Pin-Point Health & Social Care Support Service

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Type of inspection:
Unannounced

Completed on:
20 January 2026

Service provided by:
Nova Payroll Management Services Ltd

Service provider number:
SP2014012262

Service no:
CS2014324191

About the service

Pin-Point Health & Social Care is a service provided by Nova Payroll Management Services Ltd. It is registered to provide a support service to adults living in their own homes or in the community.

At the time of the inspection the service was supporting approximately 100 people living in their own homes across Aberdeen City and Aberdeenshire.

About the inspection

This was an unannounced inspection which took place between 6 and 20 January 2026. The inspection was carried out by two inspectors from the Care Inspectorate.

To prepare for the inspection we reviewed information about this service. This included, previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:
- spoke to five people using the service
- spoke to 17 family members
- spoke to 11 staff and received feedback from two staff by email
- received feedback from several external professionals
- observed practice and daily life
- reviewed documents.

Our inspection raised significant concerns in relation to how people's health, welfare and safety needs were met. As a result, we issued the service with an Improvement Notice on 23 January 2026.

For further details of this enforcement see the service's page on our website at www.careinspectorate.com.

We worked with external partners to ensure relevant stakeholders were fully informed of the associated risks. Some adult support and protection concerns were submitted to the local authorities over the course of the inspection.

Key messages

• We took enforcement action to require the provider to improve the management and leadership of the service to ensure people's health, welfare and safety needs were met.

• There was no registered manager in place which meant there was no management, oversight or leadership of the service which had impacted on people's health and wellbeing and placed them at risk of harm.

• We identified a number of significant concerns, where due to missed visits, people had not received the care and support they should have, leaving them without medication, food and fluids and personal care.

• Staff had no support or direction, and some were unclear about their role.

• Personal plans did not accurately reflect people's needs and outcomes.

• Changes to people's health and wellbeing needs were not recorded or communicated effectively which meant that there was a risk of people not receiving the appropriate care.

• We graded the service as unsatisfactory across all key areas as significant improvements were required to ensure people were safe.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	1 - Unsatisfactory
How good is our leadership?	1 - Unsatisfactory
How good is our staff team?	1 - Unsatisfactory
How well is our care and support planned?	1 - Unsatisfactory

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 1 - Unsatisfactory

We were very concerned about aspects of the care being provided and we evaluated the service as delivering an unsatisfactory level of care for this key question.

As the service was performing at an unsatisfactory level, we were concerned about the welfare, health and safety of people. We issued the service with an improvement notice connected to these concerns. For further details of this enforcement see the service's page on our website at www.careinspectorate.com.

We observed staff working with the best intentions to care for and support people under challenging circumstances. During the inspection we witnessed warm interactions, including staff assisting someone to arrange patient transport. The person told us they "appreciated the care and support" they received. Some people and their families described the staff who supported them regularly as "great" and said that they got on well with them.

However, people's experiences of care were inconsistent. We consistently received unsatisfactory feedback about how care was provided and the impact this had on people. People and families told us of situations where staff did not greet them on arrival, where their relative had been spoken about in a disrespectful way, and one person told us that they didn't feel safe with the staff who provided their personal care. We also heard concerning examples of poor practice. These included staff sleeping during shifts, failing to report injuries to families, and sitting for prolonged periods using their mobile phones rather than providing support. People and families told us they had lost confidence that care would be delivered in a safe and attentive way. This was not acceptable practice which compromised people's dignity and rights.

Missed visits continued to be a significant issue and had a serious and distressing impact on people's wellbeing. As a result of missed visits, people were sometimes left without essential care, food, fluids, and prescribed medication. Families told us that relatives had been left in soiled clothing and one person described the lack of care as something that "could have been catastrophic." A person receiving care said, "I felt undignified, unsupported and uncomfortable." People and families also told us that when they contacted the on-call telephone, they often received no reply or were advised that staff were "on their way," when this was not the case.

We identified several serious incidents where people had been left without support for extended periods, resulting in missed medication, unmanaged pain, lack of access to fluids or meals, and compromised dignity. These incidents presented significant risks to people's health and wellbeing. We raised a number of adult support and protection concerns during the inspection for events that had not been identified or acted upon by the service, and we heard of several people being placed in respite due to the provider's inability to consistently deliver care. This demonstrated that the service was unable to provide safe, reliable support, leaving people exposed to avoidable harm.

Most people told us their care was not reliable. In addition to missed visits families said visits were often late and that they were not kept informed about changes. They said communication was poor and that visit times were inconsistent, which created distress and uncertainty for the person using the service as well as their family. Families told us that for their relatives who required routine to feel safe, the unpredictability of visits caused anxiety and disruption.

External professionals shared similar concerns. They told us that they had been contacted by families who were distressed because they were unsure if staff would arrive as well as families reporting that no visits had taken place. This uncertainty added to anxiety and stress for people and their families.

People's health and wellbeing was compromised as there were no processes in place to support effective communication about changes to people's wellbeing needs and personal plans lacked detail and information. For example, one family member told us that important health information had not been recorded in their relative's personal plan, despite being shared with the provider. This meant staff did not have access to the information they needed to provide safe care. (see key question 5 "How well is our care and support planned?" for more details)

We had significant concerns about medication practices. People and families told us about errors, omissions and occasions where medication was given too early or too late, causing distress and affecting symptom control. We were not confident people were always receiving their medication safely, as prescribed or at the right time. This meant that people's physical and emotional wellbeing was placed at risk because they were not consistently protected from the avoidable harm associated with missed, delayed, or incorrectly administered medicines. One person told us, "Missing my medication made me feel very worried and anxious", and a relative told us that repeated errors caused their loved one to suffer unnecessarily. We were unable to establish whether medication errors were recorded or what actions were taken to address errors that occurred. We also saw inconsistent and conflicting information in personal plans about the support that people required with medication, which increased the risk of errors.

Personal plans lacked information about the support people required regarding their nutritional needs as well as their likes and dislikes. As a result of missed visits some people had not had access to food and fluids for prolonged periods of time. One person told us, "I had no access to fluids and I was thirsty and my mouth was dry". This meant that people's nutritional needs were not always being met which impacted on their health and wellbeing.

We also found inconsistent infection prevention and control practice (IPC). Although a local infection control procedure had been developed, there was no evidence that it had been communicated to staff. We observed poor IPC which included poor handwashing techniques and incorrect glove use during personal care. Families shared similar concerns, one said "I have seen staff carry out personal care then prepare food without washing their hands or changing gloves." This meant people were at risk of harm from infection.

How good is our leadership? 1 - Unsatisfactory

We were very concerned about aspects of the care being provided and we evaluated the service as delivering an unsatisfactory level of care for this key question. The arrangements in place did not provide safe oversight, reliable communication, or assurance that people's needs would be met.

As the service was performing at an unsatisfactory level, we were concerned about the welfare, health and safety of people. We issued the service with an improvement notice connected to these concerns. For further details of this enforcement see the service's page on our website at www.careinspectorate.com.

At the time of our inspection, there was no registered manager in post, resulting in no local leadership presence and limited oversight. As a result, some information we requested during the inspection was unavailable or could not be provided.

People and families reflected these concerns. One relative told us there was "no consistent point of contact and communication was poor." Another said staff "just pleased themselves and no one was in charge." Staff shared similar views, describing a lack of direction, supervision and clarity about roles.

Instability within the management team meant care staff were asked to take on additional responsibilities without induction, training or clarity. They described managing rotas, liaising with partner agencies, covering on-call and delivering care, often working significant hours to "keep things going." Several staff told us they did not know who to report to or what their responsibilities were. This created an unsafe working environment and increased the risk of errors that directly affected people's health and wellbeing.

Overall, the absence of effective management meant the provider could not ensure consistent leadership, clear communication or safe governance arrangements, placing people at significant risk of harm.

Quality assurance and oversight was unsatisfactory. Information about incidents was not available, and there were no clear processes for recording or reporting significant events. We identified serious neglectful incidents, including a person left without support for an extended period. We could not establish whether the provider was aware or what action had been taken. This left people at risk of unnecessary harm.

We were also unable to determine whether concerns raised with us had been investigated or followed up, and very few notifications had been submitted to the Care Inspectorate despite a previous requirement to do so. Adult support and protection concerns were not recognised or reported by the service, as also highlighted under key question 5 "How well is care and support planned?". This left people at significant and avoidable risk of harm and provided no assurance that safeguarding responsibilities were being met.

Complaints management lacked transparency and follow-through. Since the last inspection, several complaints were received by the Care Inspectorate, including some requiring provider investigation. It was unclear whether investigation work had commenced, as no evidence was available during the inspection. Families told us that concerns raised directly with the service were often not responded to. One person said they could not get through by phone, and when they attended the office in person, no one was present. This missed opportunity for early resolution and learning contributed to deteriorating confidence in the service.

Some policies for example, adult protection and infection prevention and control had been recently drafted, but we could not confirm whether they had been communicated to staff or implemented. Without clear access and training, staff may not follow current guidance. This increased the risk of unsafe, inconsistent or uninformed practice in high-risk areas such as adult protection, medication and infection prevention and control.

How good is our staff team? 1 - Unsatisfactory

We were very concerned about aspects of staffing, staff support, and the culture within the service. Overall, we evaluated this key question as unsatisfactory due to ongoing instability, poor communication, unsafe staffing arrangements, and significant failings in safe recruitment and staff oversight. These weaknesses directly affected the quality and safety of care people received.

As the service was performing at an unsatisfactory level, we were concerned about the welfare, health and safety of people. We issued the service with an improvement notice connected to these concerns. For further details of this enforcement see the service's page on our website at www.careinspectorate.com.

There had been a pattern of staff starting employment and leaving quickly, which created instability in the workforce. Several staff told us they felt unsupported, describing the situation as "there is no support, the carers are running the company" and "the situation is desperate." One staff member reported a colleague being "sacked with immediate effect", which increased anxiety within the team. Others described the current situation as "a horrible experience", and one long-standing staff member said, "This has all been stressful and devastating and the lack of support has been ridiculous."

Several staff described a bullying culture. This created an unsafe and unsupported working environment and affected staff morale and confidence. A culture where staff feel intimidated or afraid to speak up increases the risk that poor practice will go unreported, concerns will not be escalated, and people may experience inconsistent or unsafe care.

We also had significant concerns about the provider's failure to ensure there were enough staff to meet people's care and support needs. This was reflected in the high number of missed, late or cancelled visits described under key question 5 "How well is our care and support planned?". Staff told us they often felt rushed due to travel times, staffing shortages and workload pressures. Staff in more senior roles were also carrying out visits and holding the on-call phone, which reduced the time available to provide person-centred care. This had a direct impact on people's outcomes, including missed medication, missed meals, and inadequate personal care.

We found significant concerns with staff support and communication. Staff support and communication were poor. Staff and families told us the on-call system was unreliable, with calls often going unanswered because the person on call was also out delivering care. Staff told us they did not know who to contact at head office, and concerns raised were not responded to. Staff also reported that they had not received any supervision or attended team meetings since the last inspection.

One staff member said, "I have been put into my role without any induction or training. I've tried my best, but I don't know what I'm doing." Another said they received only "half an hour of training" and had to teach themselves the role. Families echoed these concerns, with one person saying, "There is no one to contact - no communication and no updates."

We were also concerned about serious failings in safer recruitment, despite a previous requirement being made in this area. We identified staff who had started work without PVG clearance, and there were delays in processing PVGs because there was no counter signatory in place.

When reviewing professional registration information, we found several staff who were not registered and a number of staff who had not applied for registration within the required timescales. These failings meant that people were supported by staff who had not had appropriate pre-employment checks, and we could not be assured staff were safe, suitable, or accountable for their practice. Combined with poor induction, lack of supervision, and limited leadership oversight, this created an unsafe care environment and contributed to the poor outcomes experienced by people using the service.

How well is our care and support planned? 1 - Unsatisfactory

We were very concerned about aspects of the care being provided and we evaluated the service as delivering an unsatisfactory level of care for this key question.

As the service was performing at an unsatisfactory level, we were concerned about the welfare, health and safety of people. We issued the service with an improvement notice connected to these concerns. For further details of this enforcement see the service's page on our website at www.careinspectorate.com.

Staff could access personal plans online, which allowed them to view information wherever they worked. However, the quality of personal plans had not improved since the last inspection despite this being a requirement.

We found that people's personal plans remained basic, incomplete and lacking key information. Plans reviewed at the last inspection had not been updated. In a further sample of plans most were found to be incomplete, lacking in sufficient detail, and in some cases, inaccurate. We also found gaps in daily notes, with some visits not being recorded at all. This meant that staff did not have the clear information or guidance they needed to support people safely or in line with their individual needs or preferences.

People and their families told us they had not been involved in care planning and had not seen their personal plans. Some families said they had requested online access, but this had not been provided, despite other families having access.

It remained unclear how the provider involved people in developing, reviewing or agreeing their plans. Several families told us they were unaware whether reviews had taken place.

Since the last inspection, the provider had introduced a review tracker. This showed that a significant proportion of personal plans had not been reviewed within the required timescales. In several of the plans that were recorded as having being reviewed, we found no completed care planning or risk assessment sections. This meant we could not rely on the accuracy of the information recorded.

These shortfalls meant personal plans did not support safe, consistent or person centred care. Staff worked without accurate or complete information about people's needs, and people felt excluded from personal planning. As a result, people's outcomes continued to be affected because their needs and wishes were not always fully recorded or understood.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	1 - Unsatisfactory
1.3 People's health and wellbeing benefits from their care and support	1 - Unsatisfactory

How good is our leadership?	1 - Unsatisfactory
2.2 Quality assurance and improvement is led well	1 - Unsatisfactory

How good is our staff team?	1 - Unsatisfactory
3.3 Staffing arrangements are right and staff work well together	1 - Unsatisfactory

How well is our care and support planned?	1 - Unsatisfactory
5.1 Assessment and personal planning reflects people's outcomes and wishes	1 - Unsatisfactory

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