Care Standards

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

[2016] 2767.EA

Heard on 28 February to 2 March and 17th March 2017 at Lancaster Magistrates Court

BEFORE
JUDGE CHRISTOPHER LIMB
SPECIALIST MEMBER – JOHN HUTCHINSON
SPECIALIST MEMBER – LORNA JACOBS

IN THE MATTER OF AN APPEAL BETWEEN:

OAKENDALE RESIDENTIAL CARE HOME

Appellant

-v-

CARE QUALITY COMMISSION

Respondent

DECISION

Representation - Counsel for both parties: Mr Thomas for the Appellant and Mr Anderson for the Respondent

Hearing – written evidence in bundle and oral evidence from Mathew Haines, Alison Martin, and Vivienne Morris (CQC) and from Raja Singh and Linda Robinson (Appellant)

Introduction and Background

1 Mr and Mrs Singh are the registered service providers and proprietors of Oakendale Residential Home at 17 Rose Terrace, Ashton-on Ribble, Preston (“the home”). They have owned the business since 2006.

2 We did not hear any detailed evidence in relation to periods before 2015 and we proceeded upon the basis that there was no relevant criticism of the home at any earlier time. From October 2010 it was registered for up to 15 service users requiring personal care.

3 There were inspections by the CQC in June 2015, October 2015 and May 2016. There were breaches of regulations in the opinion of the CQC and the written reports contain the details. A notice of proposal to cancel the registration was issued on 22 January 2016 (F62) and a Notice of Decision to Cancel the Registration was issued on 27 June 2016 (F610). This appeal is against that cancellation.

4 There is a schedule of issues completed by both parties (part D of the bundle). It was confirmed that the Appellant's part of the schedule was completed after they had legal representation.

5 We were assisted by written submissions from both counsel.

6 On the first morning of the hearing the tribunal suggested and both parties agreed that it was not necessary to make findings of fact or of breach arising from the first 2 inspections but that the content of the reports from the first 2 inspections and the consequent knowledge of the Appellants of the allegations of breach (whether accepted or not and whether well-founded or not) were relevant when considering whether any breaches found proved from the third inspection did or not justify cancellation.

Legal framework

7 Section 17(1)(c) of the Health and Social Care Act 2008 ("the Act") provides that the CQC may cancel the registration of a service provider or manager on the ground that the regulated activity is being or has been carried out other than in accordance with the relevant requirements (as defined by section 17(4)). Section 20 of the Act provides for Regulations to make requirements.

8 The requirements as relevant to these proceedings are those within the Health and Social Care Act (Regulated Activities) Regulations 2014 ("the Regulations"). Regulation 8 provides that a regulated person must comply with regulations 9 to 20A. Our later references to regulations should be read in conjunction with the full wording of those regulations.

9 Section 20 of the Act provides that on an appeal to this tribunal the tribunal may confirm a decision of the CQC or direct that it shall cease to have effect.

10 We approach our findings of fact on the basis of whether we are or are not satisfied on the balance of probabilities.

Evidence - general

11 We shall refer to the evidence and our findings upon it by broadly following the order of the relevant regulations, but we make some observations of a more general nature.

12 Both by reference to the evidence of Mr Singh and also reference to various written communications in the bundle of papers, it is plain that there has been an element of lack of trust or worse between the providers and the local authority (LA) through whom all their residents were placed (and the LA had started to remove some residents before the cancellation). The LA had communications with both CQC and proprietors. We did not hear any oral evidence from the LA employees and doubt that it would have helped us greatly. We have decided the issues on the written and oral evidence of the CQC and of the proprietors.

13 We found the CQC witnesses to be honest and reliable. We also found them, and in particular Mr Haines and Ms Martin, to be rather dogmatic in approach and if relevant would accept that their demeanour was probably not particularly relaxed or friendly during their inspections and not such as to readily put interviewees (whether residents or employees) at ease.

14 Mr Singh is not a care professional in his background. He is an IT manager. Mrs Singh is a pharmacist. It does not appear that she took a very proactive role at the home, albeit having some advisory involvement in relation to medication. There was no statement from her, nor oral evidence. The home had a registered manager, Patricia Dixon, but she was on sick leave from June to September 2015 and left employment in March 2016.

15 It was in the context of the manager's absence either temporary or permanent that Mrs Linda Robinson was appointed as deputy manager and took on some of the manager's role and that Mr Singh visited more frequently and played a more active hands-on role.

16 Although Mr Singh was committed to the home, it was plain from his evidence that he often took the position that he only had to deal reactively with issues identified to him as a concern by the CQC (or the LA) rather than take a pro-active role in ensuring that the regulations were complied with.

Evidence and findings of fact

17 We shall consider the evidence and our findings in the order of the regulations alleged to be breached. The schedule broadly summarises each party's case on each allegation. The evidence both written and oral is bulky and our findings concern representative examples or central issues.

18 Regulation 9 needs assessments/hobbies/activities/person-centred care – the essence of the allegation is that the extent of personalised activity to reflect individual interests was small and the extent of any organised activity for residents in general very limited indeed.

19 The CQC referred as examples to 2 of the residents having respectively indicated an interest in gardening/plants and a commitment to the Roman Catholic Church and a wish to see the priest privately in his room. The evidence of the Appellant as to the former failed to identify what steps had been taken to cater for the interest even within the restricted physical abilities of the resident. The impression left with us was that there was a broad wish to have residents happy but a lack of any objective plan to cater for their personal interests – we were not told of any clear plan to foster or maintain the interest. Mr Singh seemed a little uncertain as to the individual identity of the Roman Catholic priest but in any event there was no detailed plan for visits by the priest and uncertainty as to the frequency of visits and encouraging private time in his room as opposed to a meeting within the communal lounge with others present. It is questionable whether such aspect amounted to a breach as opposed to less than optimal care.

20 We found the position in relation to any activity outside of the home of greater concern. The evidence from and on behalf of the Appellant did not dispute that (apart from any group outings referred to in the next paragraph) no resident was able to leave the home unless either their family took them out or a member of staff did so in their own time. We do not accept (and there was no clear suggestion to such effect) that all the residents did not want to leave the home.

21 The Appellant contended that there were outings over a 6 month period to the Coronation Street set in Manchester, to the Blackpool lights and to a church party. The oral evidence accepted that such was not correct. Although not precise, the height of the Appellant case became that such activities occurred but over a much longer period: and therefore were very infrequent.

22 We find the allegation proved in relation to activities outside of the home.

23 Regulation 11 – consent and capacity assessment and documentation. The essence of the allegation is that there was a lack of strictness in the documentation and a lack of understanding of the principles.

24 In relation to service user 8 (SU8) it was alleged that the Appellant allowed the son to sign consent to the care plan without evidence of a relevant power of attorney (POA). We accept that LA documentation referred to the son having POA but having heard the oral evidence we are satisfied that the Appellant neither saw nor asked to see the POA (and did not suggest having done so). Having heard Mr Singh we concluded that he did not understand and/or had never previously considered the distinction between a finance POA and a welfare POA. In the context of his having in practice become the manager after Mrs Dixon's resignation, we find that very disturbing and showing a lack of understanding of an important aspect of care.

25 In relation to SU9 there was no evidence of written consent to a care plan and no evidence to explain it other than a suggested possibility that it may have been removed by Mrs Dixon or someone else (with no explanation being suggested as to why). Of equal concern is that it appears that there was no knowledge of it being absent (assuming it may have existed at some time) and therefore no system in place to monitor such matters.

26 Deprivation of Liberty forms (DOLs) were found by the CQC. We do not consider it matters for this purpose how or where they found them (a matter of some dispute) and we accept that no DOLs had been submitted to the LA. It is agreed that none of the residents required/justified care involving DOL. Despite hearing evidence, we remained unaware of why they were completed. They are by their very nature not documents to be used for people with capacity. It is another aspect of the case which in our opinion shows a worrying lack of understanding of an important aspect of care.

27 We find the allegation proved.

28 Regulation 12 - safe management of medicines. The central allegations are that audits were not carried out sufficiently frequently, records of administration were not contemporaneous, Parkinsons medication for one SU was given late, and that there was no clear plan for covert administration of medication for one SU for whom such was directed.

29 We accept the Appellant explanation in relation to Parkinsons medication that it was timing in relation to waking up and getting up that was relevant and not a precise hour of the day. We were not convinced on the evidence available whether that was or was not done, nor whether there was or was not non-contemporaneous

signing and in particular a delay in circumstances in which there was a danger of another carer being misled as to the following administration, nor as to whether audits were continued in 2016; the evidence on both sides was in our opinion too imprecise.

30 In relation to covert administration we accept that a clear plan was required in order to ensure compliance. We heard oral evidence that it was given covertly but without there being any “system”, rather relying upon the good sense of the carers. Mr Singh suggested there was a written plan but failed to produce such. We find this aspect of the allegation proved.

31 Regulation 13 – inadequate safeguarding procedures.

32 We take the view that a major but not the only aspect of such matters is whether they result in a poor level of care or lack of safety. We do not condone shortcomings in procedure in such context, but in so far as any failings result in poor care or actual or potential lack of safety they will be reflected in the other aspects of the case.

33 Regulation 17 – lack of good governance/appraisals and supervision.

34 As in relation to regulation 13, we take the view that a major but not the only aspect of such matters is whether they result in a poor level of care. We make no express findings. In so far as any failings actually resulted in poor care they will be reflected in the other aspects of the case.

35 Regulation 18(1) – insufficient staff numbers. There are several and important aspects of this allegation : only 2 staff being on duty at various times whereas at least 4 SUs required 2 carers for mobilisation and/or pressure care with the consequence that no carer was available at such times of 2-handed care if another resident required assistance; on some occasions one carer undertaking tasks requiring 2 carers; and Mr Singh undertaking the role of sleep-in carer on 5/6 May 2016 albeit he has no or no recent training in moving/handling. We do not further consider the allegation as to absence of a call bell which we consider peripheral in the overall context.

36 It is not disputed in the Schedule that 4 SUs had been assessed and were being funded on the basis of requiring 2-handed care for mobility or pressure relief care. In oral evidence (both Mr Singh and Mrs Robinson) it was suggested that only one SU required 2-handed care and possibly that even that SU only required it for a limited period of time. It was suggested that a single carer could and did give care to the other 3 SUs. That is not the case within the schedule and there was no formal assessment to support that

suggestion and we do not accept it. We note that in the Healthwatch report (page 874) there is a suggestion that 3 members of staff were on duty at all times: but that was not the evidence before us. We accept that following earlier CQC reports an additional member of staff was employed from 8am to noon and from 4pm to 8pm on weekdays, but whilst accepting that those might well be especially busy times we received no explanation as to why such cover was required only on weekdays or what happened if 2-handed care was needed at other times (for example mobilising to use the toilet). Mr Singh not only indicated in oral evidence that he was a waking carer on 5/6 May but apparently failed to appreciate that he was not an appropriate person to be involved in handling a resident : he had no relevant training and his only suggestion was of a course he had undertaken 6 years before. In so far as he was presented with an emergency that evening due to staff illness he displayed no insight into the shortcoming of his playing such a role. He similarly showed no insight or understanding of the issue of why 3 carers were not needed at all times if 2 carers might be involved with a single resident and another resident required some assistance.

37 We find the allegation proved.

38 Regulation 18(2) – inadequate staff training.

39 One aspect of the allegation related to there being no adequate training in relation to mental capacity. We accept that staff had attended training, and we did not understand that to be disputed. The allegation of inadequate understanding was largely based upon interviews of the staff : we are not satisfied that questioning in the context of unannounced inspection during an otherwise normal working day is an appropriate or reliable form of testing knowledge of staff.

40 The allegation of inadequate supervision and appraisal of staff was accepted to the extent that appraisals had been completed for only half the staff. There was lack of insight by Mr Singh as to why that was not adequate. Whether there was one or whether (the Appellant's evidence) there were two members of staff with first aid training, it was accepted that there were times without any first aid qualified member of staff on duty. There was lack of insight as to such being important. This was also one of the areas in which it appeared that Mr Singh only considered that action was necessary after the CQC had identified a need rather than there being a need to consider a requirement for training of his own volition. We find these allegations proved.

41 Regulation 19 – inadequate recruitment procedures, with particular reference to whether employees had current DBS checks prior to

commencing employment, had appropriate references from earlier employers, or had identity checks.

42 Lack of any relevant criminal record is self-evidently important in the context of potentially vulnerable elderly people. References and proof of identity are also important. Such was not disputed. It was (correctly on the evidence) not disputed that at the time of the May 2016 inspection there were (in the words of the written closing submissions) “clearly gaps in the personnel records even when one takes account any records that Ms Pat Dixon took with her at the conclusion of her employment in addition to her own file”. The Appellant argued that in the context of previous lack of criticism in earlier inspections, there can be little concern that fit and proper persons were not employed.

43 Eight staff at the time of inspection in May 2016 had upon the documents started work before DBS checks and there was no documentation to confirm DBS checks at all for 3 members of staff. There were no references or ID checks in the papers for 9 members of staff. Even if it is accepted that there were DBS checks, references and ID checks in the past (of which we are sceptical but do not entirely reject as impossible), it inevitably follows from undisputed evidence that at the time of the inspection the proprietors were entirely unaware that such were missing or alternatively failed to consider that such was important. In our opinion such matters are of very great importance to the safety and wellbeing of vulnerable elderly people and a lackadaisical approach is totally unacceptable. It shows lack of insight at best but also a negligent approach to the crucial issue of residents’ safety both physical and more generally.

44 We find the allegation proved.

Proportionality

45 We now consider whether the allegations we have found proven do or do not justify cancellation of the registration.

46 Both counsel accepted that some allegations are inherently more serious than others. Implicitly rather than explicitly the allegations under regulations 18 and 19 were put forward as the most serious. We agree that those matters are those that pose the greatest dangers to the safety and wellbeing of the residents. Objectively robust systems are essential to the recruitment of appropriate staff, to their appropriate training and continued appraisal and to adequate numbers being employed to give proper and safe care. We find those breaches particularly serious.

47 We also consider that the multiplicity of examples of breaches is important. The breaches are not isolated either in number or nature.

48 The breaches of other regulations are of importance in their own right but also because they demonstrate that the shortcomings are numerous and widespread in many areas of the home's functioning.

49 We consider that the 2 inspections and reports in 2015 are of importance in highlighting not only specific alleged failures but more generally making it obvious that there was a need to appraise the home's method of operating and management. In lay terms the proprietors were clearly "on notice " and should have realised that it was necessary to review their methods and operation. It was probably never acceptable to await warnings or allegations from the CQC before reviewing practices and procedures but it was certainly not reasonable or responsible to do so after the 2015 reports. Although there were areas of improvement, the breaches found by us are serious and numerous and most relate to regulations alleged to be breached in the earlier reports. We do not consider that there is any basis upon which we can foresee that the breaches we have found proved in May 2016 will be resolved in the future.

50 Mr Singh on several occasions seemed to believe that it was sufficient if he responded rather acted of his own volition but also that it was sufficient if he took some positive steps even if not adequate ones. In the context, it is not sufficient to make improvements if they are not adequate improvements and many areas of breach of regulations remain.

51 In various respects (of which we have given examples) Mr Singh showed lack of insight even when a shortcoming was brought to his attention.

52 It was said by Mr Singh sometimes explicitly and sometimes implicitly that it was not financially viable to do everything asked, especially in relation to staff numbers. We suspect that there may well be financial difficulties in running a home with only a small number of residents but residents with notable needs, for example need for 2-handed care for some activities. However, we do not consider that such problems, even if far more clearly spelt out and calculated than in this case, can justify running a home in breach of regulations.

Conclusion

53 In all the circumstances we consider that it is proportionate and appropriate to confirm the cancellation of registration in this case.

Decision

54 We confirm the decision of the CQC to cancel the registration of the Oakendale Residential Care Home.

Tribunal Judge Christopher Limb
Care Standards
First-tier Tribunal (Health Education and Social Care)

Date Issued: 2 May 2017