Santos Care Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Santos Care Limited is a domiciliary care agency providing personal care to people living in their own houses and flats. At the time of our inspection, the service was supporting 20 people with personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
Risk assessments were not always in place to guide staff how to manage clinical risks to people. People told us they were not always supported by the appropriate number of staff to meet their needs. People's medicines were not always managed safely. People's medicines records were not always completed accurately and there were no protocols in place to guide staff when to administer 'when required' medicines. Staff did not always know when to raise concerns regarding people's safety. Accidents and incidents were recorded inconsistently so trends could not always be identified to reduce the risk of reoccurrence.

People's assessments were not always detailed and did not always guide staff how to meet people's diverse needs. People told us staff were not always well trained although records indicated they had completed an induction and were up to date with training. Mental capacity assessments were not completed when needed. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's care plans were not always consistent and were not always reviewed when people's needs changed.

Staff did not always have sufficient English language skills to communicate effectively with people and their relatives which placed them at risk. Calls were often late and people did not always have their staff preferences met. Complaints were not always managed and addressed consistently.

Systems in place to check the quality of the service failed to identify errors in people's medicines records. Quality checks did not identify where risk assessments and mental capacity assessments were not in place and where there were inconsistencies in documentation. Systems in place were not effective in ensuring people's care calls were on time. The registered manager and staff did not always understand the issues and risks facing the service. People and relatives engaged with questionnaires and feedback calls but told us action was not always taken to address any concerns they raised.

People were supported by staff who knew how to prevent and control infection. People were supported to prepare meals of their choice by staff. Staff informed relatives where there were any health concerns. People and relatives told us staff were kind and caring and treated them with respect. Staff supported people in a

way that preserved their privacy and dignity. Staff supported people to maintain their independence. Staff told us the registered manager was supportive and approachable. The registered manager understood the duty of candour.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 22 November 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about neglect, moving and handling practices and concerns regarding late calls and staff training. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to the assessment of risk and medicines administration, consent, staffing, providing care in line with people's needs and preferences and the governance of the service.

Please see the action we have told the provider to take at the end of this report.

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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring 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?

Requires Improvement

The service was not always 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 inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. 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 1 inspector and an Expert by Experience. 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
We gave a short period of 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.

Inspection activity started on 2 March 2023 and ended on 14 March 2023. We visited the location's office on 7 March 2023.

What we did before the inspection

We reviewed information we had received about the service since they registered. We sought feedback from the local authority and professionals who work with the service. 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 the registered manager, a care co-ordinator and 5 care staff. We also spoke with 3 people who received support from the service and 9 relatives.

We looked at 6 people's care records and reviewed 6 people's medicines administration records (MARs). We also viewed 3 staff files, call log records and documentation related to the governance of the service.

The provider sent us further documentation we had requested during and following the site visit including training records and action plans.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely
- Risk was not always assessed and managed safely.
- Risk assessments were not always in place to guide staff how to manage risk to people. For example, where people had complex clinical needs, there was no risk assessment in place to guide staff how to mitigate risk. This meant people were at risk of not having their clinical needs met safely.
- People were not always supported by the appropriate number of staff to meet their needs safely. One relative told us, "Sometimes we only have 1 carer when there should be 2". Electronic call records confirmed there were some instances where carers were not logged at calls at the same time. This meant people were at risk of harm.
- Risks were not always identified and staff competency checks were not always undertaken when needed to minimise risk to people.
- People's medicines were not always administered safely.
- Protocols were not in place to guide staff when to administer people's 'when required' medicines. We discussed this with the registered manager but they lacked knowledge regarding what a protocol was. This meant people were at risk of not receiving their medication when needed.
- People's Medicine Administration Records (MAR) were not always completed accurately. For example, staff had recorded on a person's MAR that 2 'when required' medicines had been administered twice daily on a regular basis. We raised this with the registered manager who investigated and confirmed the medicines had not been administered by staff.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service and medicines were not administered safely. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff knew how to support people with their moving and handling needs. People told us they felt safe when staff were supporting them.

Systems and processes to safeguard people from the risk of abuse
- Systems in place did not always keep people safe.
- Staff told us they had received safeguarding training and records corroborated this. However, staff did not always have sufficient knowledge to know when to raise concerns regarding people's safety. Staff we spoke with told us they would escalate any concerns to the registered manager.

● Accidents and incidents were not always recorded consistently when they occurred. Some were recorded on accidents and incidents forms but others were recorded directly onto an electronic call log. This meant accidents and incidents could not be reviewed thoroughly to identify trends and reduce the risk of reoccurrence.
● The registered manager knew when to make safeguarding referrals. They told us they would make a safeguarding referral if they became aware of any form of abuse. The registered manager told us they had not had to raise any safeguarding referrals as where there had been concerns, the local authority had been notificed of this before it had come to the provider's attention.
● People and relatives told us staff supported them to stay safe. One person told us, "I am very safe, they have nice personalities and are kind and caring."

Staffing and recruitment
● People were not always supported by a sufficient number of staff. One relative told us, "They don't come on time, they're definitely short staffed." Electronic records confirmed there were a high number of late calls.
● Staff recruited did not always have the appropriate skills to meet people's needs and competency checks were not always effective. For example, people told us staff did not always have adequate English language skills to meet their needs effectively.
● Poor staff performance was not always identified which left people at risk of harm. For example, where call rotas showed staff were regularly late to calls, this was not always addressed with staff.

The provider had failed to ensure there were a sufficient number of suitably qualified, competent, skilled and experienced staff to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not permitted to work until the provider had received a Disclosure and Barring Service (DBS) check, satisfactory references and shown evidence of their right to work. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● The provider did not always learn when things went wrong.
● Sufficient action was not always taken to reduce the risk of reoccurrence following complaints from people or relatives or when safeguarding concerns were shared by the local authority. For example, when a relative raised concerns about the language skills of a staff member, the provider failed to take sufficient action to address this.

Preventing and controlling infection
● People were supported by staff who wore Personal Protective Equipment (PPE) in line with current guidance.
● Relatives told us staff washed their hands and wore aprons and face masks when needed.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated 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
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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

- The service was not working within the principles of the MCA.
- Mental capacity assessments had not been completed where there were concerns regarding people's capacity. The provider told us they did not complete their own mental capacity assessments.
- Consent to care forms had been signed by relatives when there was no evidence to suggest people did not have capacity to consent to their own care. This meant that people were not always supported to make decisions and consent to their care themselves.
- Prior to the inspection, we asked the registered manager to seek consent from people and relatives to share their contact details with us. However, during calls to people and relatives, they told us they had not been asked for their consent. We spoke to the registered manager regarding this and they confirmed they had not sought consent prior to sharing their contact details.

Systems had not been established 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(1) 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 assessed prior to the commencement of the care package. However, assessments sometimes lacked detail and did not always contain specific information about their needs. For example,

where people had complex health conditions, assessments did not always provide sufficient detail to enable care to be delivered in a way that met their needs.
● People's diverse needs under the Equality Act 2010, such as religious needs, were identified in their assessments but there was no information regarding how these needs could be met. This meant staff did not know if people needed support to meet their diverse needs.
● People's assessments did not always identify the goals people wished to achieve.

Systems in place did not always ensure that the care and treatment of people was appropriate and met their needs and preferences. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● People and relatives told us staff were not always well trained. One person told us, "I don't think they always get enough time to do training." A relative told us, "Some staff are well trained, some are not."
● Staff received an induction when they started their employment. Staff told us this included shadowing more experienced staff on specific care calls. However, some relatives told us staff who provided care had not undertaken any shadowing of their particular call prior to the start of the care package.
● The registered manager had completed some competency checks with care staff to assess if they were able to meet people's needs effectively. However, these did not always identify concerns that were shared by people and their relatives. For example, staff competency checks did not identify where concerns had been raised around communication.

The provider had failed to ensure there were a sufficient number of suitably qualified, competent, skilled and experienced staff to meet people's needs. This placed people at risk of harm. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Training records indicated staff had completed mandatory training. Staff also told us they had undergone training to ensure they understood how to manage people's specific needs related to clinical needs.

Supporting people to eat and drink enough to maintain a balanced diet
● Where people had specific dietary needs, this was not always clear and consistent in their care plans. For example, one person's care plan indicated their diet needed to be monitored due to a health condition but also documented they had no specific dietary needs. We raised this with the registered manager and this was addressed in their care plan immediately.
● People were supported by staff with meal preparation when needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives told us staff identified concerns regarding people's health needs. One relative told us, "Staff advise me if they have spotted my relative is getting a sore."
● Electronic care records indicated the provider had liaised with health professionals regarding people's care to try to provide effective care.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
- People and relatives told us they weren't always able to express their views due to a language barrier with some staff. One relative told us, "I can't understand [care staff] as it's difficult to know what they are saying."
- Staff did not always recognise people's preferences or when they wanted support. For example, staff were often late for calls which meant people did not always receive care at a time that had been agreed.

Ensuring people are well treated and supported; respecting equality and diversity
- People and relatives told us staff were kind and caring. One relative told us, "Staff are caring, they are very good."
- People told us staff spoke with them in a respectful way.

Respecting and promoting people's privacy, dignity and independence
- People and relatives told us staff supported them in a way that preserved their dignity and respected their privacy. One person told us, "They ask me if I want a shower and wash me but always with dignity." One relative told us, "They wash my relative in the bedroom and close the curtains."
- Staff supported people's independence where they were able to. People told us staff enabled them to do what they could themselves but supported them when they needed it.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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

- People's care plans were not always consistent and were not always reviewed when needed. Some care plans provided clear guidance to staff on how to meet people's needs. However, care plans in place for people with complex clinical needs were not always adequate. This meant staff did not always know how to meet people's complex clinical needs which placed them at risk.
- People's care preferences were not always met in line with their care plans. For example, where people had requested a carer of a specific gender, rotas showed a high number of instances where care was provided by a staff member of a different gender.
- People's preferred call times were not always considered when call rotas were implemented. For example, we saw 1 carer had been allocated to 2 care calls at the same time which meant care could not be delivered to both people at the preferred and agreed time.

Meeting people's communication needs

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 were supported by staff who did not always meet their communication needs.
- Relatives told us they had difficulty in understanding some staff due to a language barrier. One relative told us, "All of the staff have broken English." This meant people's needs may not be met and placed them at risk of harm.
- Staff did not always adapt their communication techniques to meet people's needs. For example, a staff member made assumptions regarding a person's cognitive ability rather than using different forms of communication to support the person to understand them better.
- Following the inspection, the registered manager told us they had enrolled some staff members on an accredited English Language course to improve their skills.

Systems in place did not always ensure that the care and treatment of people was appropriate and met their needs and preferences. This was a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints were not always addressed and managed consistently.
● A complaints policy was in place but complaints were not always responded to in line with the policy. For example, feedback was not always provided to the complainant once a complaint had been investigated and resolved.
● Where concerns were raised directly with the registered manager, these were not always documented as a complaint or concern. Therefore, this did not form part of any complaints analysis undertaken by the registered manager.

End of life care and support
● People's end of life wishes and preferences had not been considered in their care plans. The registered manager told us they did not currently support anyone who was at the end of their life, but they would discuss people's end of life wishes if they were at that stage of their life.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Medicines audits failed to identify where protocols were not in place to guide staff when to administer 'when required' medicines. Medicines audits did not identify errors where medicines had been recorded as administered when care staff had not administered them.
- Quality checks of care files failed to identify where risk assessments were not in place to guide staff how to mitigate risks related to people's clinical needs.
- Systems in place failed to identify where mental capacity assessments had not been undertaken when there were concerns regarding people's cognition. This meant people were not always supported to make decisions and consent to their own care.
- Systems in place were not effective to ensure calls were on time. Call logs showed a high number of late calls and relatives told us calls were regularly late. Call rotas also showed that the same carer had been assigned to provide care at 2 people's homes at the same time. This meant both calls could not be delivered on time.
- The provider failed to sufficiently address concerns raised by relatives regarding people having difficulty understanding some staff members due to them not having adequate English language skills. No staff competency checks were undertaken, and staff continued to be deployed to calls. This meant people were placed at risk of harm.

Systems had not been established to ensure the quality and safety of the service was assessed, monitored and improved effectively. This placed people at risk of harm. This was a breach of regulation 17(1) 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

- Systems in place did not help to promote a clear vision or values within the service.
- The registered manager and staff did not always fully understand the issues and risks facing the service. This meant people were not always empowered to achieve good outcomes.
- Staff told us travel times between calls could be excessive which did not promote a positive culture amongst staff. Care was not always person centred as excessive travel time meant calls were not always on time.
- Staff told us the registered manager was approachable and supportive. One staff member told us, "The manager is supportive, I would approach them immediately if I had any concerns".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● Improvements were not always identified so learning was not always disseminated. This meant care did not always improve as needed.

● The provider undertook face to face and telephone questionnaires to obtain feedback from people and relatives regarding people's care. However, relatives told us this was not always acted on. One relative told us, "Once I filled in a survey but nothing was done."

● Staff told us they had team meetings where they could feedback regarding the service.

Working in partnership with others

● The provider engaged with commissioners when needed but showed little evidence of proactively engaging with other organisations.

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 registered manager understood the duty of candour and their responsibility. They told us, "The duty of candour means we should be open and honest to the clients." However, they did not always have the knowledge to identify where something had gone wrong.

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 Systems in place did not always ensure that the care and treatment of people was appropriate and met their needs and preferences.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems had not been established to ensure care and treatment was provided with the consent of people in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were a sufficient number of suitably qualified, competent, skilled and experienced staff to meet people's needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service and medicines were not administered safely.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been established to ensure the quality and safety of the service was assessed, monitored and improved effectively.

The enforcement action we took:

We served a warning notice and asked the provider to evidence how they had made improvements to evidence compliance with the regulation.