[2016] UKFTT 734 (HESC)

Care Standards

The Tribunal Procedure Rules (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

IN THE MATTER OF AN APPEAL

Before;

Judge H Khan (Tribunal Judge)
Ms B Graham (Specialist Member)
Ms Wendy Stafford (Specialist Member)

BETWEEN:

Mr Russell Smith (1)
Mrs Gail Smith (2) **Appellant(s)**

V

Care Quality Commission

Respondent

[2016] 2625.EA & [2016] 2734.EA

DECISION

The Appeal

1. The Appellants appeal to the Tribunal against the following decisions:

   a. The decision dated 8 February 2016 to cancel the first Appellant's registration as a Registered Manager in respect of regulated activity of accommodation for persons who require nursing or personal care at the location of Benamy Care, 25 Candlish Terrace, Seaham, County Durham, SR7 7BA dated 8th February 2016.

   b. The decision dated 26th May 2016 to cancel the first and second Appellant's registration as a service provider in respect of accommodation for persons who require nursing or personal care at the location of Benamy Care, 25 Candlish Terrace, Seaham, County Durham, SR7 7BA.

Paper Determination

2. The appeal was listed for consideration on the papers, pursuant to rule 23 of the Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008 ('2008 Rules'). Both parties must consent, which they have in this case, but the Tribunal must also consider that it is able to decide the matter without a hearing. In this case, we have sufficient evidence regarding the allegations made and the conclusions reached. In the circumstances, we consider that we can properly make a decision on the papers without a hearing.

Restricted Reporting Order

3. The Tribunal makes a restricted reporting order under Rule 14(1) (a) and (b) of the 2008 Rules, prohibiting the disclosure or publication of any documents or matter likely to lead members of the public to identify the service users in this case so as to protect their private lives.

Events leading to the cancellation of the registrations

4. The Appellants were registered as a service provider on 1 October 2010 at Benamy Care, 25 Candlish Terrace, Seaham, County Durham SR7 7BA. The location was registered to provide the regulated activity of providing accommodation for persons who require nursing or personal care. On 13 January 2011, Mr Russell Smith was registered with the Respondents as the Registered Manager.

5. There have been a number of inspections carried out by the Respondent. The service was inspected on 4 January 2013 and 21 October 2013 when no breaches of regulations were identified and the service was judged by the Respondents to be compliant.

6. A further inspection was undertaken on 24 July 2014 and the service was found to be *"inadequate"* and the service provider was judged to be in breach of seven regulatory requirements under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

7. An action plan was requested from the service provider to show how they intended to improve the service. This was submitted by the Appellants on 30 March 2015. The action plan did not address all the breaches and therefore a further action plan was submitted on 30 April 2015. The Appellants stated that they would be compliant with the Regulations by July 2015.

8. The service was inspected again on 19th & 20th August 2015. The Respondent concluded that the Appellants were in breach of five regulations pursuant to the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 and a further breach of the Care Quality Commission (Registration) Regulations 2009. These were:

- Regulation 9 (Person-Centred Care)
- Regulation 11 (Consent)
- Regulation 12 (Safe care and treatment)
- Regulation 17 (Good governance)
- Regulation 18 (Staffing)
- Regulation 18 of the 2009 Regulations (Notification of other incidents).

9. In line with the Respondent's continuing duty to inspect, a re-inspection was carried out on 12th February 2016. This identified continuing failures which had persisted over the last three inspections in breach of the 2014 Regulations. These were:

- Regulation 9 (Person-Centred Care);
- Regulation 11 (Consent);
- Regulation 12 (Safe Care and Treatment);
- Regulation 17 (Good Governance);
- Regulation 18 (Staffing).

10. A further inspection was attempted on 13 September 2016. However, the Respondent claims that the Appellants obstructed this inspection and refused to co-operate.

11. The notices regarding the cancellations were served on 8 February 2016 (Registered Manager) and 26 May 2016 (service provider). The Appellants submitted their appeals on 1 March 2016 (Registered Manager) and 23 June 2016 (service provider). The appeals were subsequently consolidated.

Legal framework

12. The statutory framework for the registration of providers of regulated services is set out in the Health and Social Care Act 2008 (the Act). The Respondent is a statutory organisation set up under the Act. It has the statutory responsibility to inspect regulated activities.

13. Section 17 sets out that the Commission may at any time cancel the registration of a person as a service provider or manager in respect of a regulated activity on the ground that the regulated activity is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements. It also sets out that relevant requirement means any requirement or condition imposed by or under this chapter and the requirements of any other enactment which appears to the Commission to be relevant. The Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014 regulations are the relevant requirements. Regulation 8 makes it clear that a registered person must comply with the regulations in carrying out regulated activity.

14. The powers of the Tribunal are set out in section 32 of the Act. The Tribunal has the power to confirm the decision of the Respondent, direct the decision of the Respondent to have no effect and to direct the imposition of any such discretionary condition as it thinks fit. The Tribunal considers the appeal on the basis of the available evidence at the time of the hearing.

Evidence

15. The Tribunal had before it a bundle of documentary evidence. We considered all the evidence and took it into account in reaching our decision. We have summarised some of the evidence below.

16. The Respondent's evidence included inspection reports, fire safety updates, email exchanges and executive strategy minutes. The Respondent's evidence also included witness statements from the following:

- Rosalind Sanderson, Head of Inspection of Adult Social Care
- Nicholas Mulholland, Head of Inspection for Hospitals
- Jean Pegg, Inspection Manager for Adult Social Care
- Gavin Bainbridge, Inspector for Adult Social Care
- Aileen Gilbert, Inspector for Adult Social Care
- Carole Charman (formerly Mole), Inspector for Adult Social Care

17. The Respondents case was set out in the statement of Mr Gavin Bainbridge. He set out his involvement in the inspections on the 19 & 20 August 2015. He described how some documents had been seized under Code B of the Police and Criminal Evidence Act 1984.

18. He described how regulations 9, 11, 12, 17 and 18 had been breached. In summary the breaches related to a service users communication needs not being recorded, no instructions given to staff as to how an individual was to be supported to wear hearing aids, what staff should do if he chose not to wear them and what other communications staff could use.

19. Furthermore, he described issues around a service user not attending a daycare centre in the mistaken belief that the daycare centre could not support anyone who was taking oxygen such as the service user.

20. He also focused on the inadequate understanding of the Deprivation of Liberty Safeguard (DOLS) process and a lack of training around mental capacity. He was concerned about a lack of differentiation between different individuals care. There were no instructions regarding the application of prescribed creams

or any documentation regarding how to apply them. Furthermore, the evacuation plans contradicted the care plans, there were a lack of background checks on the neighbour. He described a lack of auditing and identified specific examples where effective auditing and reviewing would have identified major discrepancies in users care documentation.

21. In addition, he set out the background to the inspection of 12 February 2016. He found that the Appellant had failed to make significant improvements despite support from a consultancy firm (Resolve) and the Local Authority. He found that regulations 9, 11, 12, 17 and 18 continued to be breached. The breach of these regulations included the failure to identify, plan or make reasonable adjustments for service users despite there being clear opportunities to do so. Further, there was no involvement of service users or their families in any reviews of care or support. There remained a lack of understanding around mental capacity issues, consent, DOLS and best interest decision making.

22. Furthermore, risk assessments were not detailed and staff understanding of specific risks was inadequate. For example, one staff member was unable to describe the symptoms of a lack of oxygen. He also found that the Appellants had not implemented a number of actions set out in their own action plan which had been completed with the assistance of a consultancy. Auditing remained poor with audits of care file and training not yet in place. He also found inaccurate information on service user care files.

23. His second statement set out the circumstances around the attempted inspection on 13 September 2016. He described how Ms Smith informed him that "*they hadn't made any changes since the last inspection and were ready to move on"*. Furthermore, both Appellants confirmed that they did not intend to do any further work. He was also asked to leave and was unable to complete his inspection.

24. The details on the other statements included confirmation of the above and details of earlier inspections.

25. The Appellant's evidence included a letter from Mr Smith to the Respondent, a two-page witness statement, factual accuracy comments log for the draft inspection report and various emails.

26. The Appellant's case was set out in a brief statement. They confirmed they had five long-standing, happy and healthy service users. They couldn't understand why they were deemed *inadequate* nine months after receiving a good report. They described their care as being pragmatic and of a high standard though they accepted that *"documentation has always taken second place*". They had been working with Resolve between October 2015 and March 2015. They disputed the contact between Mr Bainbridge and the service users in preparation of his report. They do not believe that enough emphasis has been given to the

thoughts and feelings of the service users in relation to the care. Furthermore, they confirmed that the service users did not wish to move.

Tribunal's conclusions with reasons

27. We carefully considered the evidence submitted to the Tribunal. We also took account of the legal provisions under the Health and Social Care Act 2008, the Regulations and, where applicable, any relevant case law.

28. We observed that the Appellants had provided limited information in support of their appeal. Their evidence included a brief statement, copies of their factual accuracy comments submitted to the Respondent regarding the inspection reports, copies of a blog and various correspondence. The Appellants had not provided any formal witness statements nor had they completed the Scott Schedule setting out their detailed reasons for opposing the appeal.

29. We reminded ourselves that the Regulations prescribe the kind of activities that are regulated activities for the purposes of the Health and Social Care Act 2008 and set out the requirements that apply in relation to the way in which those activities are carried out.

30. The service provider and the Registered Manager were both providing the regulated activity of 'accommodation for persons who require nursing or personal care'. There was no dispute between the parties that the Appellants were carrying on a regulated activity.

31. We had no reason to doubt the Appellants assertion that it was the perception of the servicer users and their families that they were in a comfortable environment and did not wish to be moved. However, the issue was whether or not the Appellants as registered service provider and manager were in breach of the Regulations. We concluded that the Appellants were in breach of the Regulations. Our reasons are set out below,

32. We concluded that here was a breach of Regulation 9. In our view, the care and treatment of service users was not appropriate, it did not meet their needs and reflect their preferences. We accepted the unchallenged evidence regarding the inspection on the 19 & 20 August 2015 of Mr Bainbridge and concluded that the care and planning information did not contain instructions to staff regarding how an individual was to be supported wearing hearing aids, what staff should do if he chose not to wear them or what other forms of communication staff could use. The Communication Plan from 2013 onwards stated *"that all staff were to be aware of the service user B needs"* but did not state what these needs were.

33. Furthermore, we accepted the Respondents submission that there was a failure to follow or implement recommendations of medical professionals into care plans. For example, advice had been received from the Speech and

Language Therapy Team (SALT) regarding using the communication tool to help improve Service User B's communication skills. However, the service user care plans made no reference as to how this tool might be used to support Service User B's communication needs.

34. Furthermore, at the inspection on 12 February 2016, the position had not altered substantially. The person centred care was still not provided as not all the care plans had been completed pursuant to the Appellants own action plan and the Registered Manager confirmed to Mr Bainbridge that neither the service users nor their relatives were involved in reviewing or writing the new plans. It is difficult to see how the care and treatment of service users reflects their preferences if they and/or their families are not involved in the process itself.

35. We also concluded that there was a breach of regulation 11. The Appellants understanding of mental capacity, deprivation of liberty safeguard (DOLS) had not improved by the time of the inspection in February 2016. Ms Smith had still not undertaken training on the Mental Capacity Act and the Registered Manager was not aware of what a best interest decision was.

36. Furthermore, the Appellants' employees also did not have a working knowledge of the Mental Capacity Act, DOLS or best interest decision making. The lack of knowledge was demonstrated when Mr Bainbridge reviewed the care files and observed that two individuals had been asked to sign documents to confirm they consented to care and treatment alongside mental capacity assessments that stated these individuals did not have the capacity to consent to such a decision. We acknowledged the Appellants submission that they had made improvements as a result of ongoing liaison with safeguarding and health care professionals. However, the feedback gathered by the Respondent demonstrated that while some assistance had been provided to the Registered Manager to complete the relevant forms, their understanding remained poor.

37. We concluded that there was a breach of regulation 12. We once again accepted the unchallenged evidence from the Respondent that the risk assessments were not sufficiently detailed and staff understanding of the specific risks was not adequate. There was no proper and safe management of medicine, for example, there was no guidance for staff as to how or where medication should be applied. Furthermore, there was no proper assessment of the risk to the health and safety of service users receiving the care or treatment. For example, Service User E had a condition leading to instability in the ligaments of the neck and spine yet the Appellants accepted that they had not undertaken a risk assessment and informed the inspector that their only strategy to manage this was to prevent Service User E from going on *"rollercoaster's or trampolines".*

38. Furthermore, there had not been much improvement by the time of the February 2016 inspection. For example, service user E was assessed as having

a risk of not receiving the right amount of oxygen. This was incorporated into the care planning. However, when Mr Bainbridge spoke to a staff member, they were unable to describe what symptoms a person might display due to a lack of oxygen. So whilst progress had been made in relation to updating some of the paperwork, the Appellants did not ensure that the staff providing care or treatment had the competence, skills and experience to do so safely.

39. We also concluded that there was a breach of regulation 17. The Appellants had failed to implement a number of actions set out in their own action plan. The inspection of August 2015 had found an inability to make improvements based on an action plan. The inspection in February 2016 found the service to be in breach of the same regulations as in August 2015. The auditing remains particularly poor, with care file audits and training audits not yet in place and inaccurate information being recorded on service users care files. We accepted the unchallenged evidence from the Respondent that the records produced by the Appellants were not accurate, complete and contemporaneous. Furthermore, in our view, had feedback been sought and proper audits been carried out, a number of the issues raised in this appeal could have been picked up earlier and addressed.

40. We also concluded that there was a failure to ensure staff training was up-to-date so staff were able to meet the needs of the users. Although the Appellants state in their appeal that staff appraisals, meetings and supervisions had been reintroduced, no additional documentary evidence was produced to substantiate this assertion. We had no reason to doubt the Respondents evidence that there were no plans and adequate systems in place to ensure staff training was up-to-date and appropriate.

41. Whilst we acknowledge that the Appellants have taken steps such as engaging the services of a consultancy agency (Resolve) and have produced an action plan, nevertheless, despite that, they have failed to comply with their own action plan within their self-imposed timescales. Furthermore, the Appellants themselves accept that whilst they have been pragmatic in providing high standard day-to-day care, the documentation has *"taken second place*".

42. We also took into account the number of inspections. The Appellants have been inspected on three occasions and have been subject to 3 inadequate ratings with continuing failures in the same areas. We agreed that the Appellants had been given a number of opportunities to submit action plans and carry out those improvements. However, despite their assurances, they have simply failed to deliver. We concluded that the situation cannot be allowed to continue indefinitely and that the Appellants have had sufficient opportunity to put things right.

43. Furthermore, the Appellants had an opportunity to demonstrate compliance at the inspection that was scheduled for 13 September 2016.

However, they prevented the inspection from proceeding and confirmed that they confirmed that *"they had changed nothing".*

44. We also considered the Appellants submissions about the impact that deregistration will have on the service users. We accept that cancellation will have an impact on the service users. However, the regulations set the standards that have to be met for the safety of such vulnerable service users. Our findings above in relation to the service users care has led us to conclude that such disruption, whilst not ideal, is an unfortunate consequence of the Appellants lack of compliance with the regulations covering key areas such as person centred care, consent, safe care and treatment, governance and staffing.

45. In our view, looking at the matter overall, we were satisfied that there has been a breach of the above regulations. We have had regard to the totality of the matter and concluded that action taken by the Respondent was justified and proportionate given the long-term and substantial failures to comply with a number of regulations. Accordingly, we uphold the Respondent's decision to cancel the Appellants registration as a service provider and that of the Registered Manager. We, therefore, dismiss the appeal.

Decision

The appeal is dismissed.

Judge H Khan
Lead Judge Primary Health Lists/Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 1 November 2016