Care Standards

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

[2016] 2836.EA

Heard on the papers on 2 March 2017

BEFORE
JUDGE - JOHN BURROW
SPECIALIST MEMBER - DENISE RABBETTS
SPECIALIST MEMBER - BRIAN CAIRNS

IN THE MATTER OF AN APPEAL
BETWEEN:

Carole Ann Montague

Appellant

v

Care Quality Commission

Respondent

[2016] 2836.EA

DECISION

1. In this case Mrs Montague appealed under Section 32 of the Health and Social Care Act 2008 against the decision of the CQC Inspector on 14 September 2016 to refuse to grant her application to be registered as the Registered Manager in respect of regulated activity at Ancona Care Home.

2. With the agreement of both parties the appeal is to be heard without an oral hearing on the papers. The appeal was heard on 2nd March 2017.
3. The bundle consisted of tabs A-F up to page F88. Both parties submitted skeleton arguments. All documentation was considered by the tribunal.

The Case for the CQC

4. Mrs Montague was registered as the Registered Manager of Fallowfields Residential Home (FRH) on 5 January 2011. She

remained as Registered Manager at FRH until 5 February 2016, when she applied to deregister at FRH. She then applied to be registered as the Registered Manager at Ancona Care Home (ACH). It seems she took up employment there on 29 February 2016.

5. The CQC inspected FRH on 15 and 19 August 2014. During the inspection a failure to comply with regulations 10,12, 20, 22 and 23 of the Health and Social Care (Regulated Activities) Regulations 2010 (the 2010 Regulations) was recorded. The failures related to infection control, particularly in the laundry room, staff numbers, care plans, supervision of staff, and insufficient audits to monitor the quality of service. The overall rating of FRH was "Inadequate", and compliance actions were set. In January 2015 an action plan on behalf of FRH was sent in to the CQC.

6. On 22 October 2014 a service user at FRH left the home by a fire escape door and stairs. The user dismantled a lock to the rear gate and accessed the street where they fell, causing a cut to the chest and hand. Mrs Montague notified the CQC that fire escapes were to have alarms fitted.

7. On 19 March 2015, another service user at FRH was found at the bottom of a fire escape at the rear of the house. Emergency services attended but the service user was pronounced dead at the scene, with injuries consistent with having fallen down the fire escape stairs. Later investigation found the service user had exited the house by a fire escape door in a bedroom at the rear of the house which had not been alarmed.

8. On 11 and 16 June 2015 FRH was again inspected by the CQC. A failure to comply with Regulations 9, 11, 12, 15, 17 and 18 were recorded. Concerns included cleanliness, risk of infection, incomplete MAR charts, medicine fridge not working properly, staff not trained in the use of fire safety equipment, inadequate staff numbers on duty, and a failure to follow the Mental Capacity Act 2005. The findings of the CQC were that the safety, effectiveness and responsiveness of the service required improvement, while the leadership at FRH was found to be inadequate.

9. On 5th August 2015, three warning notices arising from the June inspections were issued under Section 29 HSCA 2008. The first referred to a failure to comply with Regulation 12 of the 2014 Regulations, which required that care and treatment must be provided safely. Concerns included failure to train staff in the use of evacuation sleds, a failure to manage medicines safely, gaps in MAR sheets and infection control.

10. The second warning notice related to failures to comply with Regulation 17 of the 2014 Regulations which requires that systems must be established and operated effectively to ensure compliance. Concerns

included actions taken following the incident on 22 October 2014, when a service user exited the premises through a fire escape door and stairs and fell and was injured on the street. Mrs Montague had since placed a pressure alert mat in front of this fire escape door, but had not alarmed three other fire escape exits. On 19 March 2015, another service user had exited through one of these doors, had fallen from the fire escape stairs and had been pronounced dead at the scene. Mrs Montague had subsequently alarmed all four fire escape doors and placed movement sensor alarms elsewhere. As a result alarms were continually being activated making the environment at the Home too noisy

11. Further concerns in the second warning notice were that systems put in place after the inspections in August 2014 were not effective in finding shortcomings, including infection control, evacuation sleds, staffing levels and meaningful activity provision. Further concerns in the warning notice related to a failure to follow the Mental Capacity Act 2005, and a failure to ensure the environment of the home supported service users with dementia.

12. The third warning notice issued on 5 August 2015 related to a failure to comply with Regulation 18 of the 2014 Regulations which required the deployment of sufficient staff members. The concerns included reports by service users that there was not always enough staff to meet their needs.

13. On 14 March 2016, Mrs Montague was interviewed by two CQC Inspectors at the Ancona Care Home. This was as part of the consideration of her application to be a registered manager there. On entering the home, inspectors found a staircase with unrestricted access had not been risk assessed by Mrs Montague. She said she had not given it a thought.

14. During the interview she was asked how she would ensure that the care and treatment of service users at Ancona Care Home would be delivered in a safe manner in compliance with the regulations, given her history of non-compliance at FRH. Mrs Montague accepted she had not sought advice or support when the providers at FRH had declined to act on her suggestions. With prompting she accepted she should have sought support from the LA Safeguarding Team or the CQC.

15. Mrs Montague was asked how she would ensure the safety of users at Ancona Care Home. She replied the provider at ACH was more hands-on with care. She spoke of being given a kick to ensure she took the necessary actions. Mrs Montague was asked how she would ensure compliance with regulations at ACH, given her failures at FRH. Mrs Montague blamed the provider at FRH for the failings there. Mrs Montague was asked about her failure to mention the failings while manager at FRH, in her application to be registered as manager at

Ancona Care Home. She later said she had not meant to hide these matters.

16. When asked about her understanding of her role as a registered manager, she said she had been a bit complacent and didn't access guidance enough. She also said tighter regulation has highlighted more issues than before. She again repeated that the failings at FRH were caused by the provider there.

17. On 21 December 2016, a staff member at Ancona Care Home contacted the CQC and expressed concerns about the care of some service users there. The staff member described rough handling, unexplained bruising, poor support for eating, drinking and washing, and pressure sores. The staff member had raised these concerns with Mrs Montague who failed to notify the CQC or take action. The CQC later raised a safeguarding alert with the Safeguarding Authority.

18. The case for the CQC was that Mrs Montague was unfit to be registered as a Registered Manager. She lacked transparency and failed to make full disclosure about failings at FRH in her application to Ancona. In inspections into the running of FHR in 2014 and 2015 she had received ratings of inadequate with 11 failures to meet Regulations and 3 warning notices. Some of the failures in 2015 were in the same areas as failings in 2014.

19. In her interview she had failed to demonstrate an ability to carry out day to day management of the regulated activity, particularly where she felt she had not had support of the provider, and had not shown an ability to take a failure of support further to the CQC or LA Safeguarding. She had demonstrated a similar failure at Ancona. She had failed to show that she would use different strategies at Ancona to those used at FRH. She blamed the providers at FRH for incidents that she herself had responsibility for and had shown a lack of knowledge and skills in meeting standards in the Regulations. She had apparently relied on the ability of the provider at Ancona to ensure she carried out her tasks as manager. The CQC stated that she was generally unfit to perform the role of registered manager and no condition on her registration could ensure that Regulations would be met.

<u>The case for Mrs Montague</u>

20. Mrs Montague sent two documents in response to the CQC's notification of an intent to refuse her application to be registered as manager of Ancona Care Home. The first described difficulties she had encountered over the previous 18 months. She said the August 2014 inspection was carried out under new Regulations. Prior to this she had been manager at Fallowfields since 2002 and had a good compliance record.

21. She said that as a result of the August 2014 inspection, the providers at FRH had sent an 'Action Plan' to the CQC in January 2015. However a series of personal incidents had occurred at about this time. Her mother had died on 1.1.2015 which hit her hard. She was asked by the providers at FRH to cover night shift for absent staff. Many of her suggestions for improvements to the providers "fell on deaf ears." On 21 January 2015 close friend committed suicide which had a huge impact.

22. She said she realized she should have gone off sick but she continued to work to support other staff. She worked a full day shift then would have to cover an absent staff's night shift. This was affecting her health. She told the providers but no support was offered. She was deeply shocked by the death of a service user but continued at work. In June 2015 the second inspection occurred when she was away on holiday. She was asked to return by the providers.

23. Following the inspections in June 2015, the providers still did not support her and although eventually staff numbers were increased, they remained insufficient and Mrs Montague had to struggle to be compliant. She felt unwell and was not functioning correctly in November/December 2015. She applied for the manager post at Ancona Care Home, and started there on 29 February 2016. At the time of the CQC interview on 14 March 2016 she had been in post for only 2 weeks, and was still getting to know staff and residents and the administration there.

24. In respect of the three warning notices she said in relation to staff shortages she had asked the providers for more staff, but was refused. She accepted she should have reported her concerns to the LA Safeguarding Team and the CQC. She accepted she had not trained staff in use of the evacuation sled, but did so after the inspection. She accepted her use of medicines had been inadequate with unclear labeling, but said after the inspection she had implemented a new system.

25. She accepted the medication fridge was not fit for purpose at the time of the inspection, but obtained a replacement afterwards. She accepted there were gaps in the MAR sheets, but after the inspection she implemented a new auditing process involving two people. She accepted the infection control concerns, saying she had failed to identify the failings. In respect of a failure to alarm all four fire escape doors she said she had raised it with the providers, they declined to carry out the work. She said in general she was not supported by the providers.

26. In respect of the interview on 14 March 2016, she had only been in post for two weeks. She had not had time to carry out a risk assessment on the staircase. Afterwards she did put up a "No Admission" sign. At the interview she had felt under pressure and felt

some of her answers did not fully reflect her intentions. She accepted her answers did not indicate she would carry out effective risk assessments, but she now said she would do so. She said she had better support at Ancona than she had at Fallowfields.

27. She has undertaken training courses to increase her understanding of the new regulatory approach. She has started a Level 5 in management, and has booked courses in Health and Safety and Risk Assessments. She has completed a course on CQC regulation. She was manager at Fallowfields for 13 ½ years and the reports were good. She said it was never her intention not to disclose later failings at Fallowfields. She thought the CQC would already be aware of them.

28. Mrs Montague sent a letter to the CQC dated 9 October 2016. She said because of covering night shifts her health was suffering. She had tried to comply with the Warning Notices but she was "not quite there". She had done work on infection control but again was "not fully there". She had raised staff shortage with the providers at Fallowfields, but they did not agree with her. She accepted she should have contacted Safeguarding and the CQC. The staff level issue noted in the June 2015 inspection was a different issue to the 2014 issue.

29. The failure to alarm fire doors was a result of a refusal by the providers at Fallowfields. Mrs Montague had submitted a report to the CQC setting out the actions she had taken. She again pointed out she had been a manager for a number of years with good reports.

30. On 10 May 2016 the provider at Ancona Care Home sent a reference for Mrs Montague to CQC. She said Mrs Montague had attended a manager's course for CQC compliance, and had started a Level 5 manager's course. She described Mrs Montague as a good manager.

31. Mrs Montague case was that she had a good history over many years of managing FRH. In 2014 and 2015 she found it difficult to adapt to the new inspection regime. She had done her best but was "not quite there". Further she was experiencing a number of personal difficulties. She blamed the providers at FRH for the shortcomings there because of their failure to support her but accepted that she should have contacted Safeguarding and the CQC. She expected the new manager at Ancona to be more hands on to ensure the Home was managed properly.

Conclusions

32. We had regard to Section 15 of the Health and Social Care Act 2008 which inter alia says we should have regard to whether the requirements of any other relevant enactment are being or will continue to be complied with. Conditions may be imposed varied or removed. We also had regard to Regulation 7 of the HSCA 2008 (Regulated

Activities) Regulations 2014 which states that a person shall not manage the carrying out of a regulatory activity as a registered manager unless she is fit to do so.

33. A person is not fit to be a registered manager unless she is of good character, has the necessary qualifications skills and experience to manage the carrying on of a regulated activity and is able by reason of her health after reasonable adjustments are made of doing so. The burden of proving fitness is on the appellant to the civil standard. Our powers are to confirm the decision of the respondent or direct it shall not have effect.

34. We have drawn a number of conclusions from the evidence. First we have found a discernable thread, continuing up to Mrs Montague's most recent submissions, of a readiness by her to blame others for a failure to meet standards which it is in fact her own responsibility to meet. An example of this is the shortcomings at FRH which she blamed on the providers.

35. We give all the credit we can to the difficult personal circumstances she was experiencing at the time, and to her previous good record, but as a registered manager she bears a responsibility for compliance with the Regulations. These are important responsibilities as the death and injury to residents confirms. If she is frustrated in her ability to perform these responsibilities by inadequate support from providers it is for her to take action to ensure compliance by contact with regulatory and enforcement authorities. She failed to do this at FRH and despite accepting her shortcomings in this area she has failed to do this at Ancona by failing to take action or report the abuse of patients by a staff member.

36. A second concern was an apparent inability to foresee risks and take preemptive action in respect of them. An example of this is her failure to risk assess the staircase at Ancona. While she appears usually ready to take action after the risks have been pointed out to her, this is inadequate to meet her responsibilities as a Registered Manager under the regulations.

37. A third concern was her apparent inability to learn from past mistakes. For example some of the failure exposed in the June 2015 inspections were repeats of errors she was warned about in the August 2014 inspections. An example of this were the failures in infection control.

38. We also had concerns about her knowledge and skills in implementing the new regulatory approach. Although she says she is taking courses to improve her knowledge, she appears to be continuing to make errors at Ancona in failing to meet Regulations. An example of this is the failure to risk assess the staircase and the failure to take action in relation to allegations of rough handling by her staff. We had concerns

also about her failure to mention the shortcomings at Fallowfields in her application in respect of Ancona. We concluded that Mrs Montague was failing to demonstrate insight into her shortcomings or take adequate measures to remediate them. She lacked the necessary skills to do so.

39. We had regard to Regulation 7 of the 2014 Regulations, and we concluded she was not a fit person to be a registered manager. We accepted that there were no conditions which could be imposed which would ensure she would become a fit person. We upheld the decision of the CQC to refuse her application.

Tribunal Judge John Burrow
Care Standards
First-tier Tribunal (Health, Education and Social Care)

Date Issued: 9 March 2017