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Anonymised to protect individuals' identities

From: Nicholas Garty
contact@fixdundeehsc.com

To: Dundee Health and Social Care Partnership (HSC)

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I refer to your letter dated 12 October 2022. I find your response to be highly unsatisfactory and would refer you to my appendices.

Scope of Investigation

In September 2021 I wrote to Social Care about a litany of problems in the quality of homecare provided. HSC refused to investigate our concerns claiming that everything had previously been addressed. My view is that this wasn't strictly accurate. If all incidents had been investigated properly then mistakes wouldn't have continued and our questions and concerns wouldn't have remained outstanding. You invited new information to warrant a new investigation. I collated evidence and sent this in the form of a detailed spreadsheet. Instead of opening an investigation you merely acknowledged my submission, stating that you hoped this would provide a measure of reassurance. It didn't which I stated. I received no further reply. In view of these facts, why would I be wrong in believing that you worked to circumvent a proper investigation?

In September 2021, separately, I wrote to the Chief Executive of NHS Tayside about problems in the quality of health care provided in hospital. This was passed to a leader at HSC. You reduced the scope of that investigation on the basis that parts of my complaint were out of timescales. This reduced an investigation about matters covering an extended period to 6 months. If, as you suggest all statutory records are in order, then why didn't you simply refer to them to answer my questions?

In the intervening year, in response to my requests for update, I was invariably advised that the investigation was going. I was advised that I could escalate the matter to the Scottish Public Services Ombudsman. I replied that this would evade rather than address these matters and I required answers. I was further advised that; there have been delays drafting the final report; that there continues to be delays drafting the final report; that the final report has been drafted and is awaiting review; that the final report is still awaiting review; that the final report requires further review and is being returned to the investigator. All these delays and detours represent a dizzying unfurling of events. It also represents an inordinate amount of time taken to produce that fractional response eventually received.

I note that you have taken more than a year to point me in the direction of the records department which have yet to respond to my correspondence.

To my mind, Dundee Health and Social Care Partnership (HSC) would appear to have obstructed a proper investigation. Given these circumstances why would it be inaccurate to consider your response to my complaint as a whitewash? If there was no foundation to any of these allegations, surely this would have provided your department with an ideal opportunity to issue an evidence-based rebuttal?

I can of course understand that HSC are not happy about the exposure. But if the service seems to work so diligently at ignoring initial reports of adverse events followed by requests for a full investigation then what other option was available? For instance, if I published the detailed spreadsheet I submitted, this would hardly present a favourable impression about how HSC handles evidence-based complaints.

In my view, while seeming to specialise in avoidance and self-preservation, another opportunity for learning has been lost.

Care Inspectorate

In the absence of any investigation by social care, I escalated my complaint about inadequate homecare to the Care Inspectorate, the independent regulator for care services in Scotland.

The Care Inspectorate conducted an investigation. My complaint was upheld. Social care appealed this decision and the decision was reviewed. My complaint was upheld again.

Ultimately a report from Social Care, sent to my MP stated that an action plan including recommendations had been drafted. For a department that initially refused to process my complaint on the basis that all matters had previously been investigated this event represents a curious development.

In direct response to a statement made in your letter, I would reply; No. I haven't "been assured that we take all concerns brought to our attention very seriously and thoroughly review the issues raised in an effort to improve the experience of our patients". To my mind, I've seen no evidence that your service understands my complaint.

Statutory Reports

In respect of incident reports across both social care and the NHS I have seen no evidence that all these statutory reports exist. You refused my request for copies of social care reports citing patient confidentiality. You expressed concern that I might publish these reports, although I indicated no such intention. I requested these reports to highlight a point; that unless statutory reports are being completed, then the departments involved are failing to identify risks and anticipate problems while continuing to act irresponsibly.

Without incident reports and much needed reflection, learning fails to take place. For instance, when a vulnerable elderly person has been repeatedly injured and a safeguarding (right to enquire) report is made naturally you expect to see a record of that. I was advised by a social worker who seemed to be floundering, that this report would be circulated and I would receive a copy. But again, there is no evidence this report exists or even that the enquiry was conducted as it should have been conducted.

I have copied the following from the NHS Tayside Management of Adverse Events Policy: "NHS Tayside's policy states that incidents involving a patient should be noted in the patient's case record".

The policy also states: "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 at either health care or social care when this guidance was followed. In fact, I recall that following one major incident being advised weeks later that the incident report hadn't been completed "within 24/48 hours" because they were still trying to speak to one of the workers involved.

I retain the medical records and we also had a social care folder at home. I was never interviewed about incidents, statements were never taken and copies, if they exist were never filed in the folder kept at home. When our solicitor (with extensive experience in processing injury claims) wrote to the health board asking for incident reports he received no response. All these factors would not inspire confidence that procedure has been routinely followed and that all these reports exist in their entirety. And since you have refused to produce evidence of their existence, we shall never know for sure, shall we.

Interference

There is a reference in your earlier correspondence from social care to interference on my part. This represents a salient point and I believe you may have unwittingly touched on one of the central problems: a prevailing attitude at the heart of HSC culture that contravenes HSC policy guidelines.

How can a next of kin with primary responsibility for the 24-hour care and welfare of a service user be considered interfering? This is particularly relevant given that often desensitised and inept carers, unacquainted with a patient are briefly entering an established caring environment, and not the other way round. Many health and social care workers have limited or no understanding of the service user. How is this to be achieved without engagement? Many workers are defensive, hostile and resentful of questions, suggestions or guidance. The prevailing attitude seems to be to expect people to stand idly by, ask no questions and speak only when they're spoken to.

I thought HSC policy guidelines aspired to the values of a patient focus and public partnership? I quote from one policy:

"Involving the public in our work is an integral part of everything we do. Our approach to public involvement is to ensure that we work with patients, carers and members of the public".

Examples

As a primary caregiver, when advocating at the behest of my vulnerable mother and instructing social workers to desist from their persistent attempts to delve into her personal financial circumstances and breaching confidentiality, that doesn't constitute interference.

When I alert social care to the history of falls from bed resulting in injury, and when social care ignores this advice and inevitably she falls and fractures her neck, that doesn't constitute interference.

When I alert the hospital to the history of falls from bed resulting in injury, and ask them to keep the cot sides up at night, and when the hospital ignores this advice and the inevitable happens and they have to call a neurologist in the night to examine her injury, that doesn't constitute interference.

Following a documented series of injuries, when I alert social care to the risks of raising a profiling bed more than four feet above the floor while incorrectly rolling her to the edge of the bed and I have to dash forward to rescue her fall when for a moment, the carers weren't looking, that doesn't constitute interference.

When she was confined to bed and wearing a sling, it wasn't a fashion statement. She was wearing it because her shoulder had been dislocated again and was still healing following an operation. To the perplexed, it provided a clear visual aid. So when a carer who, despite being involved in drafting the care plan, rolled her in bed and left her bodyweight leaning on her healing shoulder and needed to be alerted, that doesn't constitute interference.

Rolling her onto a shoulder injury happened at hospital and at home and provides a key example of the utter craziness in existence across health and social care. Her shoulder was dislocated whilst being transferred in hospital using a stand aid device that had not been necessary 2 weeks earlier prior to admission. Her shoulder was re-dislocated at home during a care session, despite my regular warnings. I note that Social Care Response also ignored my incident reports and warnings of danger – so much for 'protected records'.

When a group of nurses in hospital transferred her in my presence using a hoist and I had to alert four workers to a fall in motion by explaining that they had failed to strap her in correctly, that doesn't constitute interference.

Following a series of adverse events using equipment in hospital, I notified a senior manager. We met to discuss these incidents although again I was not involved in formal reporting. When I notified this individual about subsequent events, I received no response. Clearly there was waning interest in my alerts and ignoring these warnings represents neglect.

None of these examples constitute interference. The fact that these alerts about safety breaches continued reinforces a need for intervention and training. These appeals should have been treated with genuine concern rather than apathy.

How many additional injuries did I save her from at the hands of health and social care workers? This is part of the central problem: HSC workers are often hostile to questions and suggestions.

Many workers appear to have an over-abundance of confidence, more arrogant than poised and resent guidance. No worker in HSC is omnipotent including the aloof, condescending clinicians we encountered with their talent for evasion.

It's the spectacularly bumbling response to this incessant litany of incidents that concerns most.

Worth underlining is the fact that interference doesn't seem to have been a problem for the highly qualified Community Nursing and GP team who regularly visited our home. We collaborated with both teams and maintained an excellent working relationship across an extended period without a single issue.

This suggests to me that HSC needs to shift its focus from self-centred to person-centred care. As the policies outline, inviting HSC to meet your health and social care needs when you are a vulnerable elderly adult should not mean having to relinquish control over your circumstances and to invite danger and abject misery into your life.

Common Causes of Incidents

I perceive the common causes consistent with all incidents to be:

- Hoist incidents – almost always caused by workers failing to attach the sling correctly to the device.

- Stand-aid incidents – almost always caused by workers failing to secure the sling correctly beneath the arms.

- Falling out of bed incidents – almost always caused by cot sides being lowered while workers rolled her incorrectly to the edge of the mattress, instead of spot rolling in the centre of the bed. Other incidents happened due to cot sides being left down at night when records emphasised that this should be avoided.

- Dislocated shoulder incidents – caused by workers failing to secure the stand aid sling correctly beneath the arms. Subsequently caused by workers at home and in hospital rolling her bodyweight onto the dislocated shoulder and leaving her in that position while the shoulder was still healing.

- Falling to the floor incidents whilst being accompanied by workers – (depending on the type of chair) most events were caused by encouraging her to sit before the back of her knees were aligned with the front of the chair. Others were caused because the chair was not stabilised by workers and moved from beneath her as she sat down, leaving her no place to go except onto the floor. This happened frequently at home while carers were mobilising her and was reported. This is what happened when she fractured her femur in hospital, accompanied by two incompetents visiting for the day. This contradicts the swift excuse presented within hours by a consultant based in another hospital that her legs had merely buckled, an assertion he made even before the incident report had been drafted. This assertion contradicts another doctor who baulked while telling me "whatever happened, she didn't sustain those injuries through a guided fall". My mother explained to me that, as had happened many times

previously, they told her to sit and when she did the chair moved. As I had witnessed this happen frequently, I believe her.

Your investigation has failed to identify any of these causes so how can this be constructive for the service?

Each adverse event, incident and injury was due to a lack of proper training, a lack of competence, a lack of effective management and a lack of focus and concentration while moving and handling a human being. This proves that certification doesn't always translate into competence and the practical skills of all workers need to be regularly reviewed and properly tested after a certified training course has ended.

Bad Attitudes

The attitude of a great many workers contributes significantly to this level of ineptitude. I recall a senior qualified specialist visiting her at home and in hospital. At both locations this expert observed flawed manual handling procedures and attempted to intervene and offer kindly and friendly guidance. At both locations it was resented by certified workers with a bad attitude who rejected guidance from an expert within their own profession. The workers concerned were responsible for some of these incidents. Her friendly, helpful and expert guidance was seemingly perceived by her colleagues to be "interference".

Neglect of Senior Staff

I attended an accredited moving and handling training course. The same course was attended by people entering the health and social care profession. The training was woefully inadequate and, at the end of the day, candidates were certified without having used any equipment. In my view, certification means very little. If, as you stated "performance is monitored by the team leader or Senior Charge Nurse" then this clearly isn't being done effectively. Perhaps these team leaders and Senior Charge Nurses themselves need to attend further training.

Systemic Flaws

One pertinent example of systemic flaws across the HSC system concerns the challenges involved in reasoning with HSC while alerting the service to danger.

Workers constantly raised the profiling bed to more than four feet above the floor. They lowered both cot sides before rolling her to the edge of a sinking mattress. I repeatedly emphasised that this was the next mistake waiting to happen. A level of compromise was agreed with a technical expert but strongly resisted by workers. Workers countered that due to their 'elf and safety' established practices were necessary. They seemed blithely unaware that observance of their own 'elf and safety' compromised the 'elf and safety' of the patient. Significantly, no-one was able to explain how those same workers functioned effectively to 'elf and safety' standards in the other homes they visited without a profiling bed. To my mind, this provides a case in point about the belligerence frequently witnessed.

There were numerous appeals and discussions; all strongly resisted. The service continued to argue in defence of this practice. The inevitable happened. On multiple occasions it was necessary for me to dash forward and rescue her fall when, for a moment, they weren't looking.

In my view, this single example attests to the craziness that exists within HSC.

I would draw your attention to a specific answer in your response:

I asked: "If each incident could have been avoided, please explain how my mother's injuries can be considered accidents rather than neglect?"

HSC responded: "NHS Tayside promotes a learning approach to reported incidents. Each event or incident is reviewed or investigated to determine any underlying causes or contributing factors".

That reply evades rather than answers the question. But staying with the answer provided, in my view, there seems to be incontrovertible evidence that this isn't happening as you suggest.

If the service doesn't always complete a Falls Prevention Action Plan; if many staff are not competent in the use of equipment; if every incident is not recorded and investigated according to established practices; if I am not asked for a statement and the family receives no consultation and feedback and if, when approached by a senior expert some workers are belligerent, all these factors are incompatible with your response. Denying one investigation and limiting the scope of another provides further example of failing to "promote a learning approach".

Conclusion

Consider what life must have been like for a vulnerable elderly person at the hands of a grossly inept social care service and the NHS. The daily indignities, the maltreatment, the recurring injuries and the constant suffering while enduring a grotesque catalogue of failings. Trauma was evident daily. She was subjected to monstrous treatment. In a civilised society no person should have to end their life in these dismal circumstances.

My late mother was profoundly affected by the injuries that she sustained. No patient should ever have to return home from hospital more damaged than when they were admitted. You can't know the suffering we witnessed as she ebbed away at the hands of inept HSC staff. The summary response from many across the HSC system is to scurry into the shadows seemingly offended by questions and exposure while leaving a series of excuses in their wake: the more senior that evasion the more offensive it becomes.

You may be aware that very recently the Archbishop of Canterbury publicly urged our leaders to fix UK's broken social care system. He stated "We can rise to the challenge of fixing it". My response would be, not by evading the glaring problems that exist.

Although we requested one, I don't recall anyone from social care or health care ever offered an apology for the unnecessary pain and suffering my mother endured. I know what this signifies to me. What does this signify to you?

The response to this entire matter by both social care and the NHS is, I believe unconscionable and deeply unsatisfactory. It is widely acknowledged that the service is broken and this sorry journey unfolded as a direct result of gross neglect and the constant crisis that is the health and social care system.

To my mind, the fact of the matter is that health care and social care services failed to provide safe care and treatment, exacerbated by staff incompetence. Services were repeatedly warned of dangers lurking. There is no incident in my view that couldn't have been prevented. It is reprehensible that HSC continually put her at significant risk of avoidable harm. We can only hope that this report falls into the correct hands and provides a much needed jolt to prioritise patient safety across both departments resulting in meaningful change.

Sincerely yours

N Garty