

Care Inspection & Action Plan

Introduction

This inspection has been highlighted because it resonates with many vulnerable older adults who receive inadequate care and support but who have no-one to advocate on their behalf.

HSC's Management of Adverse Events Policy states that "incidents involving a patient should be noted in the patient's case record". The policy also states that "A full, frank and factual explanation must be shared with the patient at the time of the incident. This should be done by a team of at least 2 staff members including a clinician who has a pre-established relationship with them with a clear team leader identified. State what happened, why it happened and what is being done to prevent it from happening again. Address any concerns the patient and/or family have as soon as possible. This team should inform the patient and family as soon as the organisation has any new information pertaining to the event."

I can't recall a single instance when this guidance was followed – and there were regular incidents across an extended period.

Reported incidents were routinely ignored. If HSC had taken those reports seriously further incidents might have been prevented.

Scant Investigation

HSC denied an investigation at Social Care and significantly reduced the scope of the investigation at Health Care. Timescales were cited which seems a lame excuse. If the documentation was in order, all the service had to do was to refer to established records to explain these incidents.

HSC requested new information to warrant an investigation. I submitted an evidence-based document listing matters for investigation. Instead of opening an investigation HSC acknowledged my submission. They said they had read it and hoped this provided assurance. It didn't, which I stated but typically I received no further reply.

In the absence of any investigation, incidents relating to Social Care were escalated to the Care Inspectorate, an independent scheme of inspection.

Care Inspection

Following investigation the Care Inspectorate upheld my complaint. Social Care disagreed and appealed. The Care Inspectorate upheld my complaint again at the Post Investigation Review stage.

Listed below is a hyperlink to the Inspection webpage followed by an outline of an Action Plan drafted by Social Care in response to that inspection.

The inspection report can be accessed on the Care Inspectorate's Website via [This Link](#)

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Title: Complaint about Dundee City Council – Homecare – Enablement & Support Citywide and Community Mental Health Older People Team
Case Number 2021113970

Key Findings

1. Protection of people > policies and procedures

- The service user did not experience a service with robust quality assurance processes.
- Incidents relating to safeguarding health, safety and welfare were not adequately recorded and investigated by the service.
- The evidence did not demonstrate that the service fully investigated all accidents and incidents.
- Recommendations for improvement suggested that the service should make improvements to their quality assurance process to ensure that incidents, accidents and concerns are fully investigated and the outcomes fully communicated to the service user and/or their representative.

2. Healthcare > tissue viability

- The service user did not experience adequate personal and intimate care, including the promotion of skin integrity.
- The Personal Outcomes Plan should have been fully reflective of service users' needs and how these needs should be met.
- Recommendations for improvement suggested that the service should make improvements to the assessment and care planning processes to ensure staff are fully appraised of people's needs at an early stage, including those for skin integrity and personal care.

3. Healthcare > other

- The service provider provided three staff statements. These statements did not identify any inaccuracies in the complaint report and did not present any additional evidence.
- Recommendations for improvement suggested that in order to ensure people's needs, as agreed in their personal plan, are fully met and their wishes respected the service should: make improvements to staff awareness of people's moving and handling needs, including specific arrangements in the use of equipment at an early stage. **Moving and handling techniques should be fully understood by all staff providing this support in accordance with guidance.**

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4. Record Keeping > Personal plans / agreements

- The service user did not experience adequate arrangements to ensure an up to date and relevant care plan. The care plan was not always reviewed when needs changed.
- While the provider advised that the service did not have access to accurate information provided by the Hospital Discharge Team; recommendations for improvement suggested that whilst this was acknowledged, in one example, the Personal Outcomes Plan was not completed until 15 days following commencement of the Package of Care. This meant that relevant and up to date information was not available to staff. It is the responsibility of the service provider to ensure relevant and up to date information and guidance is made available to staff undertaking the care and support, particularly when the service user has specific and complex healthcare needs.

Social Care Response

In response to the Care Inspectorate's findings, the Health and Social Care Partnership developed an action plan which the Care Inspectorate will review during their next inspection.

Actions include:

- Training and refresher training for all Organisers and Team Managers delivered by a Health & Safety Officer to ensure incidents, accidents and concerns are fully recorded and investigated.
- Incidents and accidents to be discussed as a standard agenda item at team meetings and in 1:1s.
- Feedback template updated and processes for recording incidents on the central shared recording system initiated.
- Audit tool in development and to be carried out three monthly on a sample basis.
- A short life working group established to review care plan content, and a good practice exemplar developed for sharing with all staff.
- Care planning added as a standard agenda item at team meetings and 1:1s.
- Pressure ulcer prevention training (NES) to be introduced and a new section added to the person plans in development.
- Assessment processes are being reviewed with checks by the Organisers within 48 hours for new service users to ensure plans include critical information.
- Refresher training for moving & handling is already delivered to all staff. Recently initiated steering group set up to discuss Moving and Handling concerns, improvements, legislation changes, risk assessments and training.

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Conclusion

HSC's action plan concludes by stating "I hope this assures you we take all concerns and complaints seriously".

As incident reports were not always acted on; as the alleged Safeguarding investigation failed to include all stakeholders and a meeting was not followed-up nor feedback received; as the first request for an investigation was denied; as the second submission to social work remains without response; and as HSC appealed the Care Inspectorate's initial findings, this doesn't suggest to me a service that takes complaints seriously at all. It seems to me that HSC only takes complaints seriously when faced with no alternative.

The single most important point to emerge from this case study is the fact that, despite numerous appeals the service denied our request for an investigation. HSC claimed our grievances had been addressed. Clearly they hadn't. This resistance and denial has to be the key point of learning.

Failing to act on incident reports and undertaking investigations should not have to be forced in extremis by an independent regulator. In my view this single point attests to the need for an investigative mechanism across the entire service. Introducing a similar independent scheme of inspection at Social Work and the NHS would improve quality assurance procedures while providing far greater transparency and support. My MP has raised this with the Cabinet Secretary for Health and Social Care.