Santos Care Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Santos Care Limited is a small domiciliary care provider. At the time of our inspection there were 15 people using the service.

People's experience of the service and what we found:
Care plans and risk assessments lacked detail, peoples wishes and preferences were not always recorded to ensure care was provided in a way they chose or wished. Some risk assessments were generic and not person centred. Risk assessments did not always contain information on how risks were managed or mitigated.

Health management plans were generic and contained details which could mislead staff in relation to what support fell within or outside of their competencies.

Care plans held conflicting information as to the care that was to be provided. What was written in the care plan did not always reflect the actual care taking place.

The provider had ineffective systems and processes in place to ensure full and effective oversight of the service and the quality of care provided.

People and relatives were not confident that staff were trained and competent in completing tasks as part of their or their relatives' care.

Best interest meeting records did not capture full details of the decision to be made or why it was needed, also records did not always demonstrate all the relevant options had been explored.

Where people took medication, it was not clear who was responsible for the management and administration of medication.

People consistently received late calls.

Rating at last inspection and update
The last rating for this service was Requires Improvement (Published 26 April 2023).
The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At our last inspection we recommended improvements to be made in regulation 9 (Person centred care, regulation 11 (Consent), regulation 12 (Safe care and treatment), regulation 17 (good governance), regulation 18 (Staffing). A warning notice was issued for the breach of regulation 12 (Safe care and treatment and regulation 17 (good governance). At this inspection we found the service remained in breach of

regulations.

Why we inspected
When we last inspected Santos Care Limited on 7 March 2023 breaches of legal requirements were found. This inspection was undertaken to check whether they were now meeting the legal requirements.

You can see what action we have asked the provider to take at the end of this full report. Please see the Safe, Effective, Responsive and Well led sections of this full report. For those key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Santos Care Limited on our website at www.cqc.org.uk.

Enforcement [and Recommendations]
We have identified continued breaches in relation to Regulation 9 (Person centred care), Regulation 11 (Consent), Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not always effective.

Details are in our effective findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

Santos Care Limited

Detailed findings

Background to this inspection

The inspection
We carried out this performance review and assessment under Section 46 of the Health and Social Care Act 2008 (the Act). We checked whether the provider was meeting the legal requirements of the regulations associated with the Act and looked at the quality of the service to provide a rating. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 3 inspectors and 1 expert by experience who made calls to people and relatives remotely. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was announced. We gave the service 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 7 relatives. We also spoke with 4 care staff, 2 office staff and the registered manager who is also the nominated individual. A nominated individual is a person who supervises the management of a regulated activity across an organisation. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We contacted 2 integrated care boards (ICB'S) to gain feedback on the service. We reviewed 4 care plans and a selection of call records, daily notes, medicine records, risk assessments, audits and policies and procedures. We also used technology such as electronic file sharing to enable us to review documentation sent to us by the provider following the site visit.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to establish effective systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service and medicines were not administered safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management
The provider did not assess risks to ensure people were safe.
●Care plans and risk assessments lacked the detail required to ensure people received safe care. For example, information to guide staff in how to keep a person safe who may at times require emergency support for a long-term condition was not recorded in a care plan or risk assessment. Staff were not able to assure us that they knew how to keep this person safe in the event of an emergency.
●Staff did not have access to the information they needed to mitigate people's individual risks. For example, a risk assessment in place for a person who required continence equipment recorded generic information relating to the use of this equipment that fell outside of the competencies of the staff working at the service. This meant there was a risk that staff would complete tasks they were not qualified to complete.

Systems and processes to safeguard people from the risk of abuse and avoidable harm
People were not safeguarded from abuse and avoidable harm.
●Not all systems were embedded in the service to protect people from the risk of abuse and avoidable harm. Daily note records staff completed were not checked to identify potential abuse or safety concerns. This meant there were missed opportunities to identify and report safeguarding concerns. Systems were found to be in place to monitor staff attendance to care calls and accessing the log system to register the visit. Following our inspection, we made a safeguarding referral to the local authority that the staff and provider had not identified as a potential safeguarding incident.
●Staff were not able to identify potential signs of abuse. Whilst staff had received safeguarding training, they could not describe how potential abuse could present. This meant people could be at risk of potential abuse.
●People received inconsistent care calls that were regularly late. This had potential to cause harm to people who received medication administration as part of their care call, and possible side effects as the result of not having medication at their prescribed times. No system was in place where the provider was monitoring or taking action to improve late calls. The provider had not contacted the organisations who commissioned peoples care to inform them they could not meet the commissioned call times.

Using medicines safely

Clear assessments of who was responsible for the medicines management of people was not clear, this meaning people did not receive their medication in a safe way.
●Care plans and medication records did not always contain accurate information about the medicines people were prescribed. This placed people at risk of receiving inconsistent and unsafe medicines administration.
●Lack of clear assessments for people and who is responsible for the management of medicines and administration of medicines meant it was not clear who should have as required medication (PRN). We found people received PRN medication for agitation, however, no guidance on if it was the staffs responsibility, including the reasons as to why the medication was needed were not found.
●Risk assessments in place did not show clearly how decisions had been reached to ensure medication was safely administered. For example, a person who was visually impaired had medication left out for them to take independently in the absence of care staff. Risk assessments did not show the risks associated with this had been identified and planned for.
●There was a lack of provider understanding around what should be included under medicines administration. Some people's care plans stated they had no medication support needs, however, daily records showed staff were applying prescription creams. This meant the application of these creams were not included in any of the provider's medicines oversight systems, therefore concerns around these medicines would not be identified and rectified as required.

The provider failed to ensure care and treatment was provided in a safe way. They did not ensure all risks relating to the safety and welfare of people using the service were consistently assessed, recorded and managed. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, although we identified concerns with staffing, this was not identified as a regulatory breach.

●The provider did not always operate safe recruitment processes.
●The provider failed to ensure recruitment folders were audited prior to employment to ensure all essential checks were present and satisfactory. For example, we found gaps in employment history on application forms, there were no recorded attempts to gain reason for the gaps present.
●Some staff who required a visa to work in the United Kingdom did not have an in-date visa stored in their recruitment folder. This did not assure us that the provider had a robust system in place to ensure staff working had the correct right to work documentation. After we raised this with the provider, they obtained the latest visas for these staff.
●The provider failed to ensure staff recruitment files contained accurate and up to date information about staffs' recruitment history and visa status. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
●The provider told us they had sufficient numbers of suitable staff. However, people told us and records showed that actual care call times regularly did not meet agreed call times. Therefore, we were not assured that enough staff were employed to cover the care calls for people in a consistent way.

Learning lessons when things go wrong
The provider did not always learn lessons when things had gone wrong.
●The provider had documentation in place to be used when an accident or incident took place. The

registered manager told us that no accidents or incidents had happened at the service. As the documentation had not been used, we could not be assured that there was an effective system in place to record accident and incidents.

Preventing and controlling infection
People were protected from the risk of infection as staff were following safe infection prevention and control practices.
- The provider had infection control protocols in place. Protocols detailed how staff should ensure they protect people from poor infection control practices.
- Staff we spoke with told us they had enough PPE to wear when completing care calls.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
At our last inspection the provider had failed to ensure care and treatment was provided with the consent of people in line with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. During this inspection no people were being deprived of their liberty.

- Consent for care had been gained, however, where a person had mental capacity relatives had signed the consent to care. No reason was recorded as to why this had been completed on the persons behalf, we were not assured that people who had capacity had consented to their care.
- For people who lacked mental capacity, best interest meeting records held very basic detail and did not capture why the meeting had taken place and how the decision had been made in the best interest of the person.
- The provider had completed best interest meetings for people who had been assessed as having mental capacity. This meant the principles of the MCA were not always followed

The provider did not ensure people's consent was gained prior to support being provided. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
People's needs were not assessed, care and support was not delivered in line with current standards. People did not achieve effective outcomes.

- Care plans and risk assessments were not consistently reviewed. This meant that information recorded within the records did not match the care taking place and people were at risk of receiving ineffective and inconsistent care. For example, a medication change had not been updated within the care plan, meaning

the care plan was not reflective of the person's current needs.
●Staff told us that people's care plans and risk assessments were accessible and were accessed using an electronic application.
●Some staff struggled to tell us about people's long term health conditions or the support they required with these. This meant we could not be assured people's health conditions were being monitored.

Staff support: induction, training, skills and experience
●Staff did not always have competence assessments to ensure they are able to meet people's diverse needs. For example where a person used a continence aid, staff supporting the person with this had not had sufficient training. This had the potential risk of causing harm to people.
●Staff did not always have specific training to enable them to meet people's diverse needs. For example, where a person used a continence aid, staff supporting the person with this had not had sufficient training. This had the potential risk of causing harm to people.
●Some people and relatives we spoke with told us they did not feel confident that staff were skilled enough and at times family members had stepped in to show staff how to complete a task.
●Competency assessments were not carried out to check staff were competent to administer medication safely. ●
Staff had completed training deemed essential by the provider which included health and safety, safeguarding and food safety.
●Staff told us they felt supported by the registered manager and met with the manager or senior in the office regularly.

Supporting people to eat and drink enough to maintain a balanced diet
●People's fluids were not effectively monitored. Fluids were recorded in daily records for people, however, this was not easy to identify or show records were consistently recorded. Where people required monitoring of fluids, there was no formal document to record this. Fluids were recorded in daily notes which made it difficult to clearly see input and outputs.
●People who received support with preparation of food and meals and their relatives told us they had no concerns and always have choices and options.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has remained Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences, meeting people's communication needs

At our last inspection the provider had failed to ensure that the care and treatment of people was appropriate and met their needs and preferences. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not always understood and supported.
- People did not have communication care plans for staff to follow when providing care to people. For example, care plans for people whose first language was not English had no guidance within them to enable staff to effectively communicate to ensure the people's needs were understood and met.
- Care plans and management health care plans lacked person centred detail and held generic information that was not personalised to individual people". For example, specific health plans did not hold information on how to support the individual to meet their needs, the information was generic guidance provided as a general care to a person with the specific health needs. Information in care plans did not fully capture peoples diverse needs.
- Care plans and risk assessments did not show where people or appropriate relatives had been involved in the planning and reviewing their care. Some people we spoke with told us they had met with the provider at the start of their care package, however, after this no further review had taken place.

The provider did not ensure people received person centred care. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Some people told us they did have choice and control over the care that took place within their homes. Some people and relatives told us they felt staff respected how they wished to live and the way they wished to receive their care.
- Some relatives and people we spoke with told us at times it was difficult to communicate with staff and there was at times a communication barrier.

End of life care and support

●Systems were not in place to ensure people were supported at the end of their life to have a comfortable, dignified and pain free death.

●Some people had end of life care plans in place, however, the care plans were lacking detail and did not capture fully what the persons last wishes and preferences would be.

●At the time of this inspection nobody was following an end of life plan.

Improving care quality in response to complaints or concerns

People's concerns and complaints were listened to, responded to and used to improve the quality of care.

●The provider had a complaints procedure and concerns system in place, this captured the detail of the complaint or concern been made and action taken from this.

●At the time of this inspection no complaints or concerns were currently open or reported.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection the provider had failed to ensure the quality and safety of the service was assessed, monitored and improved effectively. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, understanding quality performance, risks and regulatory requirements and continuous learning and improving care

- The provider had failed to take appropriate action in relation to regulatory breaches identified at their March 2023 inspection. This meant we identified continued regulatory breaches and people remained at risk of receiving unsafe and inconsistent care and support.
- The provider did not effectively monitor the safety and quality of care provided in order to identify where improvements were required.
- Medication audits in place only covered very basic checks and did not identify the medicines concerns we found during our inspection.
- The provider had failed to implement an effective system to ensure people received their care calls at their agreed time. People told us and care records showed people regularly received care calls outside of their agreed call times.
- The provider had failed to implement an effective system to monitor the quality of information in people's care plans. This meant care plans were not always accurate and detailed enough to enable staff to support people in a safe manner and in line with their individual needs and preferences.
- The provider had failed to implement an effective system to monitor daily records to identify any missed opportunities to escalate safety concerns, including missed incidents that may have met a safeguarding threshold.
- The provider had failed to implement effective systems to ensure staff were suitably trained to provide care in a safe manner.
- The provider had not created a learning culture at the service, so people's care was not improved. During this inspection we found numerous concerns relating to the care people received, for example, a staff member who was trained to complete specialist care had left the service. The provider had not sought additional training to upskill other staff members appropriately to be able to complete this specialist care. This meant the needs of the person in receipt of this care were not being met. The provider had informed the commissioners of this gap in care after the staff member left, however a proactive approach was not taken to prevent this gap in care.

The provider did not ensure effective systems were in place to monitor and improve the quality of care provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider did not always have effective systems to provide person-centred care that achieved good outcomes for people.
- People did not have outcomes to achieve within their care plans. Care plans lacked the information and detail to show what outcomes people were working towards to empower them.
- Documentation in place such as care plans and daily records were not completed in a person centred way to show how peoples wishes and preferences were met when completing their care call. This did not assure us that people received the care they wished to receive.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and staff told us they were not always involved in the running of the service.
- Care plans in place did not capture peoples' full characteristics and held limited detail. This meant we could not be assured that people's protected characteristics were understood and planned for.
- During this inspection the registered manager told us they had recently sent out surveys to gain feedback from people who use the service, however, they had not yet gathered the feedback to collate and respond to any actions to improve.
- Staff attended regular team meetings, this presented an opportunity for staff to discuss or raise any concerns around peoples' care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider understood their responsibilities under the duty of candour.
- The registered manager who is also the registered provider showed clear understanding and knowledge of the process and procedure in responding following the duty of candour.

Working in partnership with others

The provider did not always work in partnership with others.

- The provider worked with district nurses and had contact numbers for health professionals when required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure people received person centred care.