First-tier Tribunal Care Standards

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

2024-01088.EA

[2024] UKFTT 001123 (HESC)

Hearing held

on 10th-11th December 2024

Before
Tribunal Judge Judith Crisp
Specialist Member Matthew Turner
Specialist Member Roger Graham

Between:

Santos Care Ltd

Appellant

v

Care Quality Commission

Respondent

DECISION

The Application

1. The application before the Tribunal relates to an appeal against the Notice of Decision ("NoD") issued on the 26th of February 2024. The appeal was dated 26th March 2024. Such "NoD" was to cancel the Appellant's registration as a registered provider in respect of the regulated activity, namely 'personal care'.

Attendance

2. The hearing was attended by Ms Chei who is the Nominated Individual for the Appellant and Mr. Khan who is the Registered Manager and Mr. Connor and Mr. Okunpolar on behalf of the Respondent.

Late Evidence

3. The Respondent issued an application dated the 9th of December 2024 to adduce late evidence relating to a service user allegedly of the

Appellant. The information had been provided to the Respondent on the 3rd of December. The Appellant opposes the late evidence being filed and submits that the exhibits provided in support are a breach of GDPR.

4. It is accepted that a previous application to adduce late evidence had been made by the Appellant on the 5th of December which was not opposed and granted.

5. The Appellant confirmed that it was a different company which was registered to provide regulated services. The bank details on the documents provided did not match the only bank account which was operated by Santos Care Limited. The service user was not one for whom Santos Care Limited were responsible.

6. The application was not granted by the Tribunal on the basis that we accepted that the company was not Santos Care Limited from the scant evidence provided.

7. The Tribunal however due to the concerns raised in the evidence did require the CQC to investigate the position outside of this hearing.

Background

8. The Appellant was registered on 22nd November 2021 to provide the regulated activity, namely ‘personal care’.

9. An initial inspection was conducted on the 7th of March 2023. The assessment received an overall rating of requires improvement. Specifically, breaches were said to have been found
    a) Regulation 9 – Person centred care
    b) Regulation 11- Need for consent
    c) Regulation 12- Safe care and treatment
    d) Regulation 17- Good governance
    e) Regulation 18- Staffing

10. A warning notice was issued to the Appellant in respect of breaches 12 and 17.

11. A further inspection was carried out on the 10th of October 2023. During that inspection breaches were identified in relation to
    a) Regulation 9
    b) Regulation 11
    c) Regulation 12
    d) Regulation 17

12. As a result of the second assessment in October 2023 a Notice of Proposal to cancel the registration was sent to the Appellant dated the 21st of November 2023. The Notice of Proposal set out the alleged breaches under
    a) Regulation 11

b) Regulation 12
c) Regulation 17.

13. Written representations were received by the Respondent on the 19th of December 2023 and a "NoD" was issued following receipt of those representations on the 26th of February 2024.

14. An urgent assessment took place from the 9-29th April 2024 after receipt of concerns raised by HLTH Group a specialist company who had been hired by the Appellant to advise in relation to the "NoD". HLTH Group advised the Respondent by email dated 3rd April 2024 that they did not believe the required changes could be implemented in the timescales necessary. At this assessment breaches were said to have been found under
    a) Regulation 9
    b) Regulation 11
    c) Regulation 12
    d) Regulation 17

15. During the course of these proceedings the Respondent undertook a final assessment in October 2024. The assessment in October 2024 confirmed observations of continued breaches of
    a) Regulation 11
    b) Regulation 12
    c) Regulation 17

These are disputed by the Appellant

Legal Framework

16. **The Health and Social Care Act 2008**

3 The Commission's objectives

(1) The main objectives of the Commission in performing its function is to protect the health, safety and welfare of the people who use health and social care services

4 Matters to which the Commission must have regard

(d) the need to promote the rights of people who use health and social care services (including, in particular, the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005(s9), and of other vulnerable adults)

(e) the need to ensure that action by the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only to where it is needed.

32 Appeals to the Tribunal

(2) On appeal against a decision of the Commission the first Tier Tribunal may confirm the decision or direct that it is not to take effect

Issues

17. The issue before the Tribunal is whether the allegations of the breaches of the regulations are proved to the requisite standard, and if so whether the decision was reasonable and proportionate in the circumstances.

18. The burden of satisfying any disputed past facts lies on the Respondent and that is the civil standard namely the balance of probabilities.

19. The Tribunal must determine the matter anew. This can include new evidence that was not available or presented at such time that the "NoD "was made.

20. The Appellant had accepted on the Scott Schedule within the bundle all of the allegations and it was agreed therefore that this case would proceed on the basis of the assessment conducted in October 2024 and whether the stated improvements could be maintained.

21. The evidence therefore for consideration related to the October assessment only and whether the breaches were found and, if so, whether the decision taken by the Respondent was proportionate.

Evidence

22. Carol Hill was the CQC inspector who undertook the inspection in October. Her written evidence was supplemented by oral evidence before the Tribunal. She accepted that some improvements had been made, in particular in respect of staffing with recruitment checks in place, support calls to service users were largely on time and there was a review of accident learning and actions taken. In addition, there was a capacity assessment for service user F.

23. There were however repeated breaches of regulation 11, 12 and 17.

24. Regulation 11- need for consent. Ms Hill set out that in relation to service user D's care plan it stated that there was capacity to consent but that the service user's mother would act on their behalf. Further information in the care plan identified from North Northamptonshire Council said that

    " xx can miss a great deal of contextual information and as such will find it difficult to process information , understand what is to happen and why, impacting his ability to make decisions or understand their impact."

    In addition, the staff member who supported service user D said they did not have capacity to make all decisions and as such some decisions were made on their behalf.

25. Regulation 12- safe care and treatment. This again related to service user D. In relation to emergency medication buccal midazolam there was conflicting information on the care plan as to when this should be administered. On page 21 it stated, " First dose of 10mg can be administered immediately symptoms commence". However further in the care plan " Buccal midazolam – if seizure lasts longer than 5 minutes, or no recovery between seizures".

26. When she asked the Registered Manager Enath Khan what the prescriber's instructions were he replied, "It should be administered as soon as possible". She then asked the staff member who replied that they would administer it after a seizure had lasted for more than 5 minutes.

27. In Service User H's care plan, it stated that two carers should be present during transfer and use of the Molift hoist for safe transfers due to her weak muscles. This conflicted with service user H's statement- " I can mobilise myself with my walking stick, but I need carers to watch me carefully" The care plan also advised that the support was provided by one carer and not two.

28. The relatives of service user H advised that she was strip washed in the morning by standing holding on to a mantelpiece. This was accepted by the staff member although it was suggested it was a table.

29. All of this information was contradictory. The risk assessment had other advice which conflicted with the care plan.

30. Service User I had had recent falls in August and September, and this was not reflected in their care plan. The care plan had not been changed by way of an interim care plan setting out the interim arrangements whilst the service user was assessed by all professionals.

31. Regulation 17 – Good governance. The audits which had been carried out did not reflect the correct situation. Service user I had been recently audited with the Appellant confirming that their care plan had been reviewed regularly and was in date when neither of the recent falls were identified in the care plan.

32. The medicines audit had not picked up that PRN protocols were not in place for newly prescribed creams for one service user. When asked the Registered Manager said the protocols should be the same but that he would check.

33. Ms Hill accepted that there had been improvements, but the non-compliance was worrying. She accepted that after the inspection she was provided with an MCA assessment of service user D which stated he did not have capacity to make decisions on personal care and finance. She said it was the contradictory information that was being witnessed and that if there was a new member of staff how would they

know? All service users needed an accurate care plan. It was a significant concern regarding the information of administering the buccal midazolam because in one place in the care plan it said immediate and in another after 5 minutes.

34. It was the continuing breaches which caused her at the Management Review Meeting (MRM) to confirm her position that no other options were available other than cancellation due to the high risks which had continued since March 2023.

35. Helen Nichols is the CQC Operations Manager who approved the CQC to carry out a further up-to-date assessment of the Appellant to see if improvements had been made. She had provided a written statement and gave oral evidence. She was one of the parties to the MRM in November 2024. She advised that the decision was made following a decision-making tree. She accepted there had been some improvements but she stated that even with service numbers decreasing such as they were only 5 and 4 by the time of the appeal, it was poor governance not to be able to sustain improvements and the fact that there were repeated breaches was a significant risk to service users, in her view.

36. She had made the recommendation in October 2023, but the final decision was with the deputy director. She stated that at the initial assessment in March as there was no previous history the risk rating would not have been so high. For each breach they place a risk rating, and it was that which had increased over time which was concerning.

37. When asked under cross examination about the risk to a service user over the administration of buccal midazolam she said the risk if given immediately was significant. She said when considering the care plan of service user D that on the 11th and 13th pages it records to administer if a seizure is over 5 minutes which is in line with NICE guidelines but on page 21 in red and highlighted in yellow ' First dose of 10mg can be administered immediately symptoms commence. The symptoms are expected to last within 30 seconds to 2 minutes' The latter was not in line with NICE guidance.

38. Her concern was the risk of significant harm which she advised that even with the improvements was still present. On the decision-making tree the risks even with mitigation still presented as high.

39. Both she and Andy Brand who is the deputy director said they had considered urgent enforcement action but due to the fact that most service users had family living with them and this therefore mitigated any potential risks they did not proceed. They also took legal advice and were advised that it did not meet the threshold test for urgent action.

40. Ms. Nichols had however issued a notice of proposal to cancel registration as a manager to Mr. Khan dated 3rd July 2024. This has been repeated in a further letter dated 25th September 2024 following representations received from him on the 14th of August.

41. Andy Brand is the CQC deputy director. He too had provided a written statement and gave oral evidence. He gave evidence about the structure of the decision making within the MRM and the guidance which they have to follow. He advised that any enforcement action has to consider various stages.
    a) An initial assessment
    b) Legal and evidential review
    c) Selection of the appropriate enforcement action
    d) Final review.

42. In conducting the MRM the breaches are considered and the seriousness of the breaches are validated. It was assessed as to whether the breach was serious and the likelihood of it occurring again, and those two factors led to the risk factor.

43. In the earlier assessment in October 2023 the risk was deemed to be a moderate assessment overall, but the likelihood of repeat was probable and that meant the overall assessment of risk was high. The second part of the assessment had been evaluated on the basis that warning notices had been issued in March and some 6 months later the same breaches were found.

44. He said cancellation was a last resort and they had considered suspension and conditions before deciding that neither would meet the risks identified. In the recent assessment the risk remained high. Again the potential impact was assessed as moderate and that arose from uncertainty around care plans, discrepancies and the audits. The likelihood was probable and that placed the risk as high.

45. He stated the Appellant's own governance did not pick up the risks and it took the CQC to point out those risks. It was his belief that it was likely harm could have occurred. There were still several concerns over the breaches and that had been a concern since March 2023.

46. Mr. Khan who is the Registered Manager of the Appellant company had provided a witness statement and gave oral evidence. His evidence was that the CQC advised him at the feedback meeting on the 20th of November that they accepted that there were positive aspects of the service and that he had recorded Carol Hill, with her consent, so that the Tribunal had a complete picture.

47. He said that vast improvements had been made with which Carol Hill had agreed, feedback from the users, staff and relatives was very positive. There were no problems regarding staff recruitment or call

times. There were capacity assessments in place and more information in the care plans.

48. He had attached signed client feedback forms which were positive.

49. He said with regard to SUD that an MCA assessment had been completed which set out that he had capacity. He was asked about this under cross examination as there were two MCA assessments dated 29th May 2024 which stated that SUD did not have capacity. He said that a further MCA assessment had been undertaken in August. That was not provided and had not been submitted either to the Tribunal or the CQC.

50. He confirmed that one member of staff undertook the assessments and that he had been on specialised training for over a week. He thought that was in July or June. He said previous to the inspections in April 2024 they had undertaken MCA assessments on all service users as they thought that was a requirement. He now accepted that it was only a requirement for service users who appear to not have capacity.

51. He accepted that Service User D had conflicting information in the care plan. His evidence was that people caring for him knew that buccal midazolam should be administered after 5 minutes. He did not think it placed the service user at risk. He was asked about what would happen if there was a new staff member and advised they would have a period of training and shadowing. He did not believe Service User D had been placed or would be at risk. He accepted it was an oversight on the care plan and it had not been picked up on audit or rectified.

52. He accepted on Service User H that there was a discrepancy on the care plan and risk assessment but said Ms Chei was responsible for that service user.

53. He also accepted that Service User I's care plan had not been updated to reflect the recent falls. He said the service should not be penalised for the fact that it took Occupational Health, the Local Authority social workers and the District Nurses over two months to come up with a formulated plan. He said there was a significant amount of information and accepted they had received temporary advice to care for Service User I in bed. They had instructed the carers on interim plans, and he did not believe it was necessary to write an interim plan whilst they were awaiting the final plan from the multi-disciplinary team. He stated that they were not in breach of regulation 17 as a care plan cannot be changed until there is a clear plan in place going forward.

54. He maintained that whilst yesterday he had said that in respect of Service User F that the PRNs were not in place that what he said previously may not have been correct.

55. He accepted under cross examination that the care plans could be reviewed more regularly but they had all been updated after the assessment and could be done more frequently. He said they had new systems in place, they were changing, but it was still a work in practice.

56. Ms Chei had not provided a witness statement but had assisted with the preparation of a document provided to the Tribunal dealing with the concerns identified by the CQC and how those would be rectified.

57. She accepted that there was a discrepancy on Service User H between the care plan and risk assessment. She said that she amended the care plan after it was pointed out but could not recall when. The one in the bundle dated the 11th of September was not the final care plan. It was an oversight on her part and had not been picked up on audits which she said were double checked.

58. She accepted on Service User I that the care plan had not been changed and said they would only amend the care plan annually. Going forward however they intended to check 4 monthly.

59. The staff had access to both the risk assessment and the care plan which she accepted differed. When asked which one the staff should follow, she said the care plan. She accepted that she was not aware of how the staff were implementing the care plan and said that they did spot checks and checked the written notes daily.

The Tribunal's conclusions with reasons

60. It is an accepted fact that over the course of 4 assessments ranging from March 2023 until April 2024 there were repeated breaches of regulations. The issues we need to determine are those which were found in the October assessment.

61. Overall the Tribunal found the evidence of the CQC was consistent, coherent with their written evidence and in particular convincing at times when considering the decision making, the point made about the fact that the Appellant needed them to point out their breaches and had not evidenced any learning from previous breaches was compelling.

62. The evidence of the Appellant was incoherent, evasive and vague. Both witnesses at times had no answers to questions or would respond with "I cannot remember" or "I do not know exactly how may staff there were". In addition no up to date documents were submitted to the Tribunal to support their assertions despite the Tribunal admitting late evidence as late as Friday before the hearing commenced on their application. In particular no evidence was provided at all from the new consultants they had instructed.

63. The Appellant submits that the breaches now are feeble and those that are present are not such as to cause cancellation. It is a disproportionate sanction to apply.

Consent Regulation 11

64. The two Mental Capacity Act (MCA) assessments of Service User D were dated 29th May 2024. The care plan is dated 28th July 2024. The latter says he does have capacity, the former which predates the care plan says he does not. The member of staff said the Service User did not have capacity. A later assessment which we have not seen as the Appellant has not produced it which was allegedly undertaken in August apparently said that Service User D had capacity. If this is correct the carer who was spoken to by the inspector in October was of the view that the Service User did not have capacity. This raises concerns over training and which care plans the carers are following as clearly this carer was not following the care plan. Equally if the MCA assessment had been undertaken in August as Mr. Khan stated the carer had not been advised of it. Any new member of staff on reading the care plan would read that service user D had capacity and this would place the Service User at significant risk of harm if the carer were to make a decision which they should not be making or vice versa.

65. We find also that Mr. Khan despite having been told that all Service Users do not need an MCA assessment, still shows a lack of understanding as he confirmed in evidence that an MCA assessment had been completed showing that Service User D had capacity.

66. We find that the only MCA assessment which were in place were those stating that Service User D did not have capacity. This fits with the staff members comments. No subsequent assessment, if it has been carried out, has been provided and no explanation was forthcoming from Mr. Khan or Miss Chei as to why that document had not been produced in evidence. We bear in mind also that this was a two-day hearing and either of the witnesses could have obtained any further information overnight.

67. The care plan therefore does not accurately reflect that Service User D does not have capacity.

68. This discrepancy has not been picked up on review of the care plan, or on audit and clearly shows as has been the position throughout the inspections that the Appellant does not understand the requirements of consent.

69. The document which the Appellant produced , in response to the various breaches the CQC had found and the subject of the Scott Schedule, which we will refer to as a “ protocol ” on page A49 in response to the concern that there was a lack of understanding which led to conflicting care plan documents and mental capacity

assessments where it was not clear who had mental capacity and who required assistance set out the following

> ' We acknowledge the concern. This has been rectified. The Registered Manager understands his responsibilities and has facilitated further training on MCA.'

70. The above protocol either has not been followed or the Registered Manager does not understand his responsibilities.

71. The above is a breach and this has been a repeated breach since March 2023.

Safe Care and Governance Regulations 12 and 17

72. The breach in relation to the medicines audit was initially accepted by Mr, Khan and we were advised that this was a mistake. He later retracted that statement and said he could not confirm if the documents namely the PRN protocol were present, they may have been.

73. On the protocol page A53 the Appellant has responded to the earlier allegation of safe care and treatment regarding medication

> ' We recognize the previous shortcomings and have taken significant steps to address – the staff meticulously record medication administration; we carry out medication audits daily and live call monitoring is done every day'
>
> On page A 54 in response to 'there was a lack of oversight and record keeping of any changes in medication to service users'.
>
> 'We acknowledge the concerns raised by the CQC, however this has now been rectify(sic) and all staff are trained.'
>
> If their protocol was followed Mr. Khan would have known what documentation was in place. If the stated PRN protocol was in place, we find that either it would have been referred to in his written statement or it would have been provided to the CQC or to the Tribunal, none of these things occurred. This was an allegation that the CQC set out in their evidence and one which could easily have been rebutted. There is no compelling evidence that the PRN protocol was in place.

74. It follows therefore that if the PRN protocol was not in place the only one that was in place was for the administration of Drapolene and not Epimax or E45 which were given to Service User F. If the medication audit was undertaken daily this should have been picked up. It was not. This casts doubt on the Appellant's evidence that medication audits were undertaken daily. This is especially so when the evidence of the Appellant was that there were only two service users on medication.

75. The discrepancies on the care plan of Service User D in relation to the administration of buccal midazolam are shown with contrary advice as to when it should be administered on three separate pages. This is a significant risk of harm to the service user. The evidence of Mr. Khan

was concerning as he stated that he had not been placed at risk and he hadn't suffered any harm. There is no contemplation of future risk. We accept the evidence of Helen Nichols in that the risk if this medicine is given immediately rather than as per the NICE guidelines is significant.

76. The fact that the care plan highlights in yellow the first dose can be administered immediately is a serious risk as any new carer would be drawn to that advice. The care plan again has not been audited effectively or reviewed and has serious discrepancies. Neither Ms Chei nor Mr. Khan have picked up the conflicting advice set out in this care plan.

77. We accept with Service User I that the Appellant was awaiting a multi - agency meeting before amending the care plan due to two recent falls however we believe that an interim plan should have been in place as such a meeting may have taken 6 weeks or so to arrange. In fact as the evidence showed it took over two months. Not to update the care plan for this period of time places the service user at risk of harm. It is not known as to how often the specialist advice was chased but after 2 weeks, we would expect to see an interim plan in place pending further advice.

78. Further the two recent falls were not documented in the care plan. On the protocol document at page A74 it states that a new falls risk assessment is now in place. We have not seen the new falls risk assessment but again this protocol has not been followed.

79. Service User H has contradictory information. The risk assessment advised that to reduce the risks of falls two carers should always be present. The care plan differs. The evidence of Ms Chei was that the hoists identified in the risk assessment but not the care plan had been removed from site. When asked which document the staff should follow, she advised it would be the care plan. Her evidence when asked as to what would happen if the staff looked for a hoist elsewhere as was set out in the risk assessment was unsatisfactory.

80. Again clearly the care plan had not been effectively audited and there are potential risks if the care plan does not follow the risk assessment. What is concerning about this service user is that neither policy was being followed. The evidence which was unchallenged was that the service user was being washed in an unsafe manner as pointed out by her relatives. This had not been identified by Ms. Chei.

81. All of the above breaches are found at the requisite standard that must be applied and therefore breach of regulations 11, 12 and regulation 17 is met.

82. It is concerning that despite the reduction in service users and the location covered being reduced in size, there are only 4 service users now, 5 at the time of the assessment, that this level of breaches

continue to occur. If such a small size of service users cannot be managed effectively this is a significant concern. The four inspections carried out from March 2023 until October 2024 have all found the same breaches with the exception of Regulations 9 and 18. We accept that there have been some improvements but significant issues and concerns still remain and it is further concerning that there appears to be little evidence of learning by either Ms. Chei or Mr. Khan or in the case of Mr. Khan an acceptance of the seriousness of the situation regarding his own status as registered manager.

83. The evidence both about their previous employment and qualifications was evasive. In addition despite being asked how many hours they worked for the Appellant and in what capacity, we were left with no clearer picture as to their responsibilities either jointly or individually. If 30 plus hours, which was their evidence, were being expended each week by both and with the benefit of a Management Company in addition, one would have expected significantly better record keeping and governance.

84. We are unclear that either the Nominated Individual or the Registered Manager has the experience and/or qualifications necessary to fulfil these roles.

85. We have considered the decision-making tree and the guidance provided by the CQC. We accept the Respondent’s assessment of the breaches as moderate – this is a risk where there could be a temporary disability of more than one week but less than one month; reversible adverse health condition; significant infringement of any person’s rights of more then one week but less than one month or a moderate reduction in the quality of life. It is clear from the findings which we have made that this would be assessed as moderate.

86. We also find the likelihood assessment as probable given the facts lending rise to the breach will likely happen again. We base this on the fact that there have been the same repeated breaches in regulations since March 2023 a period of some 18 months or so. These two factors combine therefore to produce an overall risk assessment as High following the guidance of the CQC.

87. We must now consider whether there is any lesser sanction which we could impose. If the seriousness of the breach is high, we can consider cancellation, suspension or imposition of conditions. As with the MRM we considered the same in reverse order.

88. It is unlikely that any imposition of conditions would meet the serious concerns as the Appellant could not be monitored daily due to the resources that would be required and the daily audits are not robust. As Andy Branch the deputy director said – it takes us to point out what the mistakes are before they are rectified. In addition the Appellant has throughout the process provided scant or no documents when required

to do so. This is an unacceptable risk and cannot be managed by the imposition of conditions. We also believe that the record keeping is such that it would not be kept up to date and therefore reliable. There are no conditions that we can think of that would meet the risks identified.

89. A suspension would be in order for a service to reflect and put in place adequate protocols and measures such that the breaches would not occur again. The single fact that the Appellant has been in breach of several regulations since March 2023 leads us to the fact that this would not be an appropriate sanction. It is concerning that as late as October 2024 some 6 weeks before the hearing that the Appellant still had not been able to rectify the previous breaches and even in evidence there was no reflection about what they could do to ameliorate those breaches. Further there was no evidence from the most recently engaged consultant as to planning or rectification.

90. The only sanction which will not place the service users at a significant risk of harm is cancellation.

Decision:

91. The appeal is dismissed.

Tribunal Judge Crisp

First-tier Tribunal (Health, Education and Social Care)

Date Issued: 16 December 2024