Summary & Recommendations

Anonymised to protect individuals' identities

A gross failure of the system

In my view, this is a disturbing case but it is not an isolated case. Far from being a unique experience the reality is that this case represents only a single example of gross systemic neglect. The fact that avoidable incidents and substandard care happened both at home and in hospital resulted in a double whammy.

These problems are far from unique and nothing said here is new. My late mother suffered greatly and unnecessarily. Trauma was evident daily due to being caught up in this never ending crisis. No patient should have to return home more damaged than when they were admitted to hospital as a result of incompetence and neglect. No service user should be forced to live out their days in utter misery due to the serial blunders of social care workers at home and health care workers in hospital.

To my mind, systemic failings caused or more than minimally contributed to these incidents and her injuries. Her situation and her suffering were contributed to by neglect and a gross failure to provide adequate basic care.

Response from HSC

In my estimation, the response from HSC doesn't inspire confidence. It has the stench of implacable arrogance. There is no sense of genuine concern or evidence of any need to scrutinise this particular patient journey more thoroughly.

HSC hasn't deigned to offer an apology.

This failure to offer an apology is a matter that will be pursued.

The investigators have described my report as "an account of [my] experience". My response would be; so what is HSC's account? We don't know what their account is because they've avoided providing answers, provided scant response and refused to disclose key records. And even that took them a year to produce. If the service has a different account then why doesn't it open up the matter to proper scrutiny?

We know the service denied the account I provided to social care. We also know that the Care Inspectorate subsequently investigated and upheld my account. Social care then produced an action plan listing a number of recommendations; some around training. This represents a curious outcome for a service that initially considered everything to be in order compared to my "account". Thank goodness that the Care Inspectorate exists to cast an eye.

Why doesn't HSC have the social work and health care matters investigated independently and follow the evidence already at their disposal?

Of course, HSC doesn't seem to consider that my complaint has any validity. HSC resents the exposure. HSC resents the request for a full investigation. HSC offers excuses for denying an investigation at social care while narrowing the scope of the investigation at healthcare. To my mind, HSC has done as little as it can get away with. It provides a case in point about how the service seems to specialise in the art of deflection, denial and evasion.

This stance serves to perpetuate these problems. We have learned very little. The service doesn't appear to have learned anything. There remains an absence of recognition, responsibility and accountability. This exercise has failed to shed any light over many of our questions. We remain in the dark. The service remains in the dark. In my view, the system is in bad shape being lead by leaders who need to shape up.

Why did the service's hands need to be forced? What does this suggest about HSC's abilities to investigate itself?

In the face of this opposition, if it was necessary to ask the Care Inspectorate to independently scrutinise home care services, who is independently scrutinising social work and health care?

A lack of good practice

At source, this exercise exists to question why what happened, happened to the extent that it did. It aims to find the answers to questions about what happened, what has been learned and how future adverse events might be avoided. A major theme is questioning whether Adverse Event Management Policy and statutory procedure is routinely followed properly while questioning the existence of statutory records. Statutory policies and procedures exist for a reason. Full compliance is vital. When implemented effectively, policies and reporting:

- provide a roadmap for day-to-day operations
- prevent operations from devolving into complete chaos
- allow the organisation to use time and resources more efficiently
- provide a rich source of learning for employees
- ensure a better quality service
- provide a safer environment
- encourage accountability

How can this deplorable patient journey and this series of adverse events, as far as possible be avoided in the future?

The future

Beyond this individual crisis, there lies a greater one. The demand on health and social care services continues to rise inexorably. These pressures are massive and unsustainable.

There are resource problems resulting in a mismatch between supply and demand; delayed discharges resulting in bed blocking; millions stuck on waiting lists; ambulance services in crisis and industrial action by a demoralised workforce. With constant talk for years and little sign of action and resolution, this imbalance is a source of immense tension and the situation is only getting worse.

In my view, the elderly are an easy target. We need to make fundamental widespread changes. Prevention is better than cure. The service needs to see prevention becomes a priority – better training, better risk assessments, far better incident reporting. Widespread organisational malaise needs to end.

There is a critical need to ensure statutory procedure is routinely followed, even for minor events. Failing to take a statement from the key witness reporting many of these adverse events and failing to offer feedback would suggest that, even if these reports do exist, they can hardly have been completed accurately.

I strongly believe that in future, those who occupy senior positions in the HSC sector must be required to account for any failure to protect vulnerable elderly adults from harm. They shouldn't be able to take a laissez-faire approach to situations when things go wrong with a focus on their own positions in place of the truth.

When incidents happen, it is vitally important to first understand what went wrong in the way health and social care workers acted, and how deficiencies in their organisations contributed.

In my view, the evidence suggests that one major deficiency is staff working with vulnerable service users who may be certified but who may not be properly trained and fully competent.

The single most important change in the future must be the drawing of a clear line of accountability, from top to bottom ensuring:

- Workers are competent and not just certified
- Statutory procedures are properly followed from the beginning of the patient journey
- Complete transparency in incident reporting (not hiding behind confidentiality legislation and sending family members on a wild goose chase in the search for records that are unlikely to be disclosed)
- Procedures are properly followed so that people learn from adverse events and
- The default position of evasion and ambiguity when things go wrong is eradicated

Time and again it was dispiriting to listen to the 'buck passing' from those who attempted to justify their positions. It was disappointing to listen to implausible explanations by people immediately blaming a vulnerable service user while evading investigations of even minor adverse events. To achieve the proper protection of vulnerable adults this evasive culture must end. We can only hope that this exercise encourages people in positions of influence to look at things through a new lens. We can only hope that it opens up a new debate that seeks progressive solutions about how the entire system operates.

Ultimately, we hope this will prompt the service to make long overdue changes.

Better Scrutiny

The perceived gross failings that I note about this case highlight a need for consideration to be given about the ways in which current arrangements for the protection of vulnerable elderly adults might be strengthened.

To my mind, current arrangements for scrutinising our HSC services are clearly not working. This would suggest a need for more forensic inspection. What HSC still needs to add to its action plan is regular independent service user audits and a far greater level of scrutiny. The only way nationally, HSC is going to make progress is through the formation of a new national independent scheme of inspection. This is needed to scrutinise HSC services by introducing spot-checks as well as comprehensive independent in-depth scrutinisation.

Significant Questions

Following that opaque response to my complaint about my late mother's torturous journey the following in-tray of agonies remain outstanding. These represent only a few scattered questions that our leaders need to ask themselves about the way in which HSC currently functions. These represent questions that our leaders at HSC should already have asked themselves:

NHS Tayside

- Does every elderly patient have a Falls Risk Assessment and Falls Prevention Action Plan and are all patients being assessed for their risk of falls within 24 hours of admission?
- Is there a copy of the falls plan contained in every elderly person's medical record?
- Do all nursing staff read these plans?
- Are perfectly capable elderly patients being left to languish in bed unnecessarily and being passed to the RVH to recover their mobility?
- If so, what are the staff resource implications and what impact does this have on bed-blocking?
- Is transferring some elderly patients to the RVH completely avoidable?
- Are all patients receiving proper post-operative care?
- Are staff being properly trained in moving and handling, and not just certified?
- Are agency staff being properly screened for competency before being approved?
- According to policy guidelines are incident reports being completed for ALL adverse events (whether minor or extreme) and are proper and timeous investigations being held?
- Are families properly informed about and involved in the investigation process?
- Is there complete transparency in the record retention system?
- Are the recommendations from investigations being followed up?
- How are the voices of ALL service users being independently heard?
- How do we know the accuracy of answers to these questions?

Social Home Care

- Does every elderly patient have a comprehensive care plan drafted before care visits commence?
- Does every elderly patient have a comprehensive moving and handling plan drafted before care visits commence?
- Is there a copy of these plans contained in every elderly person's home?
- Are carers being properly trained for care duties?
- Are carers being properly trained in moving and handling, and not just certified?
- Do carers read plans?
- According to policy guidelines are incident reports being completed for ALL adverse events (whether minor or extreme) and are proper investigations being held?
- Is there complete transparency in the record retention system?
- Are the recommendations from investigations being followed up?
- How are the voices of ALL service users being independently heard?
- How do we know the accuracy of answers to these questions?

Public Partnership Policies

Despite patient focus and public partnership policies stating “Involving the public in our work is an integral part of everything we do”, is that level of engagement really welcomed and is theory always put into practice? Why do parts of the service appear to be hostile in response to attempts at engagement? Why are attempts at engagement, made by the people best placed to, described as interference? After all, the evidence proves that many workers in the service are far from invincible.

Recommendations for Improvement

The investigators response welcomed feedback. Therefore, my recommendations for improvement would incorporate the following suggested actions:

- Patients and service users should be advised about their human rights and what they can expect from nursing and community care, upon admission to hospital and before embarking on a program of home care.

- Vulnerable patients and service users should be advised how to make expressions of concern within the HSC setting.

- All complaints should be taken seriously and thoroughly investigated.

- Patients and service users should be advised how to access external support organisations.

- Organisations across the HSC system should be independently audited.

- Manual handling training and auditing should be independent.

- A no blame culture should exist to encourage workers and service users to speak out.

- Workers regularly recite the mantra ‘elf and safety’. People need comprehensive training so that they develop a proper understanding of H&S legislation.

- Professionals need to develop greater awareness of their duty of care including the expectation to take reasonable care.

- Manual handling training needs to encompass theory, practical exercises, supervision, mentoring and monitoring.

- Every person using a piece of equipment should have a professional monitor prepared to sign off on their competence.

- Every service user receiving care in the community should receive regular independent surveys, not just a select few.

- Every patient receiving care in hospital should complete an independent survey on discharge.

- On admission every vulnerable elderly patient should have a Falls Risk Assessment and Falls Prevention Action Plan completed. The service needs to ensure these plans are included in medical records and are read and understood by all staff coming into contact with the patient.

- When accidents or injuries occur, however minor, all reports should be readily accessible to patients and service users. In addition to being stored remotely on internal systems, redacted copies of incident reports should be contained within a patient's medical file or care folder at home; DATIX reports being one prime example.

- All patients upon discharge should have a care plan in place including a continually revised moving and handling plan.

- All patients should receive post operative care by default.

- The health board needs to respond to all formal correspondence within reasonable timescales.

- All capable elderly patients should spend some of the day out of bed to maintain their levels of mobility and for obvious health reasons. If this is happening due to insufficient resources then that needs to be addressed, instead of finding excuses to justify this practice.

- In certain cases, any decision to catheterise and give fluids intravenously to a capable elderly patient needs to be reviewed.

- In certain cases, where a patient leaves hospital in a worse physical condition than when they were admitted, this should be flagged and properly investigated.

- ASP (safeguarding) reports need to be taken seriously and conducted in accordance with policy guidelines, including the provision of feedback to families.

- In the community, there should be proper screening and assessment of every individual applying for a care role.

- Services should refrain from re-writing a service users narrative when it becomes inconvenient to their own self-serving agenda.

What next?

If there are failings in Homecare provision and Social Care Response members of the public have independent recourse via the Care Inspectorate. No similar wholly independent mechanism exists for the Council, Social Work or the NHS however, who largely mark their own homework. This would suggest a need for the formation of a national independent scheme of inspection: an independent inspectorate for the Council, Social Work and the NHS. It is suggested that this is a matter for the Scottish Government to review.

Keeping our elderly safe

Have these incidents continued in homes and in hospital? I would suggest people should read the falls incident reports posted on the walls of every hospital ward. However, I would be more interested in reading the inaccessible incident reports in short supply at social care. I would be interested in talking to individual service users. I would suggest this provides another important reason why we need greater independent scrutiny of all aspects of these services.

My sympathy remains with those approaching old age. One day we will all face old age and many of us will require some level of intervention.

In my view, and it is a view steeped in extensive personal experience, countless people fail to appreciate how desperate things are for many of our elderly.

When you enter the HSC system you are completely at their mercy and powerless to do very much about mistakes that happen or things that need to change. The majority of people, sadly, are stuck with the HSC system as it exists. In our case, despite attempts we were powerless to change the situation very much.

As a society, we need to start treating our elderly as though they are living not just existing. The narrative around elderly people and how they are valued, treated and perceived needs to change.

To work in an elderly care environment, at all levels, whether in hospital or within the community, kindness and compassion should be included as competencies on all job descriptions involving service user contact. These can be quantified by sub-dividing these competencies into measurable elements. It is kindness and compassion that brings humanity to these services and what, in many cases, I perceived to be sadly lacking. Common sense also seems to have sadly passed away.

If you know of someone elderly and vulnerable without adequate supervision and support, show that person some kindness, compassion and community. Check if they're receiving proper assistance. If necessary, point them in the direction of help. If our experience is anything to go by, heaven knows they'll need it.

**A range of organisations offering information, guidance and support to both carers and service users is available on the main website. Dundee Carers Centre is an excellent first point of contact.*