Infinity 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?	Requires Improvement
Is the service well-led?	Inadequate

Summary of findings

Overall summary

About the service
Infinity Care Limited is a domiciliary care agency providing personal care to people in their own homes through live-in and domiciliary care. At the time of our inspection there were 23 people using the service. 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
The provider did not always identify risks to people's health and safety. When risk assessments were completed, they did not always include clear measures to reduce risks to people. This exposed people to a risk of avoidable harm.

The provider did not have effective systems and processes in place to ensure people were protected from the risk of abuse and improper treatment. The provider did not complete robust investigations to allegations of abuse or identify potential abuse and improper treatment. However, people and relatives told us they felt safe with staff.

Medicines were not managed safely. Safe staff recruitment practices were not always followed to ensure staff were suitable to work with people. The provider did not identify learning or areas for improvement when things went wrong, to reduce the risk of future incidents.

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. Best practice guidance was not used to inform care plans. Staff felt they had enough training, however they did not receive training for people's individual needs, such as diabetes or catheter care.

Staff told us they felt supported and received regular feedback. People were encouraged to eat and drink, and staff were aware of their preferences. The provider was not always consistent when supporting people to access healthcare services and support.

The provider did not understand the regulatory requirements and was not aware of relevant legislation. There were no robust systems and processes to assess and monitor safety and quality, which meant concerns weren't identified and people were at risk of receiving unsafe care. Policies did not reflect current legislation or best practice. We have made a recommendation about this.

Despite the concerns we found, it was clear the provider and staff team cared about the people they supported. We received good feedback from people and relatives about staff and management.

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

Rating at last inspection
The last rating for this service was good (published 5 September 2018).

Why we inspected
We received concerns in relation to the management and reporting of incidents and safeguarding concerns, handling of complaints, robust management oversight and whether the provider was supporting people in line with the principles of the Mental Capacity Act. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Infinity Care Limited on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified breaches in relation to risk management, medicines management, safeguarding, recruitment, governance, consent, notification of incidents and complaints. We have made a recommendation about duty of candour.

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 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.

Special Measures
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 timeframe 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Infinity 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 was carried out by 2 inspectors 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 the service 24 hours' notice of the inspection. This was because we needed to be sure that the registered manager would be in the office to support the inspection.

Inspection activity started on 26 April 2023 and ended on 11 May 2023. We visited the location's office on 26 April and 3 May 2023.

What we did before the inspection

Before the inspection we looked at information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. 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 2 people who used the service and 5 relatives about their experience of the care provided. We spoke with 6 members of staff including the registered manager, assistant manager, administration officer and staff members. We had written feedback from a further 5 members of staff, including 3 staff members contracted to provide live in care. We looked at a range of records. This included 5 people's care and medicines records, 5 staff recruitment files and the provider's policies and procedures.

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 good. At this inspection the rating has changed to inadequate. This meant people were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider did not fully assess or reduce risks to people. When risk assessments were completed, they did not contain enough information to inform staff how to support people safely.
- For example, 1 person's falls risk assessment said they were at risk of pressure sores and advised staff to monitor their skin. However, there was no risk assessment or care plan in place to monitor and reduce the risk of skin breakdown. Multiple entries in the person's daily notes referenced 'bottom sores' but there was nothing to indicate what follow up action was taken. Another person's care plan advised staff to monitor their skin but was not clear what areas staff should check. When monitoring records indicated a clear decline in skin integrity, there was no evidence these concerns were raised. This exposed both people to an increased risk of skin breakdown.
- When people were at risk of falls, risk assessments had limited information and advised staff to follow people's care plans. However, 4 people's care plans had either no information, or conflicting information, about this risk. The provider did not investigate reports of falls and there was no evidence risk assessments were reviewed or updated after falls.
- For example, records showed a person told a staff member they fell out of bed in the middle of the night. The staff member reported this to the office but said they thought it was a dream as they didn't think the person could have got back into bed unsupported. No further action was taken. Two days later the person complained of leg pain and was struggling to walk, and 6 days later they had a fall. We saw no evidence the provider investigated the incidents, identified any potential link, or reviewed risk assessments. This exposed the person to an increased risk of further falls.
- A person's care plan stated they had a recent seizure. There was no further information about this in their care records. There was no risk assessment or care plan with information about the seizure, when it was, any potential triggers or a procedure staff should follow if they had another seizure.
- Records showed staff who were not clinically qualified provided clinical advice without consulting health professionals. For example, a senior staff member instructed a person how to treat a potential pressure wound and advised they would review it the following week. The staff member had not seen the wound, was not qualified to complete clinical reviews or assessments, and was not following a current treatment plan. On another occasion, the same staff member advised the person to stop using a prescribed antibiotic cream as they were told care staff thought the infection had cleared. Care staff were not qualified to complete clinical reviews or assessments. We saw no evidence the prescription was checked to confirm the full course was completed as prescribed, and there was no medicines administration record. This put the person at risk of unsafe or inappropriate treatment.

Failure to assess and mitigate risk exposed people to the risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse and improper treatment. The provider had a safeguarding policy but did not follow it. Staff told us they were confident the management team took appropriate action when they reported concerns. However, we found the registered manager did not understand their safeguarding responsibilities, complete robust investigations, or make referrals or notifications when required. We found multiple incidents staff had not identified as potential safeguarding concerns.

● For example, the provider and staff told us they locked 1 person in their home and records showed this had been happening for at least 4 months. We saw staff reported having to "distract" the person so they could leave and then heard them calling out from inside. Another record described the person banging on their front door and rattling the door handle when staff arrived. No one identified this as a potential concern and the registered manager told us this was to keep the person safe, as they had previously been found walking in the street. We saw no risk assessments about this, and a staff member told us, "I'm not sure it is entirely necessary now as [person] has calmed down a lot". We saw no evidence processes were followed to ensure locking the person in their home was in their best interests or they were not being unlawfully deprived of their liberty. This meant the person's human rights may not be being upheld. We asked the provider to make a referral to the safeguarding team, which they did immediately. However, we remained concerned the registered manager did not understand why this may be improper treatment.

● We saw 1 person and their cleaner made 2 allegations against a staff member providing live-in care. A member of the management team spoke with the staff member, observed their practice, and prompted them to be kinder in their approach. We saw no evidence any further action was taken. We raised this with the registered manager who said, "after speaking to the carer in person we did not feel there was an issue it was her mannerism that caused a miscommunication". The registered manager had not identified 2 allegations of abuse as needing a robust investigation, referral to the local safeguarding authority or notification to CQC. This exposed the person to a risk of harm.

● Staff meeting minutes showed the provider instructed staff to ignore 1 person if they made comments about other staff members, as 'most of the time what [person] is telling you is fabricated'. A member of the management team told us this referred to comments made about staff's private lives. However, they were not able to clarify further or provide assurances concerns raised by the person would have been addressed.

The failure to have effective systems and processes to prevent and investigate abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Despite the concerns identified, people and their relatives felt safe with the staff supporting them.

Staffing and recruitment

● Recruitment checks were not always carried out safely, in line with the regulations. We looked at recruitment records for 5 staff, and all had gaps in their employment history with either insufficient or no recorded explanations.

● We found 3 staff members had started working before a Disclosure and Barring Service (DBS) check was received. DBS checks provide information including details about convictions and cautions which helps employers make safer recruitment decisions. This meant people were exposed to the risk of being supported by staff who were not suitable to work with them.

● We found 1 staff member started supporting a person on 1 November 2022, but their DBS check was dated 14 December 2022. The registered manager told us this was an emergency placement. However, they were unable to evidence the emergency or whether the decision was risk assessed. As this was a live in care package, this meant the person spent most of their time alone with a staff member, increasing the risk

further.

Failure to ensure fit and proper persons were employed was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People and relatives told us they felt there was enough staff, who were always on time. Staff told us they felt there were enough staff, they had plenty of travel time and worked as a team to cover staff sickness or holidays.

Using medicines safely

● Medicines were not managed safely. When medicines were prescribed 'when required' (PRN), there were no protocols to guide staff how to administer these safely or effectively.
● For example, 1 person was prescribed a PRN topical steroid cream. However, medicines administration records (MARs) showed staff had applied the cream every day for at least 7 months. Staff had not recorded the reason for applying it every day, and it was not identified as needing escalating to a health professional. We raised this with the registered manager who sought advice from the GP and advised the cream should not be applied for longer than 2 weeks at a time. Records showed a minimum of 4 different staff members supported the person with medicines, and all MARs we reviewed had been signed as checked by a senior member of staff. However, the processes were ineffective as they had not identified the error, which meant the person was exposed to a risk of avoidable harm.
● A person was prescribed a PRN medicine for a heart condition but had no PRN protocol. The provider was responsive when we raised this, and a member of the management team produced a PRN protocol on the same day. However, this was done in the office without the person or their prescription. Therefore, we were not assured of the providers knowledge and understanding around PRN protocols. Following the inspection, the provider told us they were working hard to put person-centred PRN protocols in place.
● We found multiple errors on MARs, which included staff recording regular prescribed medicines as not required, without an explanation. For example, 1 person's MAR stated they were prescribed a medicine to be administered every other day. However, in February 2023 staff recorded this was not administered as it was 'not required'. This indicated the person had not received their medicine as prescribed and exposed them to a risk of harm.

Failure to manage medicines safely was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Learning lessons when things go wrong

● The provider did not complete effective investigations into accidents and incidents and had no system to identify or monitor patterns and trends. This meant they missed opportunities to reflect, learn and improve the quality and safety of the care provided.
● We saw a staff member's appraisal record showed they sometimes queried advice provided by staff in the office. This was identified as an area of improvement for the staff member, and stated office advice was always passed by GP and nurses. The only action recorded was 'reassurance'. However, we found multiple examples where clinical advice was provided without consultation with health professionals. Dismissing and discouraging the staff member's queries meant the provider did not reflect on the feedback or use it to drive improvement.
● Minutes from a staff meeting in May 2022 showed the provider was aware improvements were needed in medicines management. A staff newsletter from October 2022 stated medicines administration records (MARs) had been reviewed with 'minimal mistakes'. However, the provider had not implemented an improvement plan or way to monitor progress and therefore did not identify the breaches of regulation we

found around medicines management.

Failure to operate systems and processes to monitor and improve the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

● Staff received infection control and food hygiene training. Senior staff carried out spot checks which included checking staff were following good infection control practice. People and relatives did not have any concerns about staff infection control practices.

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.

At our last inspection we rated this key question good. At this inspection the rating has changed to 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.

● People were not supported within the principles of the MCA. When a person is assessed as lacking capacity to make a specific decision, any decision made on their behalf should be in their best interests and the least restrictive option. However, the provider told us they did not complete mental capacity assessments or follow best interest decision making processes.
● For example, the provider told us 1 person could never be left alone, for their safety. However, there was no evidence the person had consented to this, and no mental capacity assessment or best interest decision had been carried out. There was no risk assessment or care plan for the person needing constant supervision. This meant the person was exposed to the risk of being supported in a way that was not the least restrictive of their rights and freedom.
● Another person's care plan told staff to 'top up' what snacks were available, but not too many as they would eat them all at once. There was no evidence the person had consented to not having access to all their food items, and no mental capacity assessment or best interest decision had been carried out. There was no risk assessment or care plan about nutrition or eating, and we did not see consideration of people's right to make decisions others may think are unwise.
● When the provider took instruction from people's relatives, they did not confirm they held Lasting Power of Attorney (LPOA) for health and welfare giving them the legal authority to make decisions on their relative's behalf. We saw consent forms signed by relatives who did not hold LPOA for health and welfare.
● As detailed in the safe section of this report, staff were locking a person in their home without their consent, and there were cameras installed in their home. The provider advised this was for the person's

safety, however there was no risk assessment, mental capacity assessment or Court of Protection order to authorise depriving the person of their liberty. There was no evidence any less restrictive options were considered.

Failure to work within the principles of the Mental Capacity Act 2005 was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People, relatives, and staff told us staff asked for consent before supporting people with daily tasks such as personal care. A person told us, "Before they shower me, they always ask if I am happy with what they are going to do". Staff also understood people's right to refuse. For example, one staff member said, "If they refused [personal care] I wouldn't ever force them against their will".

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider did not use evidence based, best practice guidance, such as NICE guidelines, to inform care plans and risk assessments. Care plans and risk assessments sometimes lacked detailed and did not always explore the full range of people's individual needs, including protected characteristics.
● For example, 1 person often declined personal care and sometimes communicated anxiety and agitation through physical and verbal aggression towards staff. However, the only guidance for staff was to provide reassurance and there was no proactive plan for them to support the person. A member of staff told us the person didn't like to be touched, but this was not in their care plan, and we saw no evidence this was explored as a potential trigger.

Staff support: induction, training, skills and experience
● The provider's training record showed some staff training was overdue, and not in line with their policy. For example, 1 senior staff member's safeguarding, mental capacity, nutrition and equality and diversity training was overdue by 5 months. They told us their role involved acting on concerns raised by people and staff and completing care assessments. This meant the staff member did not have up to date training in key areas relevant to their role.
● Although staff told us they felt they had enough training, we found some lacked understanding in areas such as safeguarding and the mental capacity act. Staff did not receive training in specific conditions, for example, diabetes and catheter care. This meant people were at risk of being cared for by staff without the knowledge and skills to meet their individual needs.
● We found staff supervision records picked up areas for improvement but did not see evidence of action taken in response. However, staff told us they felt supported by the provider and received regular feedback about their practice.

Supporting people to eat and drink enough to maintain a balanced diet
● When staff supported people with eating and drinking, care plans contained some information about people's dietary requirements and preferences. For example, 1 person's care plan stated they normally liked to have fish and chips on a Tuesday. Another person's care plan listed some of their favourite foods, and preference for vegetables to be well cooked to make chewing easier for them. However, a person with diabetes had no information in their care plan about whether they needed any specific support in relation to their diet, or how it may affect their diabetes. This was an area for improvement.
● Care plans advised staff to make sure people had plenty of fluids available to them before leaving and people's daily records indicated this was followed, to reduce the risk of dehydration.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

● The provider sometimes supported people to access healthcare services and support. For example, we saw records showing staff contacted the GP in a timely way when a person was showing signs of an infection. A person told us, "They keep a close eye on me and if I am not 100% then they will contact the surgery for me". When a person's stairlift broke in the late evening, the registered manager made sure an out of hours call out was prioritised to prevent any negative impact on the person's health.
● However, people did not have care plans for specific health conditions. This meant there was no guidance available for staff on how the condition affected them, signs and symptoms that may indicate a decline in health, what actions to take or when to seek support from healthcare professionals. This was an area for improvement.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders did not assure the delivery of high-quality care.

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

● The provider did not have an effective governance system or robust quality assurance processes. Therefore, they had not identified the widespread concerns and multiple breaches of regulations identified during our inspection. Quality assurance audits were not completed, the registered manager told us this was because they were a small provider and were aware of everything going on.

● Some checks were completed, but they did not identify issues. For example, most of the medicines administration records we saw were signed as checked but had not identified the errors we found. People's daily logbooks which detail the care staff provided during each visit were not consistently or adequately checked. For example, 1 person's logbook for the period between 20 October 2022 and 8 February 2023 was returned to the office on 23 February 2023 and only 5 days were checked. Multiple concerns we found, such as an incident on 2 December 2022 where the person was reported to have pulled their bedroom door off its hinges, were not identified. For another person, logbooks for the period between 7 June 2022 and 8 October 2022 were returned to the office on 14 November 2022, with a total of only 6 days checked. The provider did not have any system for how often logbooks should be returned to the office and what a suitable sample size was. This meant there was poor oversight of the care provided and errors or concerns could not be picked up in a timely way.

● The registered manager did not demonstrate an understanding of the regulatory requirements or relevant legislation. For example, they asked when the Mental Capacity Act (2005) had been introduced and said no one had told them about the regulations. We found policies and procedures were often written in line with old legislation, for example the Domiciliary Care Agencies Regulations 2002, which were revoked in 2010. This meant we could not be assured the provider kept up to date with changes and best practice guidance. Following inspection feedback, the provider sent us a plan which did not identify any clear priorities, objectives, or specific actions. The provider showed a desire to make improvements, however we were not assured concerns would be identified and action prioritised based on risk to people.

● There were no systems or processes to assess, monitor or improve quality and safety and incidents and accidents were not effectively reported or investigated. The provider sometimes focused on attributing blame to other people and organisations, which meant they missed opportunities to investigate, learn and improve outcomes for people.

● In February 2023 we asked the provider to complete a review of records following concerns incidents and safeguarding concerns were not identified, investigated, or reported. The registered manager told us at the time they completed this, no further incidents were found, and lessons were learned. However, during this inspection we identified continuing concerns in this area and there was no evidence of learning outcomes or

actions.

Failure to ensure systems and process were in place to assess, monitor and improve the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider's complaints procedure did not fully reflect legal requirements and restricted who they would accept complaints from. We asked to see the outcome of a complaint made in February 2023, and the registered manager told us the complaint was not directly addressed to them so did not need to respond. However, records showed a member of the management team spoke to the complainant, who confirmed they were making a complaint, and told them they would follow their complaints procedure. The registered manager sent an outcome letter to the complainant during the inspection, which was dismissive of their experiences and did not reflect good practice.

Failure to establish and operate an effective system for receiving, handling and responding to complaint was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Providers are required to notify CQC of significant events, such as allegations of abuse and serious injuries. We had not received any notifications from the service since they registered in 2014, however we found multiple examples of notifiable incidents before and during the inspection. For example, allegations of abuse and when a person sustained a notifiable injury.

Failure to notify the CQC was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

● During the inspection, the provider was responsive when we raised immediate concerns and took requested actions. Following the inspection, the provider told us they were working hard to address the concerns found and accepted support from the local authority to improve.

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
● We did not see evidence of any notifiable safety incidents that would fit the remit of the duty of candour regulation. The duty of candour regulation sets out specific requirements that providers must follow if a defined notifiable safety incident occurs. Although the provider had a duty of candour policy, this did not reflect the requirements of the regulation. This meant we could not be assured notifiable safety incidents would be identified or the required process followed.

We recommend the provider reviews their policy to ensure it reflects the requirements of the regulation.

Working in partnership with others
● The provider did not always consistently seek advice from health professionals in a timely way, however, we saw this was done at times. For example, when 1 person was showing signs of an infection, the staff member contacted the GP. For another person who developed a rash, a staff member contacted a pharmacist for advice.
● The provider did not work in partnership with key organisations, such as the local authority, as they did not make safeguarding referrals and did not always seek support when needed. However, during the inspection the provider was open and honest with the inspection team. Following the inspection, they have engaged with CQC and the local authority to support making improvements.

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

- The provider sent surveys to people and their relatives yearly to seek their feedback. These were reviewed individually, however they were not analysed collectively, to allow for trends or themes to be picked up across the whole service.
- Some staff told us they were not asked for their views or feedback to help develop the service. However, all staff told us management were approachable and felt they listened when staff proactively went to them.

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

- Although we found multiple concerns and areas for improvement, detailed throughout this report, it was clear from conversations with the provider and staff they cared about people they supported, and each other. Staff we spoke with enjoyed their work and felt they worked well as a team. For example, 1 staff member said, "Working for Infinity is like a family really, I feel valued" and another said, "I love it [working in care], I wish I'd done it sooner… I wanted to do something that made me feel good and changed people's lives".
- Staff, relatives, and people spoke highly about the provider and management team. A staff member said, "She [the registered manager] is such a lovely, caring person" and another told us, "They [the management team] are so supportive… also I feel valued here; they really do listen to us". A relative said "The office staff are excellent whatever time I ring" and another said, "They have a very supportive manager". We also had good feedback about care staff, for example, 1 relative said, "They are a lovely group of girls, and they really help me so much".
- The provider and staff team showed commitment to the people they supported. However, improvements were needed to make sure they had the knowledge, skills, and processes to provide safe and effective care.

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 18 Registration Regulations 2009 Notifications of other incidents Failure to notify CQC of notifiable incidents

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to follow the principles of the Mental Capacity Act 2005

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to assess and mitigate risks to people and manage medicines safely

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Failure to establish and operate systems and processes to prevent and investigate allegations of abuse and improper treatment

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving

	and acting on complaints Failure to establish and operate an accessible system for identifying, receiving, recording, handling and responding to complaints

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure systems and processes were in place to ensure compliance with the regulations

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Failure to ensure recruitment procedures were established and operated effectively to ensure fit and proper persons were employed

The enforcement action we took:

We imposed conditions on the provider's registration