitation from a kind and caring team. The ward she entered was under the auspices of an excellent leadership team. Upon discharge, we expressed our heartfelt gratitude.

## 2. The State of the Home Care Sector

The care sector is broken. When is the problem going to get fixed?

In the period that followed, due to our perceived failings to meet many of the fundamental standards of care provision, we transferred between successive home care providers. We soon discovered that many failings were endemic. Many carers were unable to provide the quality of care they wanted to provide, while others made no attempt to.

### Logistical problems

Many carers had insufficient time factored into their rosters for travelling between clients, often working to unrelenting pressures. During visits, they were frequently contacted by their provider and asked to incorporate additional calls into their already hectic schedule.

### Rushed care

The result was that the majority of carers rushed client care. Some rushed to accrue time belonging to the patient. Others rushed for their own reasons.

### Long hours

Many carers start at 7am, working split shifts that finish at 10pm before starting again at 7am. Many carers earn little more than the national minimum wage; numerous are on zero hour contracts; several have supplementary jobs; countless work in excess of 50 hours per week.

### Unpaid downtime

In some circumstances, if carers have gaps between clients visits, these gaps are not considered working hours or a scheduled break. Some carers don't get paid for this time. During downtime, they are expected to loiter somewhere at their own expense in all kinds of weather.

### Random carers

In many circumstances, there are special care needs to manage. This requires specialist skills and competence which not every carer has. Carers visiting can change daily, resulting in a lack of patient awareness or continuity of care.

It was not uncommon for a new carer to arrive who was doing the job casually to supplement their earnings. It was often necessary to provide guidance and support. There were instances of office staff making random visits to supplement their income or provide emergency cover.

### Low morale

Morale was low. Stress levels were high. Attitudes were resentful. Some carers said they felt unsupported by their employers. Other carers struggled to cope. Many tried to provide a decent standard of care provision while struggling with the pressures of a system that is damaging their own health and wellbeing.

### Calibre of carers

Many carers don't survive, which is why there is a high turnover of staff in this sector. You don't necessarily need any qualifications or previous work experience to get a job in home care. Yet you are often solely responsible for vulnerable people and their care and safety. The reality is that many carers, without the necessary competence and unsuited to the profession are able to enter it easily. There is difficulty in attracting suitable applicants. This can affect the calibre of carers employed and the quality of care provided.

Professionals across the system have often refuted these claims. They have tried to convince us that all carers are trained and fully competent. But the evidence speaks volumes. Some are not. In the community, you don't have the immediate supervision and support present in a care home or hospital.

## Skill sets

Nurses provide skilled medical care. Carers provide unskilled domiciliary care. There are often overlaps in the levels of care required. Beyond washing, dressing and nutrition, older persons daily needs can be wide-ranging. This can involve; using equipment safely; managing skin integrity; applying dressings and prescribed creams; supporting people with dementia; catheter management; continence management; administration of medication; monitoring temperature; monitoring blood pressure or respiration while alerting medical professionals accordingly.

The majority of those tasks are the responsibility of an unskilled carer to manage. Frequently these responsibilities are overlooked until they escalate.

Some carers are unaware of how to mobilise properly or use equipment safely and, as we shall later learn, this can have very serious consequences.

## Resource driven model of home care

That isn't to suggest that community nurses should perform domiciliary care. But the central problem is that home care is currently resource rather than needs driven. In my view, far greater emphasis needs to be given to the key skills and competencies required. Adequate resource needs adequate funding. Applicants recruited to a care role need to have an appropriate level of training, qualification and remuneration.

As we so often witnessed, the impact of these pressures resulted in desensitisation and compassion fatigue. Another impact of perceived failings in the provision of fundamental standards of social care is that, care is not as patient-centred as it should be due to being resource driven. This creates significant service pressures for everyone involved in the public and patient partnership.

## Perspectives

In some cases, it's difficult not to sympathise. Your heart goes out to many community carers working in these challenging circumstances. From a service user's perspective, taking a sympathetic view and appreciating the problem is one thing. But it doesn't make enduring deficits in home care provision any easier to accept.

That the social care system is broken is an undeniable fact, widely acknowledged. Everyone seems to be in agreement that there is a serious problem. Much has been written, and lip service has been paid to the subject for many years. The consequence is that many of our elderly receive inadequate home care provision. When is the problem going to get fixed?

## 3. Botched Home Care Provision

Why aren't all carers properly trained?

Why are carers allowed to pilfer time belonging to vulnerable adults?

In my opinion, the effect of these problems across the care sector is fundamental failings in the provision of adequate care. In our experience, one manifestation was a lack of moving and handling competence and a perceived lack of kindness and compassion.

### Disregarding the care plan

Before discharge from the hospital, a care plan was drafted. This illustrated the prescribed amount of time and visits required to meet her personal care needs. Upon discharge, once the program of personal home care commenced, the sad reality set in. The care plan was rarely read or followed.

### Rushing

Prescribed time was rarely given. Countless carers swept through the house like a tornado, rushing care duties before dashing away. Many were reckless and uncaring. They just wanted to get the job done and get out. The impact of this treatment left her in a state of high anxiety which constitutes nothing short of a form of assault.

### Hazardous

The morning following discharge, two carers frenetically swept into her darkened bedroom. They switched the light on. They pulled the covers back while she slept. They attempted to drag her out of bed. It was crass and callous, not to mention very risky. There was no awareness of the impact this behaviour might have on a vulnerable, elderly person. Half an hour had been allocated to complete the duties necessary during this visit. The carers were gone in ten minutes.

The care plan underlining the dangers of rushing was disregarded. Carers were paid for the time that they had not used and which did not belong to them.

### Pilfering time

During washing, two carers frequently worked on her simultaneously to speed up the process. An hour was allocated for her main visit. Personal care was usually finished in less than half that time. They left her stressed and exhausted. But the carers always loitered until the thirty-minute mark. I soon discovered that to be paid for the full hour, carers had to remain present for half that time. It was common knowledge among the sheltered housing community that a cluster of carers spent a lot of time socialising in the adjacent day rooms. This suggests that it isn't always necessary to rush care.

I conveyed to social work the implications of private care providers pilfering time from vulnerable adults. This time is being paid for by health and social care and therefore the public purse. This was our reason for successively transferring between care providers. But unfortunately, we discovered that these practices are quite customary.

### Inadequate moving and handling skills

Moving and handling skills were often dire due to an evident lack of training. For four years there was a regular series of incidents. I was often forced to intervene to prevent or recover falls. There were no incidents while I provided care. But when she was in the care of professionals, at home and in hospital, there was a regular series of incidents.

In the early days, I used care visits as an opportunity to run errands. But I was called on my mobile to return home so frequently, that in the end it was no longer a sustainable arrangement.

## Incidents

There were incidents of mum falling while in the process of sitting on the commode chair. These incidents happened because either a carer had failed to lock the wheels or failed to support the back of the chair or, in one instance the carer was preoccupied using their mobile.

She frequently slid to the floor when sitting on her armchair because the carer had failed to align the back of her knees with the chair.

She slid off the mattress when a carer assisted her out of bed with one hand while taking a mobile call on the other.

She was rescued numerous times sliding off her profiling bed, raised to over four feet high, while the carers weren't looking; a near-miss that could have killed her.

While putting her to bed there were frequently moans and groans due to failed attempts to glide her properly. It stressed and exhausted her.

On countless occasions it was necessary to demonstrate and assist carers to use equipment.

We paid one of the care providers privately for a sitting service. This meant that mum was supervised and I was able to leave the house. The sitter got bored and disappeared without telling anyone. She left mum vulnerable and alone for four hours. The provider apologised.

## Moving and handling training certification

Due to the prevalent ineptitude, I attended an approved moving and handling training course. The course was part of the Scottish manual handling passport scheme. It was presented as, and I quote, 'an initiative designed to improve the standard and consistency of manual handling training'. Attendees sat in a semi-circle watching a presentation. This lasted all day followed by half-an-hour glancing over one piece of

equipment. Trainees were then certified to operate as carers and use equipment to mobilise vulnerable people in the community.

It supports a view that, while most carers might be trained, not all carers are **properly** trained.

## Sector recruitment practices

During covid lockdown, my cousin who runs an unrelated business needed temporary employment. As one of the few sectors still recruiting, she applied for a care position. Her training involved a short online multiple-choice test followed by two days of shadowing. She was then discharged into the community, looking after the vulnerable and operating equipment. She didn't survive very long.

## Care review

To address some of these concerns, a review was arranged. Pathetic excuses were offered by the care provider for many of these failings. One excuse was that the carers felt nervous due to another presence in the home. This prevented them from moving and handling her safely.  But when the carers visited I was usually somewhere else. It was the only time I could have a break. I only appeared when called for assistance. And I was called often. So it was a curious excuse.

Rushing care and pilfering time was denied. There was no evidence to substantiate this claim because carers had not followed standard operating procedures and logged in via telephone. The excuse for this omission was they were too nervous to ask to use the telephone. This didn't explain why they didn't use their mobile phones. Neither did it explain why the provider failed to identify these omissions on office records.

This alleged inhibition didn't seem to stop carers behaving brazenly. It didn't prevent them from rushing care, stressing her and dashing out the door

When we wanted a private sitting service, which many carers enjoy due to the nature of the role, the same carers who claimed they felt inhibited; asked for their names to be put forward.

To encourage kindness and develop rapport we offered drinks and snacks. Some didn't seem to feel nervous enjoying breakfast. During down periods, they weren't too nervous using our home for warmth rather than sitting in a freezing car.

Perhaps it was a viral condition that constantly fluctuated between nervousness and conviviality.

The provider resisted acknowledging these failings and their contractual obligations. The ultimate response of the care provider was to suggest that we should apply for Direct Payments. The provider wanted us to make private arrangements instead. This would enable the provider to sweep the problem under the carpet. No apology was offered.

Fortunately, someone from social care was in attendance and this particular care provider was prevented from taking evasive action.

These examples illustrate just some of the ways in which her home care was negatively impacted. There seems to be a level of resistance on the part of care providers to accept feedback. For such carers, particular support appears to be required. It seems clear that some carers are not suited to the role, while others are struggling with the demands of their role. To add to the challenge, some carers may have their own disabilities or conditions to manage too. Some may be floundering and feel embarrassed about asking for help.

While it doesn't preclude the impact of this situation, fortunately there were other carers with whom she was able to relax and forge a rapport. In these instances, this enabled her to receive care in a more supportive way. But it was very much a daily lottery, wondering with trepidation who was going to come walking through the door.

How many of our elderly, I wonder, live alone and don't have someone to observe some of these practices and advocate on their behalf?

## 4. Botched Healthcare Provision

Were statutory guidelines followed?
Where are the missing reports?
Why was post-operative care ignored?

Respiratory or urinary tract infection is a common problem among the elderly and mum was no different. Medical guidance usually recommended hospital admission so that antibiotics could be administered intravenously. For this treatment she was admitted to Ninewells on a few occasions.

### Neglect

During each admission, I was usually called by someone downplaying the latest incident while making references to ‘a little fall’.

During covid lockdown, I was only able to visit her for one hour daily. This meant her fluid intake and nourishment were compromised. Not all of the wards to which she was admitted, had the resources required to hydrate and nourish patients properly.

This was an issue of concern because in the hospital she was more vulnerable than usual. Not unusually for an older person, a hospital can result in the temporary onset of delirium. This created a higher level of dependency on care and nursing staff to ensure her basic needs were met. During admissions, malnourishment and dehydration were common concerns.

She was rarely showered. Her skin was not managed properly meaning skin folds created a breeding ground for bacteria. During discharge, she arrived home with skin integrity issues. This required prescribed creams, dressings, and nursing care due to a failure to maintain cleanliness. During one discharge, someone had stuck a continence pad under her breasts (a vulnerable area for the build-up of moisture). The skin was inflamed and seeping. It should have been treated and dressed; in fact,

it could have been avoided. I called the Senior Charge Nurse of the ward concerned to make her aware of what we had discovered. My feedback was not appreciated. The carers made references in her care notes.

When she initially entered Ninewells for a short course of antibiotics, I discovered she had been placed into a side room. I alerted people that she wasn't someone who could be left unsupervised. I referred to a previous neck fracture. I explained that, unless it was guaranteed cot sides were kept up, she would tumble from bed in the night. I explained she was currently delirious, a condition many elderly patients develop in the hospital. A senior prescribing nurse visited. She seemed rude and hostile. She responded to my information as if it were a request for a particular room with a particular colour scheme. In fact; I was alerting the ward to a very obvious health and safety hazard. When this nurse read her medical notes and examined her, this substantiated my claims and her attitude softened. It was a matter the ward should have picked up by default.

## Injury

Ultimately she transferred to the Royal Victoria Hospital for a short program of physiotherapy. On the evening before discharge, I arrived to discover her lying in bed in agony. While being accompanied to the bathroom, there had been a serious incident. Resource pressures on the ward meant two temporary carers were recruited for the day to provide interim cover. There was insufficient staff on duty. These bank carers operated in a ward full of vulnerable elderly patients.

They accompanied her to the toilet. She returned with a fractured femur in three places, a fractured hip, a lump, and bruising to the forehead. If a moving and handling plan existed, then it would seem these carers were unaware of it.

## Varying accounts

Mum's account is that when she lowered to sit from a standing position, the wheelchair inexplicably moved. She tumbled instead to the tiled floor. This was not unusual because this had happened many times at home using her commode chair.

Usually, the carers had failed to lock the wheels or stabilise the back of a chair before she sat down. Fortunately, at home there was carpet. The features of this fall seemed all too familiar. I believe her account because her greatest concern was about the impact on the carers. She was concerned they would get into trouble.

The hospital's account, though versions varied according to who you spoke to, is that she simply missed the chair and fell. They claimed both carers supported her with a guided fall. They didn't explain how, if the carers were close enough to support her falling, they had failed to stop the chair moving and failed to support her sitting. Many older people move and position very slowly. While positioning their bodies into a sitting motion, there is an ample window of opportunity to observe approaching hazards. But they claim – she – missed the chair.

The account offered to the paramedics was that when they were lifting her from the floor onto the bed, they heard a snapping sound. They claimed this was most likely when the fracture occurred. There are varying accounts about whether she was injured while being seated, guided, or lifted.

If she was lying on the floor after a fall and injured, why did they move her? Would guidance not suggest that she should have been made comfortable and offered reassurance until the paramedics arrived? Would guidance not suggest that the extent of any injuries should be assessed before moving a person?

## A&E

Upon arrival to A&E, she was assessed. I was asked what happened. I relayed these sketchy details. Such was the implausibility of these versions that the assessor struggled to suppress a chuckle and replied, "Whatever happened, she didn't sustain those injuries from a guided fall". This was a foregone conclusion.

When I casually mentioned this conversation to a nurse back at the ward, she glanced back at me in horror. That was when the penny dropped. Naively, it didn't occur to me that there might be cultural practices for the way in which incidents are managed.

People had already established that there were no witnesses; it was her word against theirs. Consequently, it was considered a no-fault incident; HER fault.

## Ninewells

At Ninewells, she received an operation to repair the fractures. A metal plate and pins were inserted into the knee. It was a very traumatic and painful procedure. She then returned to the Royal Victoria Hospital to continue her recovery. The wound failed to heal completely and became infected. She was transferred back to Ninewells again where she received a second operation to flush the wound and returned to the Royal Victoria Hospital to continue a program of rehabilitation.

## Operation

Early on the morning of that first operation to repair the fractures, a doctor approached me. I was escorted into a side room. There, she attempted to prepare me for the fact that giving an anaesthetic to the elderly comes with a high level of risk. I needed to be aware that she may not survive the operation. Never mind an anaesthetic; I was wondering whether she would survive much longer at the hands of health and social care staff.

The family spent the day by the telephone awaiting news which finally arrived later that day. She had made it through the first stage though there was some way to go.

## Postoperative care

As is customary before operations, preoperative fasting or NIL by mouth guidelines were followed from the previous day.

By the time I managed to visit her at nine o'clock, she had received no food or fluids for 24 hours. Her mouth was very dry. She was thirsty and hungry. Anticipating this situation, I had taken a sandwich and asked a nurse for some water and tea to serve with the sandwich. The night shift had just started around the same time. I approached a nurse and asked for some tea to serve her. The response was that

they were all busy but would ‘get round to it later’. I explained she had just come out of the theatre and hadn’t received food or fluids for 24 hours. She was diabetic. I pleaded my case so that I could hydrate her, break her fast, and get her settled in comfortably for the night. But my appeals fell on deaf ears. The senior nurse was unyielding. As I had little faith that they would ‘get round to it later’ I was disinclined to leave her. So I ventured upstairs to the concourse where I purchased a cup of tea from a machine and returned.

On behalf of the nursing team, I duly attended to her post-operative care. Following that incident, I visited every mealtime to deliver and feed her meals. It was important to her recovery and my visits ensured she received some level of hydration and nutrition. I can say with certainty that she would not have been hydrated and nourished properly if I had relied on the nursing team in that ward at Ninewells. In a civilised health care system, you would think that disabled and post-surgery patients would have more specialist care.

## Meeting

The following day I met a senior professional to discuss the matter. I explained the circumstances of the injury leading to the operation and a refusal to give her a cup of tea. A different account was offered by the nurses involved, which to me, didn’t seem to have any basis in reality. Nevertheless, when I also explained the reason for the operation, there was agreement to address the matter. Knowing that someone appreciated the situation provided a measure of reassurance.  But it doesn’t explain why postoperative care doesn’t happen by default.

This represents a striking example of neglect. Failing to provide a vulnerable, elderly patient with essential post-operative care is unacceptable.

## Cot sides

During admission to Ninewells, there was the usual reception paperwork to complete. I always emphasised that falling from bed at night was the greatest risk facing her. I referred to her fractured neck. I requested that cot sides were kept up at all times

while she was in bed. One obliging and dutiful nurse wrote this on the front of her medical file in large bold writing. But of course, staff had to read the file or even glance at the front of it. During shift changeover, the medical file was never read and the message was never shared.

Early the following morning another call arrived. Unfortunately, the night staff hadn't seen this message on the front of her medical file. She rolled out of bed in the night and banged her head. They called the neurologist who examined her and concluded that she was fine.

An important note on this point is that, during admission, where risk is identified, a falls risk assessment should be undertaken. A falls prevention action plan should then be drafted. This report should accompany the patients' medical records. Staff should acquaint themselves with this important information during handovers; especially staff directly responsible for the safety and welfare of a vulnerable patient. I have previously asked to see these but they have never been produced. I would be very interested to establish if these assessments were completed during every admission and, assuming they were, if there is any evidence to suggest they were shared.

## Rough handling

During one visit, I left her bedside to allow two carers to change her bed linen. I stood in the corridor while the carers completed their work. I heard a series of disconcerting cries. Wondering if she was struggling alone, I approached the curtain and peeped through. The nurses present were silent and appeared to be in an apparently foul mood. There was no exchange or interaction. They offered her no indication about what they intended to do. In complete silence they rolled and mobilised her in various directions. They were insensible to her cries in response to this rough handling. Good nurses communicate with a patient during moving and handling. They will explain their intentions. In this silent atmosphere, mum lay passively, checking their surly faces.

I mentioned this episode to a senior nurse. Later, he invited me for a chat. His response was that he had spoken to the carers. While it wasn't their intention to treat mum in this way, they had accepted a need to be mindful in the future about the impression given while providing care.

How is that for a play on semantics?

## New Injury

She returned to the Royal Victoria Hospital for physiotherapy on her damaged leg. A few days later I noticed significant bruising and a new injury to her shin. Mum said that the nurses were taking her to the bathroom. They transferred her using stand aid equipment and in the process banged her leg which was very painful. She called out as the machine started. She asked the nurses to stop but they didn't. I consulted the nursing team who denied any knowledge of this incident. But neither could they explain how this new, very visible bruising had occurred. It was another mystery. There is no evidence of any incident report which, in view of the history, seems an important matter.

## Indignity

On another occasion when I visited I walked in to see her sitting in a busy public area. While being dressed, her top hadn't been pulled down completely. Her breasts were exposed. In her delirious state, she remained unaware; so were the nurses regularly passing by. It was a scene of utter degradation. Witnessing this particular indignity was probably one of the more heartbreaking scenes I have witnessed in the hospital. If mum had any idea this was how things were going to turn out when she reached old age, she would have been devastated.

## Hazard

During another visit, I entered at lunchtime. Lunch had been served. She had been left lying horizontally in bed, with a trolley over her. A bowl of hot soup was placed on the table. She was reaching upwards trying to feed herself and spilling most of it on

her chest. A nurse served that hot soup without elevating the top of the bed and left her to fend for herself. Why was she even in bed?

## Indignity

During the same visit, she asked to visit the toilet. Supervised, she was able to walk. But rather than go through the time-consuming and arduous task of getting her out of bed and escorting her, the team left her horizontal. They put a bedpan beneath her although I had expressly asked them not to do this. Going to the toilet, lying prostrate over a bedpan can be a very undignified and uncomfortable experience. Mum told me she didn't want this to happen and I conveyed this message to the nursing team.

The nurses left the room and closed the door. After half an hour, there had been no apparent activity. I approached the door and heard her in a panicked state shouting for help. They had left her on a bedpan in a darkened room and forgot about her.

This demonstrates that many of the fundamental failings seen during home care provision were also seen in a nursing care environment. During that particular admission, the lack of kindness or compassion was striking.

Across both sectors, there were many examples of a critical lack of moving and handling competence. This time resulting in serious injury,

Whereas some nurses and carers seemed reckless, by contrast, the Occupational and Physiotherapy teams seemed overly cautious when using equipment. In addition to their specialist training, this probably goes some way to explaining why Occupational and Physiotherapy professionals inspire far greater confidence when using equipment.

So increasingly implausible were the explanations that, as the incidents continued, I was expecting to be told that Covid was to blame for her injuries and that the dog ate the missing reports.

## 5. More Botched Healthcare Provision

Why was she unnecessarily confined to bed in hospital?

Where are the various reports?

Why are people using equipment to move and handle vulnerable adults not always properly trained and competent?

She was admitted to Ninewells for the final time in September 2020.

Five days maximum we were told. On the day of admission, we had visited the coast followed by lunch at a garden centre. She was in good spirits. But she developed a cough indicating the onset of a chest infection. Hospital admission was recommended so that a short course of antibiotics could be administered intravenously. We were told this would offer greater efficacy than medication taken orally at home. She railed against admission. Neither of us was at all keen on her returning to hospital. Neither was her granddaughter who was present. However, we were assured she would only remain in hospital for the short course of antibiotics. She would then return home without having to enter the Royal Victoria Hospital. Ultimately we all conceded. She walked to the chair transporting her to the ambulance. In retrospect: if only we had all listened. Sadly, that proposed short stay in hospital for a course of antibiotics served only to hasten her decline. That concession represents step one in the chain of events that were to follow.

### Accidents don't just happen. They are caused

Accidents don't just happen. They are caused by a chain of events. They are caused by the actions or inactions of one or more people. Not every inaction or dangerous act produces an accident. But no accident is usually produced unless one or more factors are involved. Just as people cause accidents to happen, they can prevent them from happening.

This particular admission to Ninewells provides a case in point about how the circumstances for an incident need to be created. As the following circumstances unfold, we then discover what the consequences were.

### Step 2: Confining to bed unnecessarily

Upon arrival to Ninewells, upon admission mum remained unnecessarily confined to bed. This represents internment and can be considered a breach of a person's human rights. She was left to languish in bed unnecessarily and briefly mobilised by physiotherapy. To my mind, many similar patients remain confined to bed because getting them out of bed takes up time which many busy nurses simply don't have.

This matter is an important consideration in the events that were to follow because she was alert and mobile upon admission. But she was immediately debilitated. There was no apparent reason why she should not have been immediately out of bed the following morning and moving around as she had been at home.

Why was she confined to bed unnecessarily?

The consequence of this apparently standard practice is that these long periods of immobility, besides being unnecessarily debilitating are detrimental to health. Confinement to bed can impair respiratory function. It increases the risk of deep vein thrombosis. The longer a patient is confined to bed, the longer the recovery period. Prolonged bed rest, inactivity, and a lack of socialisation can lead to depression, anxiety, and delirium. After just twenty-four hours there are rapid reductions in muscle mass, weakening of calf muscles which in turn reduces mobility. The vicious cycle is that, as in her case, she was transferred to the Royal Victoria Hospital for physiotherapy to restore this avoidable damage.

It seems to me that she was confined to bed for no other reason than staff convenience. The inevitable consequences are that many of these problems came to pass. Ultimately, an otherwise unnecessary transfer to the Royal Victoria Hospital became necessary. This is grossly unfair to the patient. It also seems unfair to the Royal Victoria Hospital that unnecessarily inherits a problem created by Ninewells.

On what scale is this happening to elderly patients? What are the resource implications including the inevitable bed-blocking consequences?

### Step 3: Inappropriate urinary catheter use

Similarly to other admissions, she was catheterised. Again there was no apparent reason other than staff convenience. In certain cases, there may be some level of benefit but there are also significant risks associated with catheterisation. This was another lost opportunity for mobilisation.

### Step 4: Inadequate management of hydration and nourishment

Unsurprisingly, after a few days in this neglected state, she developed delirium. But the condition always subsided once she returned home. While there was a jug of water on her bedside table, staff would make a daily note of a lack of fluid intake. The team blamed this delirious patient for not drinking enough. They were blithely aware of their failures in regularly encouraging her to drink water.

Similarly, in a delirious condition, she needed help feeding but there were not enough staff to spend time assisting her with meals. When I was able to gain access I spent the time feeding her food and fluids. But during covid, visitation was highly restricted. I was permitted one hour. When visits were restricted this had consequences for her levels of hydration and nourishment.

### Step 5: Avoidable use of intravenous drip

Typically, responsibility was passed to her. I was told she wasn't drinking enough. In fact, she was delirious and wasn't drinking at all. A cycle developed whereby she would be left to dehydrate over a few days and then she received fluids intravenously. After another few days without fluids she was given another drip. Would it have taken too much effort to have pre-empted this situation? Could nurses not have encouraged her to drink water throughout the day? How long does this task take?

### Step 6: Inevitable unnecessary decline

This negligence resulted in her stay slowly extending. She started to become depressed and delirious. She became dehydrated. She rarely ate. She started to develop muscle weakness. That familiar vicious cycle started; and in my view it was completely avoidable.

As her condition started to deteriorate through this neglect it was clear I had to discharge her to the safety of her own home. I spoke to one of the team. I suggested that, since she had completed the course of antibiotics it would be beneficial to discharge her to home. A nurse tentatively agreed, pending a visit from physiotherapy. She then stood up, clapped her hands, and said to mum “right then, if you’re going home soon we need to start getting you out of bed tomorrow”. These were very insightful remarks.

### Step 7: Physiotherapy assessment

The following morning a nurse asked physiotherapy to visit and assess her for discharge. I asked to be present and was told I would be called with a prearranged time to meet. But the physiotherapists visited her without informing me. The message left for me was that her mobility was too weak to get out of bed and needed to transfer to the Royal Victoria Hospital. I asked a nurse to ask them if they would return. They made another lame attempt to get her out of bed and said again she was too weak.

I offered to demonstrate her mobility. I encouraged her out of bed and asked her to stand. She walked around the ward and back towards the bed. Significantly, this was following almost two weeks confinement. Their response was “but she does it for you”. I replied, “She’s doing it because I’m encouraging her”. The physiotherapists agreed there was indeed a level of mobility there. It was agreed she could be discharged the following Monday.

## Step 8: Confinement continues

Despite the nurse's earlier remarks, the team failed to 'start getting her out of bed tomorrow'. She remained confined to bed. When I originally proposed discharging her, her mobility was border-line. A few days later, due to continued confinement, her mobility continued to decline. We had now lost that window of opportunity. Ironically, the team were still willing to discharge her. But where transfer to the Royal Victoria Hospital had not previously been necessary, it had now become necessary.

## Step 9: Commode incident

On that same day, having all now conceded that her mobility had deteriorated to a point whereby a short course of physiotherapy was necessary, she asked to visit the toilet. Two nurses brought a commode to her bedside. She got out of bed to use the commode. I was visiting at the time and moved into the corridor. From behind the curtain, I heard some commotion followed by a groan.

I ran around the curtain to discover her on her knees; the vulnerable knee that had a metal plate and pins inserted. The weight on the knee was causing her significant pain. One of the nurses disappeared to get equipment to lift her. The other nurse stood passively by. To relieve her pain I lifted her backwards off the floor to relieve pressure on the vulnerable leg. No one was able to offer an explanation for what happened except that she slipped.

I suggested that it might be an idea to ask a doctor to examine her vulnerable leg to check that none of the pins or metal plate had moved. The carer and nurse present said this was common practice after an incident. Days later I asked for an update. No-one was able to provide details of any examination.

## What matters to you lip service

Health and social care policies propose cultural changes by shifting the focus of care support services from ‘what is the matter with you?’ towards ‘what matters to you?’

These policies aim to encourage patient public participation and engagement by ostensibly, involving people in their own health and care arrangements.

When an elderly patient is vulnerable, involvement may be achieved through conversations with those who know the patient best; a family advocate who understands and is able to convey the patient’s preferences. After all, who is better placed to advocate on behalf of a vulnerable patient than a carer and relative known to the patient for many years?

Mum was never asked what matters to her. There were meetings held about her; discussions about what should be done to her; decisions were made for her; and all these decisions were then conveyed to her. When I made approaches to ask questions or make suggestions, my input was rarely welcomed. I fail to see where exactly was the consultation and involvement.

For example, during this particular admission, there was a problem with care provision that needed to be resolved. I attempted to discuss discharge arrangements with someone in the discharge team who, for no apparent reason was caustic in response. This happened in front of a doctor who didn’t seem to mind. This offered an impression that rude behaviour is acceptable practice. Neither person was acquainted with us or our circumstances. Neither made any attempt to find out. If they had found out more about us, perhaps they would have been more civil. It might even have resulted in her discharge. I asked another clinician with whom we were acquainted to convey details of our circumstances. A week or so later I received a call at home from the same team. This individual was now friendly and polite. I was even complimented. There was no real purpose to the call other than to offer an implicit apology for what happened. It was appreciated but it also reinforces a key point.

Similarly during that admission, I made attempts to ask questions or offer suggestions to the multi-agency team, making decisions about her care and welfare. People were happy to tell me what had been decided. But my involvement, as her advocate, was far from welcomed. If they had listened, I had some valuable information to offer which might have resulted in her discharge.

For all these policies being bandied around, I struggle to see where family input is welcomed and embraced, as the policy suggests it should be. To my mind, any attempts to share your views ruffled feathers. In fact, during this particular admission it was positively resented. If our attempts at engagement were resented, then I cannot see how engagement is common practice.

## Step 10: The Royal Victoria Hospital

She re-entered the Royal Victoria Hospital for a short program of rehabilitation.

She entered a new ward at the Royal Victoria Hospital with which we were unacquainted. It was a very unfriendly setting and she seemed desperately unhappy there.

While fully alert, she was left to continue languishing in bed; nourishing, washing, and toileting in bed while staring at blank walls in silence. I would like someone to explain to me why this doesn't constitute a form of psychological torture. When it wasn't necessary, why was she left in bed? And where is the humanity in that situation?

## Accident manifested – that dreaded call

It was only two days before the dreaded call arrived. I was told again that she had "slipped" while they were using a stand-aid and her shoulder had been dislocated. Mum didn't need a stand aid two weeks earlier when she was admitted to Ninewells. She walked towards the paramedic's chair on that occasion. She should have been walking around the ward daily and retaining her mobility.

What is interesting about this “slip” is that a stand aid is aptly named because it helps the user to stand from a seated position. In normal circumstances, the patient is first securely strapped in. The equipment is designed for this purpose. There are leg protectors to prevent the legs from ‘slipping’. Indeed, the sling and straps around the waist and under the arms provide security in case the legs buckle. If the user slips, there is protection; but not apparently on this occasion. Why?

So this claim that she slipped and dislocated her arm was yet another mystery. I have plenty experience of witnessing these incidents across four years. I would strongly suggest that what happened this time is what has happened many times previously. I have frequently observed staff, at home and in hospital, failing to ensure the straps are fitted securely. I have frequently had to intervene and I have previously made complaints about near-miss incidents.

Many professionals have a habit of leaving the straps dangling around the elbow which can be fatal. The consequence was that, when the bar started to rise, the loose straps would also rise. Left to hover around the elbow, when they tightened they started to slide around the outer elbow and break free. This is what happened during the many near misses I rescued.

Moreover, how do you dislocate a sitting person’s arm if, as alleged, she slipped from a stand aid? How exactly did the dislocation enter the equation? Again there were no answers. Again the incident was shrouded in mystery. ‘She slipped’ was the best response these moving and handling certified professionals could conjure up. This constant explanation repeated for every incident is an insult to injury: another jackanory.

## Neglect

It was becoming impossible to get her out of the system. Again she transferred to Ninewells to visit the theatre to repair the injured shoulder. Following the operation, when I visited her at Ninewells, there was no water jug on the bedside table and she was soiled. She had pressed the buzzer. A nurse arrived to deactivate it before

leaving; telling her she would be back as soon as they could. That was an hour earlier.

## Under-resourced

Across the entire ward there was only one nurse who was extremely occupied. She continually disappeared and reappeared. Visiting was now restricted due to covid. The hour spent with her would be the only time I saw her that day. I visited the concourse to buy some water and fed her food and fluids during that limited time. The soiling I would have preferred to have managed before I left but unfortunately, that wasn't permitted due to health and safety! I was forced to leave after my assigned hour. I have no idea what time the team got round to attending to her soiling. The following day she returned to the Royal Victoria Hospital.

## Transfers and equipment

Because her shoulder was vulnerable and her arm now in a sling, she could no longer use a Zimmer frame for support. Consequently, she could no longer walk and it was now necessary to mobilise her using the hoist. During admission two weeks prior, she walked using it.

## No reflection and no learning in evidence

Following earlier leg and hip fractures followed by this dislocation, you might think that there would be evidence of learning. You might think that carers and nurses would be ultra-cautious when moving and handling her. Not so. The situation continued to deteriorate. This is when the seriousness of the problem across the health and social care system really set in.

## Stand-aid incident

Her confidence was now shattered and understandably she was terrified of professionals mobilising her. During future visits, if they needed to transfer her, I

would remain at her request. The staff appeared to resent it but my presence offered her a measure of reassurance.

During the next incident, the nursing team attempted to support her from an armchair to bed using a stand aid. She was in the chair because it was visiting time and I had requested it. Four people arrived. They attached the sling and started the machine. I noticed her still holding the bar as it started to rise. Her arms should have been crossed over her chest. As usual, the straps were dangling and starting to slide outwards over her elbow. This is exactly what has happened countless times before. It is almost certainly what I suspect happened the previous week when they dislocated her arm. During this incident, four people hovered around her as the stand aid bar started to rise. She clutched the bar with her hands and her arms started to rise. This was an accident in motion and not one person noticed. It was necessary to ask the team to stop the equipment and point out the hazard.

**Four people were in attendance and I intervened to prevent what might have resulted in the next 'slip'.**

**Hoist incident**

The following day, while using a hoist two nurses struggled to insert the hoist sling. Following a lot of struggling, they succeeded. They were very friendly, pleasant people and hoisted her from the bed to an adjacent armchair. She landed on the edge of the chair. They started to un-strap her. Removing the straps and leaving her in this precarious position could have resulted in her sliding off the edge of the chair. This position is particularly dangerous when pulling a sling from beneath a patient. I alerted the nurses to the space around her lumber area. They lifted her and landed her again, and I assisted by pushing the sling so that she landed at the back of the chair.

**I intervened to prevent what might have resulted in the next 'slip'.**

## Rolling in bed for washing

Having returned from the theatre with her arm in a sling and confined to bed, the team decided to wash her in bed. They rolled her from side to side to complete her ablutions. They seemed oblivious to the fact that they were placing weight onto her vulnerable arm. Her arm was supported by a sling which provided a clear visual aid if they missed all others. These were qualified nurses who didn't seem to consider this action might present a risk. I requested that she wasn't rolled in bed which would aggravate her injury. If they did have to roll her, I asked if they would only roll her onto the uninjured shoulder. It doesn't make a lot of sense why a visitor would need to point out these obvious hazards to a professionally qualified team.

## I intervened to prevent what might have resulted in the next 'slip'

## Hoist sling incident

When inserting the hoist sling in bed, similarly, I noticed that the team were again rolling her and putting pressure onto her vulnerable arm. They rolled her from side to side to insert the sling beneath her before tersely pulling it around her body. This rough handling caused her immense discomfort which she was very vocal about. Yet the nurses continued. They didn't seem to recognise that it is possible to insert a sling without causing a patient considerable discomfort – if that person is properly trained.

Fortunately, on this particular occasion, a physiotherapist was in attendance that was acquainted with our situation. I shared my concerns. Given the history, this physiotherapist was very keen to resolve these constant incidents and injuries. The physiotherapist offered the qualified nursing team guidance on how to avoid applying pressure to a shoulder injury by inserting the sling from top to bottom i.e. down the back of a patient's head and beneath the bottom. This avoided rolling a patient with a shoulder injury. It is a more comfortable method for a patient with or without injury. The nurses didn't appear to appreciate the physiotherapists' guidance.

## Confined to bed

At mum's request, I asked the team not to leave her in bed all day every day. She didn't like being prostrate all day. It was giving her bedsores and she was uncomfortable. It was affecting her psychologically. I asked if she could be dressed and transferred to a chair for, at least some of the day. I explained that she wanted to be taken to the toilet on a commode or to the bathroom. She disliked having to lay prostrate over a bedpan in bed. The team reluctantly acknowledged these requests but they were all ignored and she continued as before.

Throughout all of this fiasco, she remained mentally alert. The psychological impact was harrowing to witness. There is an undeniable need for many carers and nurses to observe proper safety practices and show compassion in their professional practice. Can education be used as a tool to improve skills in this area?

## Foreseeing incidents

An accident is simply an incident that no one could have reasonably foreseen and for which no one should be held responsible. But by definition, if you fail to ensure that the workforce is trained properly, how can leaders fail to foresee that incidents will occur?

## 6. Rescue

It was most definitely time to rescue her, for her safety and my sanity.

Having dislocated her arm, she was unable to use her Zimmer frame for support meaning she was unable to walk unaided. As this disrupted the program of physiotherapy there was nothing more the hospital could do for her. Technically, she was medically fit for discharge. But her discharge was delayed, due to resourcing problems finding home care.

It was most definitely time to rescue her; for her safety and my sanity. I arranged for a private carer to help me meet her home care needs, until care provision could be found. It was the safest option because I find the constancy of incidents and injuries highly suspect.

There was a very unfriendly atmosphere in this particular ward and mum felt very uncomfortable. One nurse was unnecessarily confrontational and aggressive. On one occasion, as soon as I arrived for visitation, without provocation or invitation, she appeared by mum's bed and tried to start an argument. When one nurse booked a visitation appointment, this nurse would call me back and cancel it. I would then need to call back and rebook. When I arrived to attend a prearranged appointment with physiotherapy and asked if she could call and alert them to my arrival, she first tried to thwart the meeting. She then walked between rooms doggedly trying to avoid making the call. This seemed to be the unremitting nature of the problem. There seemed to be a single correlation between negative attitudes and these injuries, incidents and indignities. In such circumstances, it's a problem you can live without.

The suggested causes?; metal fatigue; high levels of stress; low morale; resentful attitudes; struggling to cope; poor mental health; desensitisation; compassion fatigue; inadequate training; low competence; lack of support and a lack of leadership facing up to problems that many others see.

While many of those leading the system seem incapable of admitting it, some people work in the health and social care system that really shouldn't be there. What system exists to properly assess that people with the relevant skills are being recruited into the health and social care system? The reality is that there are people who enter the health and social care profession who are not ideally suited to it.

I can say with absolute certainty that she was safer at home than in hospital. As there was no care provision in the offing, I advised the team that I would be discharging her that Friday.

## Review Meeting

I attended a meeting to review her circumstances. It was immediately clear that I was not going to get to the truth about what happened. Indeed, the standard response to all my questions was blank glances and elective mutism. No information was forthcoming about how this new injury occurred.

I explained my view that accidents don't just happen. They are caused. I suggested that if we conducted a root cause analysis, mum's current stay at the Royal Victoria Hospital could be traced back to her admission to Ninewells. I explained the circumstances of mum's recent admission. She entered for a brief course of antibiotics. I illustrated how compound neglect created the circumstances for her current status. The key issue was that she was unnecessarily confined to bed. To my mind it suggests that, in some circumstances the Royal Victoria Hospital represents a depository for elderly patients neglected by Ninewells. As mums case demonstrates, transfer to the Royal Victoria isn't always strictly necessary. If Ninewells had maintained her mobility then she wouldn't have required transfer to RVH to recover it. Then she wouldn't have been injured and permanently debilitated in the RVH. Instead she would have returned directly home from Ninewells as mobile as she arrived. Two of the attendees nodded vigorously. The chair of the meeting glanced at me with a look of supercilious contempt. The meeting ended. If this response is supposed to represent leadership, is it any wonder that there are problems?

The Hippocratic Oath has been replaced with a new Health and Social Calamity Oath. It's no longer, first do no harm. It's, first blame the patient then develop elective mutism.

## 7. Discharge from Hospital

Why was my mother's care provision reduced?
Why did the discharge team assess her care provision based on resource rather than need?
Why was she discharged without a care plan?

### Discharge

The discharge team was responsible for arranging the details of her discharge. The first challenge was finding a package of care. Not unusually, nothing immediate could be found.

When my message that I would be discharging her for her own safety reached the team, I received a visit.

I was asked if I would give the team time to find a package of care before discharging her – effectively sanctioning a delayed discharge. I reasonably explained that this wasn't possible. She had suffered too much. Remaining in hospital, confined to bed, staring at the walls was detrimental to her psychological well-being. Being unsafely mobilised by staff was detrimental to her physical well-being. She was deemed medically fit for discharge so I couldn't permit her to remain. She had to return home for her safety and well-being. This was also her expressed wish.

I attempted to offer reassurance by explaining that I had arranged a private carer. Together we would meet her care needs until a package of care could be found. I explained that for months during the covid lockdown, no one visited. I successfully met her care needs alone and kept her safe.

Clearly, there were reservations. It wasn't that people had questions or reservations; the problem was that they seemed to make a series of incorrect assumptions and treated my responses with scepticism.

We were well known to all the community teams. All anyone with any reservations had to do was to refer to a Consultant, GP, Community Nursing Team, or Social Care. These professionals could have shared their awareness of our circumstances. Moreover, these details should have been included in her medical records.

But people continued to doubt me and didn't bother checking the facts. What was audacious about the situation is that, across the health and social care system her care needs had never been consistently met. When I was providing her personal care, she had never been injured. As evidenced during that current stay in the hospital, it seemed to me that health and social care professionals needed my guidance far more than I needed theirs.

So why did these health and social care professionals struggle to accept that her son was capable of meeting her care needs far better than any of these teams had done? Perhaps the situation might have been perceived differently if I was female? It seemed to be what they were suggesting. Why else would there be a problem?

The following day when I visited, I was approached again. An unspecified package of care had been found but it couldn't commence until the following week. Would I delay discharge until then?

I repeated my answer. There was no reason to. She wanted to return home. She was at risk of harm in hospital. I needed to remove her from an environment that had repeatedly failed to keep her safe. I repeated that I had provided care very successfully for four years. I was very capable and very experienced. We were known to community teams.

Sadly, we continued grappling over the matter. Her medical file was searched for the Power of Attorney document. It was checked to determine if there was a clause allowing the hospital to overturn our decision. In the end, the team had to accept - our - decision. In all actions I was advocating for mum's wishes and in her interests.

## Hypocrisy

Even prior to this admission, social care has questioned my ability to provide care. To my mind it was both ironic and insulting. I never received a call from social care asking about the numerous incidents that happened when she was in the care of the professionals. Neither did I receive calls asking if basic care standards were being met. But, although social care was fully aware that I provided care on my own during the covid lockdown, my ability to provide care was questioned.

In my opinion, no sane person would have left a vulnerable loved one in hospital in these circumstances.

On the morning of discharge, no details of the impending care provision had been offered. I requested an urgent meeting which a number of professionals attended. Given there was so much doubt over my abilities and claims, I asked my brother and our private carer to attend to provide evidence that she wasn't a figment of my imagination.

Professionals attending the meeting continued to doubt my ability to meet her care needs. Even with our private carer in attendance, they asked me again to leave her in hospital which was becoming exasperating.

To us, it would have been rather more appropriate to have doubted the competence of the people moving and handling her. Besides being grossly insulting, it also seemed like an act of sheer hypocrisy.

## No care planning

I asked for details of the package of care. But the same people doubting my abilities and intentions had failed to draft a care plan. No details were known. Except that the program would commence at some unspecified time the following week. Further details would be provided after she returned home and after the unspecified care provision had commenced. This meant that carers, unfamiliar with any aspect of her

care needs, would be arriving to provide personal care for an injured, vulnerable, elderly patient without any guidelines.

### Reduce care provision

Due to her recently acquired injuries, there was now a new need to use equipment. As a result, her care needs had increased. I was later to discover that, while her care needs had increased, her original care provision had now decreased.

### Gaps in provision

If people were so doubtful of my ability to meet her care needs, one key question outstanding was; who exactly was going to plug the gaps left by reducing her care provision?

When I asked this question about the reduction in care, I was told that I need to appreciate resources are limited. But according to the social care policies, assessment for care should be based on need and not resources.

To my mind, these people didn't seem to think things through. They were full of constant contradictions.

In summary, she was now being discharged in a worse state of health than when she was admitted - AGAIN. Her care needs had increased. Her package of care had been significantly decreased due to budget limitations. This left significant gaps in care provision. My ability to provide adequate care was doubted. And apparently no consideration had been given to how this gap in provision would be closed.

When I asked for clarity about how gaps in care provision would be met I was told to pull the cord at home and request additional support from Social Care Response. But Social Care Response is an emergency and on-call support service. The service doesn't exist as a supplementary home care service to plug multiple daily gaps in home care provision. If this happened on a large scale, what impact would that have on this service?

In my view, it all serves to suggest a need for health and social care services to put their own houses in order before unfairly judging and unnecessarily meddling in the lives of others.

I would suggest this bureaucratic spring clean might start by ensuring every professional is effectively manual handling trained; bringing to an end incidents and the injury of service users; ensuring all our elderly are treated with dignity and respect; planning properly for the discharge of patients; acting in accordance with policies; focussing on need rather than resources and; ceasing to place people in harm's way.

## 8. More Botched Home Care Provision and…a Hospital Visit

Despite the evidence, why did social care continue to permit the hazard of rolling a patient in bed without cot sides?

Why are some carers using equipment to move and handle vulnerable adults not properly trained and fully competent?

Why did A&E discharge a vulnerable person without proper investigation of this injury?

Was A&E's inaction a dereliction of duty?

Once home, her home care was now the direct responsibility of the Council, as opposed to one of the private providers that had previously visited.

### Drafting the care plan and the moving and handling plan

During the discharge process, a moving and handling plan was drafted. But the care plan outlining aspects of her personal care needs hadn't yet been drafted. Following the new injury, when you consider the extent of her needs and injuries it is astonishing. How would the carers know anything about the patient?

The moving and handling plan was left for the carers to refer to. The care plan identifying her personal care needs remained awaited.

Now that she lacked mobility, the profiling bed figured greatly during personal care. For this first time, all transfers were completed using a hoist. It wasn't long before the incidents started.

During the first draft of the moving and handling plan, I shared our concerns.

- Our greatest concern was her profiling bed. We were concerned about the bed being elevated high above the floor while the cot sides were lowered without any rescue in place.

- We were concerned about carers turning her in bed and placing weight onto her vulnerable shoulder, as they had done in the hospital.

- We were also concerned about the abrasive and incorrect way people were inserting the hoist sling. The sling needed to be inserted from top to bottom instead of side to side to avoid placing weight onto her vulnerable shoulder. Additionally, the sling needed to be pulled around her body and between her legs gently, so that it didn't rise up into her groin or cause skin abrasions. Whilst sitting during transfer, boned synthetic material cutting into a persons' groin can be very uncomfortable.

These important points were incorporated into the moving and handling plan.

## Plans not followed

From the first visit, the moving and handling plan was rarely read or followed. We resumed that familiar journey of daily fear and discomfort. This was accompanied by recurring diplomatic appeals.

## Social Care Response

The daily care provision required was inadequate. Whilst far from ideal, it was necessary to pull the cord and ask social care response for assistance. On the day she arrived home we pulled the cord for social care response to attend. She was in bed needing care.

## Incident

The social care responders made no attempt to read the moving and handling plan. So, I attempted to explain the circumstances of her dislocated arm. The sling she wore provided a clear visual aid. I asked them not to roll her onto her vulnerable arm or put pressure on a shoulder injury that was still healing. This message seemed not to penetrate. The negative response received was "well we're going to have to roll her a little bit". A properly moving and handling trained professional would

understand the mechanics of mobilising an injured patient and would be able to complete personal care without a double roll. I repeated my message highlighting the dangers of applying pressure to her vulnerable shoulder. I referred to the moving and handling plan.

Despite clear guidance about the situation and consequences, the carers rolled her anyway. Given that the carers disregarded these alerts, and many continued to, when her shoulder was subsequently dislocated again, I am unable to accept that this injury can be classified as an accident. To us, this represented another example of failing to adhere to warnings or act prudently. Ultimately, this inaction resulted in an injury that was completely avoidable. To my mind that seems to constitute negligence.

## Reported safety breach

I alerted social care response who resolutely refused to accept that there had been a safety breach. However, I was told that the matter would be investigated and I would receive a response. I heard nothing more.

## Home care commences

When the daily carers started, the team didn't seem to be happy following the moving and handling plan guidance. They disagreed with some aspects of it. Many were concerned about health and safety; their own health and safety. Notwithstanding that situation, it seemed very disrespectful to assume greater knowledge than their qualified superior.

## Another occupational therapist home visit

We then invited occupational therapy back again to address these concerns. A meeting was arranged attended by social care professionals and myself to discuss the plan.

## Notification of a hazard

The first discussion turned to the profiling bed. I explained the history of incidents, the hazards, and also mum's fear. I was concerned that the carers elevated the bed electronically to more than four feet above the floor, then lowered both cot sides before rolling her over to the edge of an air mattress that kinked. It was very risky and terrifying for her. The only thing preventing her from falling was a carer standing in front of her. Given the history, this seemed like a recipe for disaster. Rolling was only necessary when working on the back of the body. Access to her back was only required from one side. I asked for one cot side, the one facing her when she rolled, to remain in place for her safety and security.

## Resistance

Social care disagreed. The team were concerned about their own health and safety. Their view was that both cot sides had to remain lowered because carers could damage their backs leaning over the cot-side. I didn't consider that the hazard was fully appreciated. As I suggested, mum fractured her neck falling from a low divan. From a bed raised more than four feet above the floor, she could lose her life.

I explained that if she was being rolled to one side, this would be for the purpose of one carer working on the back area and not the front. Another carer would be in front of her. The carer wouldn't be completing any care tasks only holding her towards their direction. There didn't seem to be any leaning across the bed involved. It didn't seem necessary to lower both sides which was evidently a hazard. Cot sides provide security – indeed, this is their precise purpose.

## Compromise refused

A compromise was proposed that one cot-side could be lowered at a slant. This was what had been written in the first draft of the plan. The top end of the cot-side could be lowered and the bottom side could be left in place. This would offer some level of protection to the legs at least. This position provided no barrier to the carer. The carer would not be required to lean forward over a bar. If mum's legs started to slide

off the air mattress, the lower cot side would prevent her legs from sliding off the bed. But this suggestion was refused. Social care remained concerned about carers injuring their backs.

What didn't seem clear to me is; where equal consideration had been given to the potential injuries a vulnerable patient could suffer as a result of a tumble.

I appreciated that, to some extent there may be a valid objection raised. But the central problem is that, there didn't appear to be any consideration given to the role of the patient in this scenario and no alternative solutions to keeping all parties safe were proposed.

Ultimately, our concerns were disregarded. No compromise was offered. We were forced to accept that both cot sides were to be lowered. The bed was to be elevated to over four feet above the floor. She was going to be rolled over to the edge of an air mattress that kinked. This was considered best health and safety practice to keep the carers safe. But it still didn't seem to address the other important matter about how the patient was to be kept safe.

The profiling bed with cot sides was delivered to keep her safe. Now it provided the means with which to cause her harm. While I am sure many may disagree, to my mind, this approach to health and safety practices and the management of hazards facing her seemed to be devoid of common sense.

## Hazard manifest

Naturally, it wasn't long before the hazard I had emphatically identified came to pass.

Carers are not permitted to apply prescribed creams or perform nursing duties. During care sessions, I was required to complete these nursing tasks.

Soon after this meeting, I was applying her creams and dressings, while she hung perilously close to the edge of the elevated bed with an air mattress. She started to slide. A carer in front called for help to rescue her fall. Another ran around the bed to

catch her. This happened four times or rather; four times I witnessed this near miss. It can be safely assumed that this near-miss happened more often than I care to imagine.

During the most serious example, the carers stood on opposite sides of the bed. I was called to perform nursing duties. While I worked on the back area, I noticed her legs starting to slide forward off the front end of the mattress. Her body would soon follow. At the top end of the bed, the carers were chattering, blissfully unaware. I dashed around the bed and rescued the fall. If I had not been present, she would have fallen to the floor. This would have resulted in another injury – or worse.

This is exactly what I had been warning these professionals about and it was only because this near miss coincided with my visit that this fall didn't turn into another serious injury.

If carers need to call for support to stop an otherwise avoidable fall from a prostrate position then they are not properly trained. If carers are chattering and unaware of a serious incident in motion, then they are not properly trained.

Another curious question is, if these health and social care professionals take health and safety as seriously as they claim, where are all the incident reports including all the recommendations?

Again I alerted social care. A short grab rail was fitted at the bottom of the bed to protect her legs from sliding again. My original suggestion of leaving one part of a cot side elevated achieved the same end. But it was seemingly necessary to have this series of near misses before people would open their ears, open their eyes and open their minds and fully appreciate our concerns.

## Objection

Subsequently, various carers arrived and noticed the new grab rail. I was challenged about whether an assessment had been completed. The grab rail covered a few

inches at the bottom of the bed – enough to protect her feet. It provided absolutely no barrier for carers.

Given the lack of evidence of incident reporting and the failure of many carers to read the care and moving and handling plans, it does seems to be particularly audacious of people to start introducing health and safety objections.

I contacted social care to discuss this matter. I explained that if this short grab rail at the bottom of the bed was going to be a problem, then I would remove the profiling bed and replace it with a divan. A divan would provide none of the luxury features of a profiling bed. There would be no need for debates about cot sides or grab rails. The divan would be low to the floor with crash mats either side. As to these issues raised about leaning over a cot side, carers would be forced to lean much farther over a patient in a divan. If carers didn't want to stand leaning over the patient they would need to kneel and lean over. But the situation had gone far enough. I heard nothing more about the subject.

## Divans are common

The sad irony is that, as some of the more amenable and supportive carers explained, in most homes; carers need to work with basic divan beds. Very few homes have profiling beds which are very adaptable. They said that carers either need to stand leaning over a divan or kneel on the floor stretching over the divan to work. There isn't any of the ease or luxury offered by a profiling bed. It seemed to me that there was a far greater risk of injury leaning or standing over a static divan, than working with a highly adaptable profiling bed.

## Rolled onto vulnerable shoulder

The following month, I was called to complete nursing duties. I entered the bedroom. Despite repeated discussion and formal documented guidance, mum was lying on her vulnerable side.

One of the carers present had collaborated in drafting the care plan and was contradicting agreed written guidance.

I asked why mum was rolled onto her vulnerable shoulder and I was told “but she seems fine”. In my view this seemed like a silly and irresponsible response that seemed to indicate a complete disregard for documented hazards, professional guidance and agreements.

As inconceivable as it may seem, this example of contradicting guidance and rolling her onto her vulnerable shoulder continued until the end of her life.

## Spot roll

I alerted social care to this incident and we were visited again. A solution was proposed to keep her away from the edge of the bed. It was referred to as a ‘spot roll’. Instead of pushing her body towards the edge of the bed, spot rolling involved placing a slide sheet beneath the body first. Once in place, the sheet would be used to roll her on the spot in the centre of the bed. This meant, in principle that her body would remain away from the edge of the bed.

Another technique was proposed to make the insertion of the hoist sling more comfortable. This involved the use of two glide sheets while inserting the sling from top to bottom.

In practice however, the opposite was true. Whether through obstinacy, indolence, or incomprehension I don’t know, but these practices were seldom followed. The risks remained. Once again, as inconceivable as it may seem, the problem of her rolling onto the edge of a profiling bed or reducing the strain cause while inserting the sling, were hazards never fully resolved.

## Sling safety & incidents

When slings are used safety must be taken seriously. The sling needs to be attached securely to the hoist and/or stand aid. If a sling is not properly attached a person’s

safety may be compromised. This can result in damage to the sling and danger to the patient. A sling can also be very uncomfortable if not attached to the body correctly. While slings are designed to be easy and safe to use, people using them need to be competent in their management.

A sling needs to be carefully inserted and there are techniques involved. While this can be achieved comfortably without trauma to the patient, it never was. Her fear, discomfort, and distress were obvious and completely disregarded.

There were many examples of the sling being attached incorrectly in the hospital and at home, even reported instances of the loops breaking free whilst in motion. I rescued mum from potential injury on multiple occasions when straps had been incorrectly attached. This incompetence resulted in a continual series of near misses.

Pulling the strap callously and abrasively during insertion resulted in bruising, scrapes, and skin burns.

## Expert carers

This perceived disregard for documented hazards while assuming greater knowledge than their qualified superior is disrespectful and unacceptable. To my mind, all the many carers had to do was to listen to the voice of qualified experience and follow that guidance.

To my mind, many unqualified carers seem to consider themselves greater experts than qualified professionals. There was never any shortage of unsolicited advice and expert opinion. Whenever a carer arrived and told us how experienced they were, this set alarm bells ringing. That was usually the time when care provision was at its worst. Ironically, the best examples of care were seen in carers new to the profession who seemed to have a gentle, caring and earnest approach and who were amenable to interaction. New carers read the care plan. They asked questions. They didn't mind listening to guidance and information. I noticed that mum was always far more relaxed in the presence of carers new to the profession.

Lack of experience was never usually our concern; that can be overcome. Our main objection was a refusal of many experienced carers to acknowledge ineptitude despite evidence to the contrary.

## Sling insertion

Due to her recently dislocated shoulder, a key recommendation was that the sling needed to be inserted correctly. The guidance advised lowering the sling behind her head from top to bottom to avoid rolling her from side to side. This is a more comfortable method for any patient whether injured or not. But due to a need for slide sheets in the process, it was more cumbersome for carers. It wasn't as easy as simply pushing her onto her side. It required a little more technique. Most seemed resistant to the idea and cut corners by failing to use the glide sheets and continued with old habits. Consequently, in many cases, all these professional recommendations were completely disregarded and the near-misses continued.

## Teleconference

When the carers were present, I usually sat in an adjacent room. I listened to her daily, moaning and groaning in discomfort. It was harrowing to listen to and totally unnecessary.

We arranged a teleconference with social care to address these concerns. I referred to these constant moans and groans. Many carers seemed completely insensible to her appeals.

We had a civilised discussion during which I explained some of the problems I had observed during my nursing tasks. I suggested that if someone is groaning, that generally signifies discomfort. She had never moaned and groaned while I was doing her care. Many care professionals seemed to disregard her groaning and tell her she was ok.

I highlighted the lack of compliance with the insertion of the glide sheet and hoist strap. I suggested that if it was inserted properly and she was treated more gently it may lessen her trauma.

I referred to personal care duties where I had observed carers rubbing inflamed skin and the anal region abrasively. Many carers rubbed these sensitive areas with a face cloth instead of gently dabbing vulnerable areas with a wet compress. It equates to rubbing burnt skin. These issues all seemed like basic common sense and surely shouldn't need to be pointed out to care professionals.

I'm sure the multitude of problems were caused by a lack of understanding rather than any malice. But to my mind, I struggle to equate some of these behaviours with competent caring persons.

One revealing example is the fact that, a specialist at social care visited our home on the day of discharge. The hoist equipment was tested and mum was mobilised. She didn't panic or moan and groan in discomfort. She was perfectly relaxed. This situation speaks volumes.

Ultimately we were told that this feedback would be passed to the team.

## Professional response to input and guidance

From my observations of training sessions, it seemed to me that many of the more established carers appeared reluctant to accept guidance. It always seemed that a gentle and diplomatic approach needed to be taken for fear of offending. To my mind, many health and social care professionals are far from the experts they seem to consider themselves to be. The history of incidents and injuries and the need to continually make suggestions for improvements, supports this fact. Conversely, from the same professionals with an inability to appreciate constructive feedback, there was never any shortage of unsolicited advice.

## Shower chair

During the meeting with social care to amend the moving and handling plan an objection was raised about the shower chair. It was claimed that it would be necessary to exchange her existing commode shower chair with a reclining one. A tilting chair would need to be ordered and this would take many weeks to arrive. We were told that, in the meantime she would need to be bathed in bed.

The danger alleged was that it was difficult to hoist and land her to the back of the standard commode shower chair in its upright position. In a tilting commode, some claimed they could tip it so that she automatically landed on the back of the chair.

Seems plausible enough but for three points.

Some carers had no problem lifting and landing her safely at the back of the commode chair. Many used the hoist to transfer her to the commode, for use as a commode or as a wheelchair. There was never any problem.

More importantly, this didn't explain why the majority of carers were perfectly able to land her easily into an armchair. Her armchair didn't tilt back. But the objection raised was that she would be unable to be landed into a shower chair until the chair tilted back. Some people didn't seem to appreciate the obvious contradiction. Some of the other amenable and supportive carers explained that very few people being hoisted have tilting shower chairs.

Curiously, no-one objected to landing her safely to the back of the standard commode chair, when it was used to transfer her out of bed and into her armchair.

To my mind, it appeared to be an excuse to avoid performing the cumbersome task of hoisting her out of bed and into the shower. Giving someone a quick wash in bed is less demanding than entering a shower. It seemed to suit social cares' agenda, whether or not it suited ours.

When the long awaited tilting shower chair finally arrived it was never used once. From the time she arrived home after her injury, she never accessed the shower again. There was no reason for her not to access the shower.

Just as she was unnecessarily confined to bed in hospital, it seemed to me that similarly, she was being unnecessarily confined to bed at home. I alerted social care. While my view of this situation was denied it was agreed that people would be asked to transfer her to her armchair daily.

## Avoiding use of the hoist

In my view, there can be little doubt that many people contrived to avoid using the equipment. It seemed very clear to me that they preferred to leave her permanently in bed.

For instance, once her personal care had finished, typically, I emerged from my room. Contrary to expectations, she was often left in bed. This was not wanted or warranted. Sometimes carers tried to leave our home before I emerged from my room. When I questioned why she hadn't been placed on her armchair they said that she wasn't up to it today. They told me she was too tired to get up. Prior to their arrival, she was fully alert. We would always have breakfast and a chat before they arrived. So it was a curious development. When mum was consulted the carers then tried to convince her that she wasn't up to getting out of bed today. When I insisted she was transferred to her armchair, it was done but they certainly didn't appear to be happy about it.

In my opinion, similar avoidance tactics were also used in the hospital which is why I suggest some patients remain in bed that don't need to be there. I do appreciate the time-consuming and cumbersome nature of transfers, particularly when people are busy. But there are many reasons why it can be detrimental to leave someone in bed all the time.

I consider that it would be very constructive to professional development if many people working in health and social care were asked to spend just one weekend in

bed. They should be asked to eat, wash and toilet in bed and to be placed in a room with only the walls for comfort. This would offer people an opportunity to experience first-hand the sense of entrapment and isolation some people must feel, including the psychological impact. In my opinion, such an experience might change the face of health and social care.

## Modus operandi

These were the circumstances in how her life continued. Many people contrived to do as little as possible in as quick a time as possible. We continued to worry and strive for a healthy, decent standard of care. The moving and handling plan continued to be disregarded. Carers continued to roll her onto her vulnerable shoulder. The bed continued to be raised to more than four feet above the ground. The cot sides remained down. Most carers couldn't master a spot roll. She continued to dangle over the edge, terrified. The groaning and moaning continued when they washed her abrasively. She never re-entered the shower. The impact on mum was harrowing to witness. Although completely alert, she was eventually confined to bed.

## Care review

Following the endless meetings and appeals, unusually, I received a call from a sympathetic professional asking me how things were going. I explained that things remained much the same. I was resigned to the matter. I provided examples of recent safety breaches. After years of flagging issues, we had failed to make progress. We were unlikely to start now.

I explained that the way I now dealt with things was to sit tight in another room. I tried not to look or to listen anymore. I blocked it all out and blind faith carried me through. I could only hope that each session passed without further incident or injury. I shared a deeply personal conversation. Mum said that she couldn't live like this any longer. She wanted to escape this daily trauma. Now she just wanted to die.

## Hospital review

One morning, my brother arrived to accompany me taking mum to hospital. She was having an x-ray to review her shoulder injury to check how it was healing. We asked the carers if, upon finishing her wash, they would hoist her into her wheelchair so that we could take her directly to the car. This request was not met with enthusiasm.

Later, we went to collect her from her bedroom. She was sitting lop-sided and far forward on the edge of the chair. There was a gap around her lumber area. She was reclining at an angle and sliding off. It was shocking. She was in a risky and uncomfortable position. I asked the carers, evidently preparing to dash out the door, if they could lift and re-land her properly. They seemed unhappy with this request but conceded.

## New injury

We attended Kings Cross hospital for an x-ray and review of her shoulder injury. It emerged that her shoulder had been dislocated again which was a sad, though unsurprising moment. We were sent immediately to A&E at Ninewells where she was examined by a team of medical professionals.

The team at A&E all seemed genial and pleasant. I explained the history of injuries and incidents and that this injury had happened, since discharge, whilst receiving personal care. The friendly team disappeared, seemingly for advice. As it turns out, they had been speaking a senior clinician acquainted with our situation.

When they returned their demeanours had changed. They were no longer interested in probing the cause of the injury. They appeared to exclude me from the conversation. They conversed only with mum. Understandably in her vulnerable condition she was not interested in engaging. We were expedited on our way. We were advised that we would be called in the New Year to discuss the new injury.

## Safeguarding responsibilities

What is astonishing about this visit to A&E, which inadvertently involved a discussion with a senior clinician, is this; if a child had entered A&E with a dislocated shoulder injury caused at home through rough treatment, would it not be a dereliction of duty to discharge that child without some form of investigation? Surely sustaining another injury so soon after the previous one would suggest a person remains at risk from harm? Surely the matter would need to be promptly investigated? I am not aware that health and social care had conducted any formal investigation into the longstanding issues of moving and handling her roughly. The real cause of her injuries was not established. Now she was being sent home with a new injury, into the same environment without any kind of formal investigation.

To my mind, they should have initiated a formal inquiry. It seems to me to be wholly irresponsible to discharge a vulnerable person back into the same environment where the injury occurred. Would common sense not suggest that she remained at risk of further harm?

Given the history, why did the team in A&E at Ninewells not investigate this new injury or take any further action? Given their initial demeanours, could it be that the senior clinician instructed the team to respond to her injury in this way?

Now that she spent the majority of her time in bed, and since there were no records of recent falls, I know that explaining away a shoulder injury as a little slip would be a challenge. But it does seem to me like far more should have been done.

During that phone call, what did their clinical superior say to the team that spooked them? What caused them to start deflecting the conversation away from me? I know what it indicates to me.

## Send the problem away

In the absence of documented evidence, it seems that there are a litany of incidents and injuries that health and social care didn't seem to take very seriously. Could it

have been because of her age that this new injury didn't warrant the same level of protection a younger person might? Was it perhaps easier for all the NHS professionals to ignore the serious implications by sending the problem away? To my mind, there can be no doubt people behaved immorally. What I would like to know is; did they behave legally?

## Review of injury

A few weeks later, in the New Year, we were called. It was one of those elliptical conversations: the great unspoken. We ignored the elephant in the room. The clinician seemed very adept at dodging references to how her injuries occurred. In the early days we shared a friendly rapport. As she started to acquire injuries and I started to ask leading questions, our rapport dissembled.

As the incidents and injuries increased, and as we questioned these failings, our profiles were raised. Although mum was the injured party, we seemed to be perceived as the problem. I believe the technical term for this behaviour is - projection. This may be another reason why, an initially amiable team at A&E, upon speaking to a clinician, became immediately guarded.

During this phone call, we steered around the subject of how the new injury had happened. We just alluded to the fact that it had. Even a senior clinician might have struggled to explain away how a shoulder injury, caused as she languished in bed, as a little slip.

There was no decision to be made. We were both in agreement. Given the recurring nature of these [unspecified, no fault] incidents and injuries, there was a high probability that, this [no fault] injury could happen again. Given the trauma she had sustained over recent years, we questioned the value of putting her through another operation. This would also involve another hospital stay [in a place unable to keep her safe]. The dilemma was a choice between living with the discomfort of a permanently dislocated shoulder and having to endure another operation. She faced a similar choice about whether to live with the ordeal of inept carers transferring her via hoist or otherwise remaining in bed to avoid the hassle. We left out the dull parts

like, the high probability of sustaining a new injury in hospital if she re-entered to treat the current one. We agreed it would be better not to proceed with another operation [likely followed by another incident]. However, we both reached that conclusion for very different reasons.

## Covid lockdown

During covid lockdown, like many people, we were not entirely sure about the risks involved. Consequently, we suspended all carers visiting the house. I temporarily provided personal care for a few months. She had recovered from her leg fracture. She was able to walk which made this arrangement possible because no equipment was required. Due to her injuries, in hospital and during care visits there were always two carers. For months, I operated alone and never injured her. She didn't repeatedly 'slip'. I wonder why?

Prior to that final admission, for a course of antibiotics, she was mobile. A single carer attended her twice daily. She returned home, unable to walk and with a need to use equipment. She then needed multiple carers and multiple visits daily.

## Skin integrity

Anyone who has treated skin integrity issues will understand the importance of treating vulnerable skin immediately. Untreated skin can become inflamed very quickly. When there were skin problems requiring nursing care, not all carers would call me. Before dashing out the door, some carers wrote in the care plan notes that her skin was "a bit red"; whereas it was fully inflamed and needed treatment. This behaviour seemed designed to exclude me from care sessions. Except that, I wasn't joining care sessions by choice. I was joining care sessions because the carers weren't permitted to do certain duties and I was asked by social care to complete these nursing tasks.

Sometimes there were references to claims that barrier cream had been applied when there was no evidence of this. Once skin becomes inflamed barrier cream is

inappropriate. If I wasn't called when I should have been, when I examined her skin, the problem was always far more serious than the carers had stated in their notes.

During those covid months when I completed her care alone, there was never a single issue with her skin integrity. The entire period passed uneventfully. This point can be supported by the fact that during this period there was never a need to involve the community nursing team or to request prescribed products.

In my opinion, the reason there were no problems is that her skin was washed properly. Most importantly it was dried thoroughly to prevent areas from becoming a breeding ground for bacteria. However, during these last months, for the first time she had recurring skin problems. Her skin was regularly inflamed and there was a recurring need to request prescribed products to treat it.

To my mind, this speaks volumes.

## Compassion

If this covid period was so uneventful, why was it so difficult to achieve quality care and safety in the hospital and within the community?

I suggest the simple answer might be that I cared about her welfare. If I was providing her personal care, I cared enough to do it properly. If I mobilised her, I cared enough to do it safely.

There is a distinction between care as a function and care as a dignified personal service. Compassion is a cornerstone of safe home and nursing care. It is a crucial care and nursing skill. In my view, only greater education can change the culture around the delivery of compassionate care.

## Inaction

To avoid a claim of negligence, leaders must take care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. If the workforce isn't properly trained, would this not constitute inaction and omission?

## 9. Botched Social Care Response

Why did SCR fail to investigate safety breaches?

Can this inaction be considered a dereliction of duty?

### Message circulated

As earlier indicated, I was now resigned to the fact that things were evidently not going to improve. It was a situation we were forced to accept with equanimity.

There continued to be a lack of adequate council home care provision. Between two planned daily home care visits, it was necessary to contact social care responders for personal care that couldn't wait.

The home care service provides a regular, planned daily personal care service. Social care response provides on-call cover out with those visits. This service is accessed by pulling a cord at home.

While many Social Care Responders were friendly and competent, some were not. There were similar problems when we accessed this service.

When we returned home from that x-ray review and discovered that her shoulder had been dislocated again, I contacted each service. Without apportioning blame or criticising anyone, I made a polite appeal to re-circulate the message. I asked people to be mindful of her new injury.

My message represented another appeal.

## Response

Social Care Response misinterpreted my message. I received a diatribe in response refuting there were safety issues. I escalated this matter within Social Care. I initially received a confusing non-response which didn't seem to follow policy guidance on dealing with complaints. There was a pithy reply barely acknowledging the matter. When I escalated it again, following extensive correspondence, the matter was eventually given recognition. Ultimately, this complaint outlined social care responses' apparent refusal to take safety issues more seriously. It referred to earlier reports of safety breaches across four years.

In response to my complaint, a revised response from social care response suggested that it was hoped we would develop a better rapport. I was confounded. What does our rapport have to do with repeatedly failing to take health and safety seriously? Continually ignoring notification of safety breaches signifies neglect and a distinct lack of appreciation for safety. It was an astonishing response.

Due to these apparent sensitivities, when there were good examples of care, I frequently called to thank the team. I wanted to reinforce the point that we fully appreciated competent and professional care.

## Rolling in bed

I previously related the incident about mum arriving home from the hospital following a shoulder dislocation. It was necessary to pull the cord for social care response. Mum was wearing a sling that supported the healing arm. I highlighted that she shouldn't be rolled to her vulnerable right side. Her shoulder was still healing. But the carers disregarded my information and rolled her anyway.

## Reported safety breach

I alerted social care response who resolutely refused to accept that there had been a safety breach. However, I was told that the matter would be investigated and I would receive a response. I heard nothing more.

## Stand-aid incident

On the first occasion I called this service; two unfriendly carers called in the middle of the night. They attempted to get her out of a chair for the bathroom. They attached straps under her arms and a body strap. The impression given, from the fact that one carer was explaining every action to the other, was that one carer was training the other in the process. The stand-aid bar started to rise. The straps hadn't been secured beneath her arms and started to slip outside her elbows. I alerted the carer and asked her to stop the equipment because the straps were not attached correctly. If the motion had continued a moment more, the strap would have dislodged over her shoulder and she would have tumbled backward. Given the history, it was another worrying incident.

## Reported safety breach

I alerted Social Care Response who resolutely refused to accept that there had been a safety breach. However, I was told that the matter would be investigated and I would receive a response. I heard nothing more.

## Rough handling and Indignity

On another occasion, during the last months of her life, a male and female attended. I left them in the bedroom with mum. I then heard a series of disconcerting sounds. I entered the bedroom to check if everything was alright. The carers seemed to be hostile. I reassured mum and stayed with her until she relaxed. She was naked. The female was performing personal care. The male stood, leaning over the cot sides, staring down at her nether region where the female was washing. It was an appalling scene of utter degradation. Once they left, mum was unusually tearful. She told me they had thrown her around the bed and hurt her vulnerable leg. Whatever the facts, it seemed clear that she had been handled roughly resulting in this very traumatic experience. Some of the incident I directly witnessed.

## Reported safety breach

I alerted Social Care Response who resolutely refused to accept that there had been a safety breach. However, I was told that the matter would be investigated and I would receive a response. I heard nothing more.

## Contravening policy guidance

Following the report of traumatic rough handling and indignity, there should have been an investigation as promised. A few days later the same carers returned. This seems to have contravened policy guidance.

## Bedroom door and social work

In response to the rough handling incident, we did hear from social care. Social care demonstrated a new interest in mum's situation. Indeed, this team was unusually committed to this matter. Shortly after this incident, the family decided it would be best to remove the bedroom door temporarily. This allowed us to listen during these visits from an adjacent room. It might also make unfriendly carers more mindful. I communicated this alteration to social work, before the carers did.

I then received a series of emails from social care about this subject, unnecessarily interfering. Concerned was expressed about this presenting a fire risk; even after being told the door had been replaced and the matter was considered closed.

Typically, social care never showed the same strength of interest in the assault itself. Social care didn't seem overly concerned about what was going on BEHIND the door, only the fact that the door had been removed.

Social care claimed that they had a duty of care to address the fire risk created by the removal of the door. But this team didn't seem to appreciate that this responsibility extended to the incident that happened behind the door.

Significantly, social care never sent a regular series of emails to ask if basic standards of care were being met daily. There were never enquiries to ask if her human rights were being respected. When I originally conveyed the matter to social care I was asked to submit details in an email. I heard nothing more about the matter.

Having taken independent advice, the door was returned and the matter was concluded with monitoring arrangements made. But a couple of weeks later social care remained entrenched in this matter. I received another email to advise me about the door. Just for my information, social care wanted to advise me about fire safety. I had already explained that I was fully aware and that a fire safety officer had visited. I was more interested in the matter of what was happening behind the door. I had never witnessed such commitment from social work over any matter. If this level of commitment and focus had been shown towards ensuring a decent standard of health care provision and safety, we might have kept mum safe and well.

Such dogged interference would have been greatly appreciated if it related to her personal care and safety. I refer back to the first entry concerning social work. In my experience, I would suggest that social work is too interested in matters that don't strictly concern them and too lacking in interest in matters that do. To my mind, this represents one of the fundamental failings of this department: inappropriate priorities and stepping over boundaries.

### Care plan directions disregarded

Social care responders visited intermittently and randomly. There was a significant lack of consistency which is the nature of the service. But because of this, there can be a lack of updated awareness. This is precisely why the care plan and moving and handling plan exist. The plan was never read so the carers were never fully briefed in her circumstances or needs.

### Sling and straps

Many times I was required to demonstrate how to insert the hoist sling and which straps fitted where. On one occasion the carers had strapped mum into a hoist. The

straps were crossed over incorrectly. When they placed her on the commode, she was unable to go because the strap was covering her below. I assisted the carers to adjust and re-land her. This constant hoisting activity, besides being risky can be traumatic for the patient. Hoist straps can very uncomfortable to the skin and limbs. If a sling is fitted incorrectly it can be very painful.

Following the recent conversation about not rolling her onto her vulnerable arm, social care responders arrived. As mum was now confined to bed it was necessary to complete all personal care in bed. This involved rolling her in bed, to the side opposite to her vulnerable shoulder.

We were acquainted with these particular carers. They were friendly and we had long shared a rapport. I sat in another room until they called for me. They rolled her to the correct side so that I could apply steroid cream. I then left the room. I was immediately called again. Pleasantly and enthusiastically they said they'd rolled her onto the other side so that I could apply cream to the other side of her body. These particular carers were kind people trying earnestly to please. They just didn't seem to understand. I explained that I had completed my duties when she was on her injured side and that she shouldn't be rolled onto that vulnerable side of her body.

As this example suggests, incidents didn't always happen because carers were unfriendly or disinterested. Many carers were very pleasant and genuinely attempting to help. Some were earnest in their attempts to provide quality care safely. It wasn't always down to ineptitude or bad attitude. In some circumstances, carers were genuinely trying but lacked the necessary training, awareness, and experience.

## Delays

Due to the gaps in care provision we frequently called social care response for assistance with continence support. There were occasions when she was left in bed soiled for up to four hours: a dreadful indignity.

It would be my wish that people working within the health and social care system, particularly those managing it, could experience any of these problems just once. I'm convinced that if they did, it would transform the delivery of health and social care.

## 10. Safeguarding

Did social care limit the scope of the ASP investigation?

Where is the promised ASP report?

Did health and social care follow statutory guidelines?

### Adult Support and Protection (ASP)

The Adult Support and Protection Act 2007 makes provisions intended to protect those adults who are unable to safeguard their own interests and are at risk of harm. The Act places duties on the council (in this case social care) to set up an Adult Protection Committee to carry out various functions and collaborate with other relevant bodies.

When the safety issues continued unabated, it was clear that following years of appeals, nothing had been achieved through the health and social care system. When I rescue another fall from bed, in desperation I sought independent guidance.

### Attempts to raise an ASP with social work

Upon taking legal advice, I contacted social work saying that I wished to raise a safeguarding concern. I was advised my message would be forwarded to someone within social work and I would receive a call. I called across the week and each time I was given the same message. When I received no response I contacted the NHS. Again I received no response. A week later I contacted the Care Inspectorate.

### Care Inspectorate

I explained the history of neglect, falls, injuries, and near misses. I explained that professionals across the health and social care system were not listening or taking me seriously. The safety issues and neglect continued. What prompted me to call was that her shoulder had been dislocated again. I had recently rescued mum from

falling out of the profiling bed from a height. My mother was suffering desperately. She had been at risk of harm for a long time. The situation continued unabated. I was not prepared to wait for the next injury.

## Care inspectorate raised an ASP with social work on my behalf

In the absence of a response from my alerts to social work and the NHS, the Care Inspectorate submitted an ASP inquiry to social work. The department would be unable to ignore submission by a Government Agency. This is a formal process and the local authority has a duty to make inquiries and to follow certain guidelines.

## Nominated investigating officer

An individual is then authorised by the council to perform the functions of an investigator. It was surprising therefore to learn that social care who were fully acquainted with our circumstances would be investigating this case. Prior to the ASP inquiry, social care was aware of our concerns. In light of this fact, it would have seemed more appropriate to me for the investigating officer to have been someone wholly independent of this team.

## Investigation

On the morning the investigation commenced, a meeting took place involving social care and social care response. Coincidentally, I called social care response on the morning in question which is when I was told about this meeting.

Some days later, social care visited our home to speak to mum for ‘a little chat’. They wanted to speak to mum alone. The full implications of what was happening didn’t become clear to me until the meeting was taking place. I then entered the room and objected. I remained as a silent observer, although the meeting was almost over. Upon leaving, I was told that they had “got what they needed to”.

Mum was vulnerable and, to my mind, the matter under alleged investigation was a legal process. It was necessary to ensure that my mother was fully aware of what

was happening. She was being formally statemented. To me, the approach seemed casual for a formal process. The following week I was contacted to arrange another meeting. While this was welcomed, I suggested that since this was a formal process, mum really needed to be advised in writing. Given the nature of her being statemented, she needed to be made aware of her rights. As a vulnerable adult, mum had a right to be accompanied or represented; just as social care had been.

Curiously, we heard nothing more about this visit.

## Plan of action?

Following an inquiry, an agreed plan of action is usually recorded on the person's care plan. This is sometimes referred to as a 'protection plan' and it often includes the responsibilities of the relevant agencies for implementation.

There was never any mention of any such plan.

## Referred to care inspectorate

After this home visit, I called social care asking for an update. I was told that, because I had raised the ASP via the Care Inspectorate that social care was unable to discuss the matter with me directly. Ironically, I raised my concern with the Care Inspectorate because social work failed to respond to my original appeals. Social care pointed me in the direction of the Care Inspectorate. I was told that in turn the Inspectorate would share the report and identified outcomes with me.

## Contradiction

It seemed an extraordinary contradiction in terms. We could discuss all these issues with social care in mum's capacity as a service user of social care, but we could not discuss the same issues with social care which related to the ASP.

When I called the Care Inspectorate, no report had been received and was awaited.

Many weeks later, the Care Inspectorate asked for a copy of this report. When I contacted social care, I was told that it hadn't been sent to the Care Inspectorate yet because it was still awaiting sign-off by a senior manager. I was told however, that some unspecified outcomes had been identified.

We never received any kind of documentary evidence or information relating to an ASP inquiry. There has never been any written indication of a formal investigation or these outcomes to which social care alluded. Neither was there any evidence of adjustments at home.

## Departments excluded from investigations

I did ask social care if the issues at social care response had been addressed. I asked because I was aware that a meeting took place between representatives from both departments on the morning the investigation commenced. Matters relating to social care response were central to the investigation. But I subsequently learned that social care response was excluded from the investigation. NHS Tayside, the hospital where most of her injuries occurred, had also been excluded.

It seems very unclear to me what purpose any investigation would serve if it fails to include two of the three departments involved?

## Scope of investigation

To date, I remain unaware of the details of any ASP investigation. I remain unaware about what happened to this ASP report that social care couldn't share with me. To date, there is no indication that it has ever reached the Care Inspectorate. I fail to understand why the scope of the investigation was limited. Given the incidents and levels of injuries she sustained, surely it was our right to see any report and to see recognition and recommendations for service improvements?

## What happened to the ASP?

To my mind, it seems to me that what happened to the ASP is what happened to years of appeals, dialogue and correspondence. Similarly, where are the incident reports and statements relating to numerous reported incidents in the home? Similarly, where are these same documents seemingly missing from her medical records? All these questions offer an impression that the majority of records and reports relating to the series of incidents have all evaporated into the ether.

I question, and I consider justifiably so, whether the absence of records and reports relating to various formal investigations indicates that, in some instances, statutory guidelines may not always have been followed. In the alternative, if these reports and records exist, then they have not been shared with us and it would appear that our access to them might have been restricted. Where are these records and reports relating to the multiple incidents concerning my mother, and what information do they contain?

To establish the answer to these questions, I have made a formal request for copies of these reports and records.

I would also like to know if A&E failed to follow statutory protocols by failing to instigate an investigation into her new shoulder injury, when a vulnerable adult, at risk of further harm, was discharged.

I am struggling to see where social care, healthcare and social care response have properly investigated all these incidents and injuries. The absence of records and information would seem to point in the direction of a dereliction of duty.

## 11. The Small Matter of Manual Handling Training

Why are many professionals, using equipment to move and handle vulnerable adults, not always properly trained and competent?
How do health and social care leaders know there is not a credibility gap between certification and performance?

### Aids and equipment

Aids and equipment in the wrong hands can be lethal. Proper training is vital including an understanding of the importance of following the rules. Not doing so can result in permanent damage and risk to life.

Professionals may be trained in principle but many are not ***properly*** trained. Based on the evidence, some are not trained at all. In the context of mum's apparently 'no fault' incidents and injuries across recent years, let's consider the evidence:

### List of Incidents

A list of incidents and injuries has been recorded on a separate page of this website. These incidents relate to professional care. No injuries were sustained whilst receiving personal care from the family at home. This fact speaks volumes.

### Reports

There are examples of how the health and social care system seems to specialise in allowing reports to disappear into the ether. This is assuming they were completed and refers to; moving and handling assessment reports, moving and handling incident reports; statements and, ASP safeguarding investigation reports.

## Care Plan

There is the example of how some carers, even those providing input and collaborating in drafting the care plan seemed unable to follow their own documented instructions.

## Training course

There is the example about how an approved moving and handling training course was a key example of training and certification. This very short one day course was predominantly theoretical with very little if any hands-on equipment training for the attendees. Trainees were certified as qualified to operate as carers and use equipment with vulnerable people in the community.

## Staff bank

Some of those carers certified in the community are able to register with the temporary staff bank at Ninewells. It was temporary carers from the bank at Ninewells who caused her leg and hip fractures, although we remain unaware of the identities of the people who caused her shoulder injury. This lack of effective training provides one example about how incompetence is able to spread its tentacles across the health and social care system.

## Care jobs

There is the example of how my cousin applied for temporary employment as a carer who completed an almost non-training course before being let loose among the vulnerable in the community.

## Incidents and injuries

There was the never-ending litany of incidents and serious injuries. There was also the recurring need for me to offer training and guidance or rescue.

### Unqualified carers arriving

There are examples of the series of carers arriving who had never used equipment or a slide sheet. There was a need for me to assist these people. A slide sheet might seem like a pretty innocuous item. But one slip or slide in the wrong direction can result in serious injury.

### Inept carers

On two separate occasions, carers were politely asked to leave. One hadn't worked for twenty years due to a problem with alcohol. Another had serious mental health problems. Neither was in any fit state to provide care provision to a vulnerable person.

### Notified incidents

We have a series of incidents and injuries in hospital and at home. All these incidents were notified yet continued.

We have a series of incidents both at home and in hospital which I rescued. On many occasions it was necessary to alert carers and nurses to hazards.

### Health and safety mantra

Across a health and social care workforce there are many people whose daily mantra is 'health and safety'. Some of these people seem to be blithely unaware of any aspect of this legal framework let alone what it represents. If people are going to constantly refer to health and safety then they need to read and understand this legislation - not use it as a token phrase. Many professionals referred to this grossly misunderstood and over-emphasised term when referring to their preferences, not the patient's welfare.

## Leaders in denial

In our experience, there were examples of leaders operating across the health and social care system who, when you raised any concern, heralded the untouchable excellence of the workforce. Many resolutely refuse to acknowledge even minor failings.

## Failure to audit performance

During one visit, a carer complained that she met her office-based training auditor in the street. The auditor was rushing to visit a series of carers on her list to complete mandatory reviews. She was running late and was unable to complete these reviews. So she asked them to quickly sign the audit sheet so she could dash off. The auditor asked the two carers not to say anything to anyone. To my mind, this suggests that consideration needs to be given to whether training audits need to be carried out independently of private care providers and health and social care.

One of those carers, who signed the audit sheet without audit, was due to start working at Ninewells as part of her nursing training. Ironically, this carer needed the most guidance in using moving and handling equipment.

## Ineptitude exists

From the evidence, there can be no doubt that an unacceptable level of ineptitude exists across the entire Health and Social Care system. The issue isn't just that this systematic ineptitude exists. The issue is that these serious systematic failings seem to be ignored and denied.

## Foreseeing incidents

An accident is simply an incident that no one could have reasonably foreseen and for which no one should be held responsible. But by definition, if you fail to ensure that the workforce is trained properly, how can leaders fail to foresee that incidents will occur?

## Inaction

To avoid a claim of negligence, leaders must take care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. If the workforce isn't properly trained, would this not constitute inaction and omission?

## Recommendations

In my view, the bar needs to be raised on the standard expected for moving and handling certification. This should be followed up with independent assessment according to the working environment. Courses need to be extensive. Training needs to be comprehensive. Competence needs to be reviewed.

## Effective training required

Surely the most progressive way to resolve ineptitude, is by ensuring everyone throughout the system is properly and effectively trained? Failures can lead to many lives being ruined. Besides being effectively trained, people need to be effectively mentored and monitored.

'Effective' is the key term. Not by doing a quick online questionnaire or attending a day course. People need to study the theory in detail followed by extensive learning of practical skills using equipment. They need to be shown properly, followed by shadowing, supervision and monitoring.

Using my own experience of certified training as a reference ground, I would suggest that a moving and handling training course needs to encompass extensive theory and practical exercises: not a few hours observing a theoretical presentation and a couple of days shadowing before being certified.

People need to understand and appreciate the importance of kindness and compassion when mobilising patients. This needs to be incorporated into training. Professionals are dealing with people with emotions, not objects.

## Training audit

When did health and social care last conduct a comprehensive staff moving and handling safety audit? I refer to an audit beyond tick box claims of having attended a course and obtained a certificate. I refer to observed demonstrable competence.

## Reports exist for a reason

Reports exist for a reason. As a vulnerable adult: was a Falls Risk Assessment and Falls Prevention Action Plan completed for mum during each admission? Were these assessments added to her medical records? Were they communicated widely to everyone before mobilising her? Were the staff moving and handling her, competent, and effectively trained? Did people all read these – alleged - assessment reports in advance of mobilising her? Were statements taken and incident reports completed following each incident? I know that mum was never interviewed. I am also advised that her medical files have significant gaps in the areas where these incident reports should be. Where are the reports?

## Community occupational therapy assessment

If social care conducts a needs assessment, surely an assessment needs to be holistic? Voiced concerns surely need to be listened to and acted on? If people are informed about a key hazard that has previously caused injury, surely this important information should not be ignored?

## Greater involvement of occupational therapy

To my mind, the hospital and community Occupational and Physiotherapy teams would seem to be the specialists in this area. Observing the team using equipment inspired far greater confidence than many clinical staff and home carers. If there isn't already, there would seem to be a role for more input from these teams, into staff moving and handling training. I my view, the competence of care and clinical staff when using equipment to mobilise patients should be on a par with physiotherapists.

## Carer's attitudes

As I observed in the hospital and at home, many people do not always like to be guided or to receiving suggestions, even by their peers. It seems to be the case that the less qualified a professional is, the less likely they are willing to acknowledge the experts. In my opinion, this seems to present a significant barrier to learning. My observation of some carers' behaviour towards a highly qualified specialist offering guidance was that many behaved disrespectfully. In my view, greater respect should be shown to professionals who direct learning. It would seem that these perceived inadequacies need to be addressed. Resisting training can have serious consequences.

## Foolproof system

Any adequate moving and handling system needs to be fool-proof with very little discretion including, where necessary, checklists to act as prompts. All that is only possible if there is enough properly trained staff to support and run the service.

This perceived lack of qualified moving and handling competence is, to my mind one of the greatest problems facing the health and social care system.

## 12. Dundee City Council, the SPSO & People with Disabilities

Did the council and the SPSO fail to appreciate and resolve my disabled mother's mobility issues that were caused by the same Government agency?

Ageist attitudes and examples of passive disengagement from serving and protecting our elderly, is an associated issue that, in my view still needs to be addressed in society. I have often observed occasions where the elderly are disregarded, and their rights are not fully recognised.

When mum started to develop mobility problems, and needed the support of a wheelchair, we purchased a mobility accessible vehicle. The aim was to allow her to continue leaving our home. Another aim was to facilitate a reasonable quality of life.

The street where we lived is very narrow. There are long-established traffic and parking problems.

One of the problems it caused for mum is that our vehicle was often blocked from travelling up the street. Often she would have to be unloaded at the entrance to the street; once in a heavy downpour.

Having to bump down the kerb in a wheelchair was painful to her neck, shoulder and leg injuries. Having to take her into the middle of a cul-de-sac to enter a vehicle was hazardous.

A wheelchair user shouldn't have to suffer discomfort, restrictions and indignities. Isn't that why disability discrimination is one of the protected characteristics in the Equality Act?

To overcome her mobility issues, I contacted Dundee City Council to request a disabled parking bay, as a neighbour down the street had one. I also requested a

lowered kerb, so that her wheelchair could access the road without bumps and discomfort.

Over many months, our correspondence went thus:

I made a written request a disabled parking bay and/or lowered kerb. I explained the circumstances of mum's mobility problems and injuries as a wheelchair user. She was the only person in the street unable to walk to her vehicle.

This request was denied on the basis that, the cul-de-sac in our street "needs to be kept clear for refuse/emergency vehicles". This seemed a plausible response but for the fact that many able-bodied residents permanently parked there. This blocked access directly outside our home.

I replied asking if the "area needs to be kept clear" then: why wasn't it?

I suggested that, within the comment that the area "needs to be kept clear for refuse/emergency vehicles" the letter should also have added "…and disability vehicles".

Given mum's problems accessing our vehicle I also asked why the council had ignored these long established problems.

My questions were apparently evaded.

When we received an unsatisfactory response I escalated the matter. I made all the same points again but emphasised, what we needed was a solution. Instead of pointing out the problems, I asked the council to offer a solution so that a wheelchair user with disability issues could access her wheelchair-accessible vehicle.

The next response advised me to report any hazard or an obstruction to Police Scotland.

I responded highlighting that the council seemed to continue to evade the central issue. I suggested that there seemed to be confusion between the disability access problem and the broader parking problems in the street. I suggested it remained principally a matter of disabled access which is not a matter for Police Scotland. I explained that my mother is a blue badge holder and wheelchair user. We are unable to park near our property to allow her easy access to her vehicle. I repeated that the council seemed to be deflecting from the central issue which is about disabled access. Police Scotland has no direct influence over this matter. I had called and discussed the matter with Police Scotland.

I pointed out that this matter specifically related to, the right of a person with a disability, to access a wheelchair-accessible vehicle. There is no disabled bay so the car cannot be brought near to the property because other able-bodied residents block the area. Even if the area was completely clear, there is no lowered kerb. A wheelchair can't access the road or vehicle from any part of the street without difficulty, if at all. I referred to the Equality Act which underpins the message that access and physical means of entry should be equal for everyone. In my mother's case, due to her disability, she was unable to easily access her vehicle or the road. The same rights of access should be conferred on her as any other able bodied resident.

Since she is unable to easily leave her home and access her vehicle, reasonable adjustments have to be made. In this context, my central question remained. I pointed out that the council's letter still failed to offer a solution to the central problem which was, my mother is a blue badge holder and wheelchair user. I asked the council to clarify where in their letter was a proposed solution? Specifically: how can my mother access and exit our wheelchair accessible vehicle without problems?

A reply from the council stated "I have arranged for the traffic engineers to carry out a further inspection for further measures to be considered to assist blue badge holders in the street, including drop kerb provision within this area".

Meantime, I received a response to my escalation of the matter. Elaborating on standard traffic information it failed to address the fundamental problem. No solution was being offered about how a wheelchair user could access her vehicle easily.

I received further correspondence advising me that council representatives had been asked to contact me directly following their observations - and I quote “proposals from their site inspection and survey”.

Four months later I had still received no update.

Ultimately, the proposal of this inspection and survey was practically the same response received many months earlier at the start of this matter. Although there was no apparent barrier to installing one, even the request for a dropped kerb was denied.

Again, I suggested we would be satisfied with some form of recognition of her disability issues. I referred again to the difficulties mum had accessing our vehicle. I suggested that some form of recognition and concession would be appreciated. Even if the kerb was lowered to enable her wheelchair to access the road and our vehicle, without bumping down the pavement. I explained the risk of injury to her open neck fracture. I explained she had a metal plate in her leg after a fall. I explained she had a dislocated shoulder still under medical review. It appeared that all this information was disregarded.

Across an extended period, having appealed to the Council for help, there were numerous inexplicable delays. Ultimately my appeals achieve nothing. There was no help offered or acknowledgement of my disabled mother’s mobility issues.

This longstanding problem negatively impacted my disabled mother who had disability issues. It affected her quality of life and it seems to me to be a situation where it was possible to find some kind of a solution, if people had wanted to.

## Scottish Public Services Ombudsman (SPSO)

A final response from the Council referred to escalating the matter to the SPSO. Before I escalated the matter, as suggested in their letter, I contacted the council again to confirm that this was their final position. The Council confirmed that their position stood firm.

The SPSO advised that the Ombudsman had no power to investigate or overturn Council made decisions. The SPSO only has the authority to ensure that the Council follows a fair complaints process. It seemed to me that, if the SPSO has no authority to inspect or overturn a Council's decision, then simply going through the motions of a 2-stage formal complaints process would meet that criterion.

It is confounding why the Council directs cases to the SPSO, if the SPSO does not have the power to investigate matters. Why bother involving the SPSO? And therefore, what exactly is the role of the SPSO? I was advised that the matter would need to be adjudicated via Judicial Review.

I appealed their findings making a substantial submission for further consideration. I highlighted a range of anomalies and perceived bias on behalf of Dundee Council and the SPSO.

I highlighted a number of contradictions in the Council's responses and put a number of questions forward for consideration. The SPSO accepted every response offered by the Council - even the responses that I highlighted as contradictory. Why were the SPSO so apparently deferential to the Council? Who exactly was the SPSO liaising with at the Council? Was the Chief Executive aware? After all, there are serious implications in failing to recognise someone's disability and refusing to make a reasonable adjustment according to the Equality Act. I can't imagine a Chief Executive fully aware of their responsibilities would sanction this decision. The SPSO refused to disclose who they were liaising with at the Council. The SPSO agreed with Dundee City Council. It didn't make any sense why the SPSO wouldn't point the Council in the direction of the Equality Act, the Council's own policies including their duty of care towards members of the general public.

Ultimately, the Ombudsman wrote to the council with guidance about how the matter could have been approached more constructively while at the same time concluding that “the Council had conducted a fair and reasonable complaints process”. Even that minor hypocrisy seemed to evade the SPSO. The SPSO closed the case which, in my view seemed to be a perverse decision for a great number of reasons.

Why are the SPSO’s findings significant? Read on ...

## Disabled Access Denial and U-Turn

Although a Government agency caused her serious injuries, that same Government agency were not helpful in finding a solution to manage those injuries or facilitate disabled access arrangements. To a litany of proposals across a period of at least two years, the Council robustly contested their case and continually referred to parking regulations and other objections. The Council even expressed concern about upsetting neighbours if they introduced minor adjustments.

The SPSO concluded that, in response to my request for a solution, the Council had provided one. The Council proposed that my vulnerable mother could make a planning application, arrange to remove railings, pave over a large area of garden, install a dropped kerb and meet the cost herself. Ignoring the audacity of that suggestion, what the Council failed to recognise is that this suggestion contradicted their earlier arguments. A paved garden and extended dropped kerb would cause far greater problems for people parking on the street than a disabled bay marking. It would cause greater problems than a sign indicating an emergency and disabled vehicle access and turning point. And it would have represented the most contentious of all possible proposals to upset the finer feelings of neighbours.

When my mother died the Council installed an extended disabled parking bay.

This U-turn completely contradicts every objection made by Dundee City Council. It brings the Council’s motivation and behaviour into question. It makes a mockery of the Council’s argument, the SPSO’s findings and the entire public services complaints network.

I alerted the SPSO to Dundee Council's confounding U-turn and asked the SPSO to review their finding that the Council had behaved 'reasonably and fairly' and ask the Council for an explanation. The SPSO refused to review the matter.

Why?

## Personal injury claim

Following her neck, leg, hip and shoulder injuries, she needed equipment and additional support. It fell to her to find that additional support. She was also expected to meet the cost.

As a result of the last injury, I was now unable to meet her needs alone. Two people are required to operate equipment and her needs had increased.

Due to the perceived injustice of the situation, we consulted a personal injury Solicitor. The solicitor took up our case with the local Health Board.

Following some initial correspondence our solicitor requested her medical records. When eventually received, it was discovered that there were significant gaps. Key documents were missing.

Our solicitor spoke to the health board who confirmed that, many months later, they still had not seen or taken statements from the relevant staff. They have never provided a clear position on the circumstances.

Putting the intricacies of the case to one side, it seems wholly unacceptable that a government agency can behave so complacently. It seems to suggest a disregard for established conventions and possibly a level of disrespect.

The crazy thing is, she needed additional help to meet her additional needs while she was alive. With it, her final years would have been far more comfortable than they were. Compensation isn't any good to someone once they're dead. I do not

necessarily mean financially. I mean that no responsibility was taken and no effort was made to meet her increased care needs. These were care needs developed as a direct consequence of injuries sustained whilst under the auspices of health and social care. Instead she was discharged with a reduced package of care.

As far as I can see, there was no apparent attempt to recognise the ethics of the situation. Health and social care didn't seem to feel any obligation to contribute towards meeting her additional care needs, caused as a result of negligence.

When mum died, I terminated all correspondence across the health and social care system. I asked our Solicitor to draw a line under the action. As the evidence suggests, across 4 years, our appeals and correspondence never seemed to amount to very much anyway. To the most formal of those appeals, the ASP inquiry, we had never received any documented response. There has never been anything to suggest to me that our concerns were taken seriously. But certainly, while grieving the loss of a loved one, the last thing you need is to be challenging a bureaucratic system for recognition. It was a conscious decision.

Besides, there seems little point in pursuing a case where, much of the key evidence from her medical records appears to be missing.

If this work succeeds in raising awareness of the need for safer patient handling and greater patient-centred care, this small advancement would provide enormous value to many other elderly people and people caring for their loved ones.

## Accidents don’t just happen. They are caused.

Accidents don’t just happen. They are caused by a chain of events. They are caused by the actions or inactions of one or more people. Not every inaction or dangerous act produces an accident. But no accident is ever produced unless one or more factors are involved. Just as people cause accidents to happen, they can prevent them from happening. To prevent accidents from happening, all that is required is for each individual to do the right thing.

An accident is commonly defined as “an unfortunate incident that happened unexpectedly and unintentionally, typically resulting in damage or injury.”

While negligence is commonly defined as “a failure to exercise the care toward others which a reasonable or prudent person would do in the circumstances”

How can my mother’s injuries be considered an accident? There was nothing arbitrary about these incidents.

Every injury she sustained was caused by a failure to act prudently. Each injury was completely avoidable. Surely this constitutes negligence?

## Summary

What is wrong with the truth?

Was it that many didn't get it or is it that they just didn't want to get it?

### Ageism

There is a view in society that ageism generates ageist attitudes. Our elders too often face stereotyping. As your age increases your value decreases. They have already lived their lives and are no longer as valuable to society. There is less commitment to healing them than someone younger. Only the future generation is worth investing in or fighting for. It is our attitudes that devalue and disempower older people, not themselves.

This perceived passive disengagement from empowering the elderly is something I am acutely aware of through my involvement across all health and social care services.

One of the basic tenets of health and social care is supposed to be kindness and compassion. What's compassionate about giving a half-soaked standard of health and social care while pouring our efforts into creating the circumstances for someone to expire before it is necessary? The elderly are often seen as a drain on resources. Whose resources are they exactly? By definition, the elderly are greater stakeholders in our health and social care system than the young. Each generation has paid for the previous one. Our elderly deserve better recognition and greater respect.

The elderly still think and feel as we all do. They sense when they are no longer valued or wanted. It affects their psychological well-being and it affects their physiological recovery.

## Serial neglect

This whole journey snowballed from the moment we contacted adult social care to request assistance with personal care.

Our entry into the system resulted in perceived discord, interference, inadequate care, neglect, injuries, and constant incidents at home and in hospital.

There were significant concerns relating to her safety, her treatment, and the quality of home and nursing care provision. This was well documented over an extended period. It isn't just the fact these incidents and injuries happened, it is the fact that they continued to happen.

Why didn't any of the professionals, responsible for her care and safety, resolve these problems immediately?

## Ineptitude across the system

Surely there is a desperate need to address this perceived ineptitude across the health and social care system?

The central issue is not just that this perceived ineptitude exists, but that these inadequacies appear to be denied. What is wrong with the truth? To whom is the truth an inconvenience and why?

## Systemic failings

So, what are the proposed systemic failings responsible for this course of events?

I would suggest that longstanding, systemic failures in senior management and oversight by a range of health and social care professionals enabled this summary neglect.

Health and social care would seem to have resisted properly investigating the cause of her injuries. They would appear to have failed to keep her safe. Other people would seem to have been derelict in their duty towards a vulnerable adult with a disability.

## Policies disregarded

I fail to see where safety and equality policies have been translated into behaviours. In many instances policies seem to have been blatantly ignored.

## Collective denial

Across the health and social care system, there seems to be a perceived state of collective denial, and where there are injuries involved, a perceived tendency to evade responsibility.

The common practice seems to be to refute, deny and ignore. Responses seemed constantly configured to support the systematic narrative. The impression offered is that many people across the system are defensive and adept at evading responsibility. To my mind, this denial may be perpetuating an endemic problem.

When implausible explanations were offered to explain away her injuries, these were offered by people that were not present during these incidents and who had no awareness of the facts. They couldn't have gathered the proper facts because there were no investigation or incident reports available. Not that incident reports were required. It always seemed to me that the institutional narrative usually started before the initial briefing had even ended. Vindication for the NHS seemed to be the priority.

To some extent you can understand people defending an organisation. But to my mind, any clinician defending the indefensible would be hard pressed to be considered a disciple of the Hippocratic Oath which promises to uphold specific ethical standards.

For those interested in looking, there seems to me to be incontrovertible evidence of serious inadequacies across the system. Why do many professionals seem to refuse to even look?

## Excuses

When I commented on the recurring nature of her injuries, one person I met flicked through her medical records and made a very curious remark, commenting “But she has been in hospital a few times”. Naturally, I asked if this justified her injuries. I received no reply. It’s a curious remark that stayed with me.

Another person tried to explain away the leg injury [saying simply, her legs buckled]. This remark was made shortly after the fracture had been sustained. I appreciate that people could hardly concede that the ward may be at fault for allowing unqualified unsupervised strangers to manhandle her, with insufficient training and awareness. But there was, and still is no evidence that statements have been taken or any incident report has been completed. There is no evidence of a full investigation. In my view, proffering opinions before proper investigation of the facts is both premature and irresponsible.

At the point of those remarks, people outside of the immediate ward environment, would have been wholly unaware of the circumstances that two unqualified bank carers were brought in temporarily to provide cover. They would be unaware that they were left to operate unsupervised. They wouldn’t have known that there were varying accounts. They wouldn’t have known that there was no evidence of a recent Falls Risk Assessment and Falls Prevention Action Plan or any indication that the temporary carers moving her had read it. They wouldn’t have known that, these bank carers would have lacked any understanding of the medical history of the patient. They wouldn’t have known that they were lacking in awareness of potential injury to the patient and any appreciation of potential hazards.

I wonder if it would alter people’s perspectives; if it subsequently emerged that some people working as temporary bank carers, have received their manual handling certification after attending the same kind of training course I attended?

People proffering these premature opinions had no reliable source of information and they weren't present. How would they have gathered enough relevant facts to arrive at an accurate and satisfactory conclusion? From my perspective, many people's opinions were ill informed and contradicted the independent evidence. Their opinions also seemed to contradict the range of versions already offered by the people directly involved and present.

If there are clinicians who respond to incidents in this way, what kind of message does that send to the rest of the workforce? To my mind, the Hippocratic Oath has been replaced with a new Health and Social Calamity Oath. It's no longer, first do no harm. It's, first blame the patient:

So increasingly implausible were these explanations that, as the incidents continued I was expecting to be told that covid was to blame for her injuries and that the dog ate the missing reports.

## Many excellent professionals

I would repeat that this is not a critique of the entire system, only the ineptitude that exists within it. There are, of course, many excellent colleagues across the health and social care system, who work beyond the call of duty to help vulnerable adults. But, in my view, these people are the exception and not the rule. It has to be said, as the incidents, injuries and indignities will testify to, there is a narrow faction of inept personnel letting the service down. Those workers operate in hospital and in community settings. As a consequence; the standard of care across the wider health and social care spectrum overall was, woefully inadequate.

It would be very nice to say the entire system was incredible, but, in my experience, that would be fundamentally misleading. You just wouldn't sustain the level of injuries and incidents my mother sustained if that were the case. That isn't to say that those inept employees are bad people or even entirely responsible. In my opinion, they're just invariably; untrained, unsupervised, undeveloped, unsupported, overworked, unthinking, and therefore unfeeling.

Where there were good examples of home care and nursing care we were quick to express our gratitude. There are many decent examples and we expressed our gratitude often.

But even within incredibly supportive and sympathetic teams, there can be problems. Even among the teams that we highly respected; that treated mum with dignity and respect; that were professional and compassionate; and with whom we shared a long-standing rapport. All it takes is one incident and one team member to let the side down.

## Final Days

For instance, during the last week of her life, as she lay in bed close to death, a team of palliative nurses visited regularly. They were all incredibly supportive. Mum had known some of them for many years.

She had largely stopped speaking and interacting, though she retained a level of awareness. She spent a lot of the day asleep. Occasionally she grimaced but I doubt she was in pain. The build-up of fluid in the airways caused a crackling cough and fluid in the lungs made her breathing uncomfortable. There were subtle changes in her breathing pattern. She started to receive hyoscine injections to dry up the secretions and reduce the discomfort.

Palliative nurses and doctors continued to visit regularly and offered immense support in trying to make her comfortable. One night close to the end, around 3am, it was necessary to call for assistance. Upon arrival her medical notes weren't read or referred to. Following a glance over mum in bed I was told she looked comfortable and sleepy. In fact, she had been far from comfortable for the previous week and, as things turned out she was days away from death.

When I requested another hyoscine injection, I was told there was no evidence to suggest that one was required. Mum coughed and the secretions rumbled. She was uncomfortable but it made no difference. At this stage of the game, a kind and

supportive attitude is what is needed. This visit contradicted the professional opinions of all the other nurses and doctors that had administered injections. Three days later they administered a syringe driver. Mum remained alert to the visit. When someone is close to death this kind of experience can be devastating.

As a result she spent an uncomfortable night which, to me seemed avoidable. Fortunately, the following day the usual palliative nurses and doctors returned. She resumed hyoscine injections under the auspices of those wonderfully caring professionals. She died a few days later.

This is an example of how, it only takes one action or inaction to let the team and ultimately the service down. Even in her final days there were problems, at a time when you least need them. It is not the kind of problem you need to be associated with a loved one passing.

This was the final incident in our agonising journey through the health and social care system. Even at death's door the system couldn't facilitate a completely uneventful and peaceful passing.

## Future

What should the future of a decent standard of nursing and home care for our elderly look like, in a sustainable way that delivers for everyone? I would suggest one that closes the gaps in moving and handling training, and properly addresses the misuse of aids and equipment. I would suggest one that improves the fundamental standard of home care. I would also suggest one that encourages ethical behaviours by applying certain principles to working practices and treating injured service users with respect.

## Root and branch investigation

Aids and equipment in the wrong hands can be lethal. Patients in the wrong hands can be harmed. One incident can be written off as a mistake. Multiple incidents suggest a serious problem needing proper attention.

I have seen no evidence of multiple risk assessment and incident reports or any comprehensive investigation across a four-year period. If anything, the lack of evidence raises serious questions.

To my mind, serious lessons need to be learned. Lessons can't be learned unless there is a root and branch investigation into the cause of all these failings across health and social care. This should include recognition of their impact on my late mother and the implications for other elderly service users and those providing care for loved ones.

In my opinion, each incident at home and in the hospital needs to be fully investigated. I would suggest that hazards need to be identified earlier. A proper safety culture needs to be enforced. This kind of frequency of incidents needs to be reduced. Incident reporting needs to be swift and comprehensive. Evidence needs to be circulated.

These incidents and injuries resulted in a devastating line of events. Failing to learn lessons from these grave errors, and failing to make the necessary improvements, would, in my view, constitute further negligence. Until these actions are taken, I would suggest that the reputation of the health and social care system hangs in the balance.

# Conclusion

My mother's last few years were largely miserable at the hands of this ineptitude. It is a level of ineptitude that materially contributed to an agonising decline.

She was continually bruised and broken. She was either continually recovering from old injuries or living with new ones. She spent a lot of time in a hospital that she didn't need to spend.

Our lives were heavily distracted by a series of incidents, injuries, indignities, neglect, inadequate care, appeals, complaints, and meetings. A cloud loomed large over her final years. All this distracted me from my primary responsibility which was to provide her with care, comfort and protection, and her right to be able to live out her final years comfortably.

Despite my best efforts to keep her safe, I know I failed miserably. Why? And who else failed?

In the final years of her life, while being cared for at home by family, the family never injured her once. This reliable stream of injuries and incidents occurred while she was under the care of health and social care professionals.

She remained mentally alert until the end, at least, until the last few days. She was conscious of everything described in this report. There were many examples of neglect and callousness. It was harrowing to witness a loved one go through this sustained level of suffering. Despite my constant challenges and appeals, I made no progress in achieving a reasonable standard of care or keeping her safe.

She lived with constant hazards and a series of inept staff moving and handling her incorrectly. It was terrifying. She lived in a constant state of fear.

I retain a long stream of futile correspondence. My hundreds of letters, calls, discussions, and appeals achieved very little. In my opinion, and I believe the

evidence points in this direction; my concerns were never taken seriously. I was treated like an imposition by both social work and the NHS. I feel confident that the findings of any full, legitimate and independent investigation would support a view that I was a troubled carer trying to keep his troubled mum safe – constantly appealing to organisations that were failing to take matters seriously - and that our concern was warranted but not fully understood or appreciated.

Before she died she received no apology for this appalling treatment. To my mind, those responsible should hang their heads in shame.

But consider this: following an avoidable neck fracture, she sustained. Following an avoidable leg and hip fracture and major surgery, she sustained and walked again. Following two avoidable shoulder dislocation injuries, she sustained. And she sustained through an endless stream of near misses and daily emotional turbulence. Clearly, she did very well mentally. Clearly, she was more motivated than those to whom her care and safety was entrusted. What she couldn't sustain is being confined to bed and moved using equipment by staff in a way that was uncomfortable, traumatic and dangerous. And she could no longer endure the strain of waiting for the next incident to occur.

A major regret is that our lives became consumed by those parts of an inadequate health and social care system that we were powerless to do anything about. This daily trauma across four years undoubtedly affected her badly. It was a level of suffering which hastened her decline.

After four years we both gave up the ghost. Mum was exhausted suffering at the hands of the system. I was exhausted challenging it.

Six months earlier, on the day of admission, she was alert and mobile. We had been out that day. She entered Ninewells for five days of antibiotics that she could have received at home. As a result of neglect five days transmuted into six weeks.

She was discharged home with a new injury and a hoist and ultimately confined to bed. Enter the carers and the daily incidents recommenced. Then she sustained

another dislocated shoulder. She died at home, five months after discharge. Not due to disease but through willing an end to her suffering and wishing for death as an escape.

The silver lining is that she no longer has to suffer at the hands of ineptitude. I no longer have to suffer witnessing this perceived inhumanity: a damning indictment of our health and social care system.

How many more have suffered and continue to suffer at its hands?

And where there is unnecessary suffering, what recourse do service users have?

How many more have suffered and continue to suffer at the hands of our health and social care system?

And where there is unnecessary suffering, what recourse do service users have?