Perennial Investment Limited

Infinite Care

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Infinite Care is a provider of community home care services. At the time of the inspection it was providing personal care to 23 people aged 65 and over. 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
People told us they felt they felt safe. However, we found significant concerns in safety and the management of the service which demonstrated people were not receiving safe care.

Information about risks in people's care plans was not always effective and placed people at risk of harm. Written information detailing how people should be supported safely was not completed or had important missing information. The provider failed to protect people from abuse and to take action when abuse was suspected.

People were at risk of harm due to poor medicines management. There was a lack of information to ensure staff understood when to give medicines which were prescribed 'as and when required'. We could not be sure people received their medicines safely, as prescribed or by staff that had been sufficiently trained to do so.

Staff had not always received training to equip them to support people, understand their individual needs and mitigate associated risks.

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. Due to the quality of the care records we could not be assured care had been provided in line with peoples assessed needs, wishes and choices.

The service was not well led. There was a lack of provider oversight and quality monitoring to identify and address risks to people. Auditing was not robust where concerns were raised at previous inspections. The provider failed to take action to sustain improvements.

The registered manager did not have enough autonomy and oversight of the service to ensure that it was being managed safely and quality care was provided.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 11 November 2020) and there were

breaches of regulation for failing to assess and mitigate risks to people, failing to work within the principles of the mental capacity act, failing to have effective systems in place to assess and monitor and failing to improve the safety of the service. The provider completed an action plan after the last inspection to show what they would do to improve. At this inspection we found the provider remained in breach of regulations.

At our last inspection we recommended that the provider update their infection control policy, improve systems to gain feedback from people using the service, improve recruitment processes and improve staff support with supervisions and training. At this inspection we found the provider had not sufficiently acted on these recommendations.

The service is now rated inadequate. This service has been rated inadequate or requires improvement for the last four consecutive inspections.

Why we inspected
This inspection was prompted by concerns we received about a safeguarding incident. A decision was made for us to carry out a focussed inspection and examine this incident, check if the provider had followed their action plan from the last inspection and to confirm if they now met legal requirements. As a result, we reviewed 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.

We found evidence during this inspection that people were at risk of harm and the provider needed to make improvements in all areas inspected. Please see the safe, effective and well led sections of this full report. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, consent, safeguarding, person centred care, staff support, training and good governance at this inspection.

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.

Since the last inspection we recognised the provider had failed to notify us of all significant events. This was a breach of regulation. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Follow up

We worked alongside the provider and local authority to monitor progress. We continued to monitor information we received about the service.

Special Measures
The overall rating for this service is 'Inadequate' and the service was therefore placed in 'special measures'. We took action to cancel the provider's registration through our enforcement process. This meant we have taken action to prevent the provider from operating this service. This has lead to cancellation of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Infinite Care

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 one inspector who visited the office location and reviewed evidence remotely using the provider's online records systems. We used an Expert by Experience who made phone calls to people and their relatives. 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service a short period of notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 4 May 2022 and ended on 24 May 2022. We visited the location's office on 4 May 2022.

What we did before inspection

We reviewed the safeguarding concern that triggered this inspection and any information we had received from the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people using the service and seven relatives about their experience of the care provided. We spoke with nine members of staff, including the director, nominated individual, registered manager and care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included 12 people's care records and multiple medication records.

We looked at all care staff files in relation to recruitment, training and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. We continued to seek clarification from the provider and registered manager to validate evidence found. We sought feedback from external professionals involved in the service.

Inadequate

Is the service safe?

Our findings

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

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

Assessing risk, safety monitoring and management
At the last inspection we found the provider had failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate risks. This placed people at risk of harm and was a breach of Regulation 12 of the Health and Social Care Act 2008. At this inspection we found the concerns which led to the breach at the last inspection had not been acted upon and people continued to be at risk of harm.

- People's care plans did not contain enough information for staff to understand how to mitigate risks. Although some risks relating to people's assessed needs were identified, we found there was no guidance to identify actions staff should take in the event of the risk occurring. For example, some people had a diagnosis of diabetes. Although care plans identified they had diabetes, there was no risk assessments for staff to understand the associated risks, such as the signs to look for if a person has too low or too high blood sugar and what action they should take. A person told us about a recent incident when staff had failed to recognise, they had low blood sugar and were at risk of harm. This resulted in the person being left by staff and found with dangerously low blood sugar levels by a relative, who took the required action to prevent further harm. This meant we were not assured staff understood risks and what action to take.
- Furthermore, where people's care plans identified their health needs, there was a lack of information about any associated risks. For example, one person had a catheter. There was no risk assessment in place to guide staff to recognise if action was needed such as, contacting medical professionals. They were also identified as being at risk of falls, there was no falls risk assessment or guidance for staff to mitigate this risk.
- Another person's care plan identified they had a grade two pressure injury. However, we reviewed their care plan, there was no information about the risk of pressure injuries or how staff should mitigate these risks. We raised these concerns with the registered manager and this person's care plan was updated to identify they needed, 'A turning regime'. However, there was no information or guidance for staff about how often the person should be re-positioned, or records to demonstrate which position the person should be moved to each time. This is important to avoid continual pressure in one area of the skin and any injuries getting worse. In addition, some people's care plans identified they required equipment to safely move. There was no detail to mitigate associated risks or description for staff on how to manage manual handling safely.
- Other people's care plans described bed rails being in place to prevent them from falling out of bed. There were no risk assessments to identify the potential risks of people using them or to demonstrate they had been assessed for the use of this equipment. The use of bedrails had not been identified as restrictive practice. Although bedrails are usually put in place to protect the person, this equipment restricts a person's ability to freely get out of bed. The risk needs to be recognised and recorded to demonstrate it is felt proportionate and necessary.

● Information in people's care plans did not consistently recognise where risks linked to other assessed needs. For example, one person's care plan identified they had diabetes. However, in the nutrition part of their care plan there was no information about this or the potential risks from higher sugar content foods.
● We discussed all these concerns with the registered manager who took action to update people's care plans to include information and guidance for staff to mitigate risks. At the comprehensive inspections of the service in May 2019 and September 2020 we found the provider had also failed to assess the risks to the health and safety of people.

We found at this inspection the provider had continued to fail to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any such risks. This placed people at continued risk of harm. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed safely. The provider used an electronic medicines administration record (MAR), to record when people received their medicines. However, this did not record the exact time medicines were administered to people. For example, one person was prescribed Paracetamol four times a day. Their MAR record showed they were receiving this medicine as prescribed. We reviewed their daily visit records and saw that between 2 May 2022 and 4 May 2022, there were four occasions when the gap between staff visits was less than four hours. We could not determine at what point during the visits the person received their medicines. However, even taking this into account, the maximum amount of time between the arrival and departure of staff who were administering their medicines, was less than four hours on these four occasions. This placed them at risk of harm.
● Where people received 'as and when required'(PRN) medicines, there was a lack of information to guide staff when to give them. For example, one person was prescribed Lactulose solution PRN, which is prescribed to manage constipation. Their medicines record did not describe what this was for or when to give it. Staff may not recognise when they should administer this medicine to prevent associated risks from constipation, which would put the person at risk of harm. Another person was prescribed three different topical creams to be applied PRN. Their care records did not describe when staff should apply these topical creams, for example, if their skin looked red or sore. Their care plan only instructed staff to, 'ask the person'. However, the person had a type of dementia that can cause both visual, auditory and behavioural disturbances, so they may have been unable to determine if and when they required their topical cream. We discussed this with the provider and following the inspection the provider told us they had added PRN details to their electronic care records system.
● Staff had not always received training in safe administration of medicines. Records showed evidence staff administered medicines to people without being sufficiently trained to do so. One staff member confirmed they were administering medicines to people and had not received training to do so. They said, "Yes, I do support people with their medicines, but I haven't done the training." Another staff member told us, "I administer with somebody [another staff member]. I've been with seniors [staff] when I have done [administered] medicines but have not done the online training, if there is any."
● Senior staff were assessing care staff members competency to safely administer people's medicines. However, the provider did not have a system in place to ensure that senior staff, who were carrying out this role, had the necessary knowledge such as completing additional training, or being assessed or monitored by the registered manager to be able to demonstrate best practice. Therefore, we could not be assured staff who were responsible for the training and assessment of staff competence to administer medicines, had the skills and knowledge to do so.
● The provider had previously failed to ensure people receive their medicines safely, we breached them for this following the comprehensive inspections of the service in May 2019 and September 2019. Although, we

found improvements had been made following the focussed inspection in September 2020, they have been unable to sustain these improvements.

The provider and registered manager failed to provide safe medicines management. This placed people at risk of harm and is breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At the last inspection we made a recommendation that the provider review and update their infection control policy to include up to date guidance for staff in relation to Covid-19. We found this had not been done.

● We asked for the providers infection control policy and any other policies they had in relation to COVID-19. The provider had failed to update their infection control policy to include information about COVID-19. We discussed this with the provider, who then shared with us their 'COVID-19 infection control measures policy.' However, we were not assured this policy had been in place prior to us raising concerns.
● We found some staff had not received any infection control training and although others had completed workbooks in infection control in 2020, there was no evidence to demonstrate if they had achieved the pass rate of 75% required, or these had been checked and verified by someone with the skills and knowledge to do so. We reviewed the workbook one staff member had completed for infection control training. The workbook did not include any information about COVID-19 and the measures needed to reduce risks to people. Therefore, we were not assured staff had received training in infection control to include information about COVID-19 and understood the risks to enable them to keep themselves and people safe.

The failure to act on the previous recommendation to ensure there was an up to date infection control policy and to ensure staff had received sufficient training in infection control, was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Although people told us they felt safe, the provider did not have consistent or robust systems in place to safeguard people from harm and abuse. The registered manager and provider had failed to recognise safeguarding incidents or to take action to safeguard people using the service. Records had not been made for two incidents of abuse, to reflect they were safeguarding concerns. Information was not shared with the local authority in line with local procedures and action was not taken to safeguard all people who continued to be at risk of harm. CQC informed the local authority of these safeguarding concerns.
● The provider had a 'safeguarding service users from abuse or harm' policy in place. However, this policy had not been followed. For example, in December 2021 a care worker raised concerns with the registered manager about one of these allegations of abuse. Despite these concerns being raised with the management team, a safeguarding referral was not made to the local authority and this was not reported to Care Quality Commission (CQC), as required. This meant this person and others continued to be at risk of harm. Although the provider and registered manager told us they had investigated the allegation at the time, no records were made of this and they failed to recognise the potential of harm to other people they had a duty to safeguard from abuse.
● The systems in place for staff to record concerns raised about the safety and welfare of people who used the service, had failed to recognise these incidents as safeguarding. This included lack of management oversight to ensure action was taken where required.
● All care staff had not received up to date training in safeguarding. Staff told us, they reported concerns through the providers electronic record system. One staff member said, "I report concerns to the [registered]

manager immediately. They would investigate it and try to resolve it. I would assume they have an obligation to contact CQC or at the very least the local authority."

The failure to protect people from abuse and improper treatment and a failure to have effective systems and processes in place to prevent abuse of people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At the last inspection we made a recommendation the provider seeks reputable guidance on the safe recruitment and employment of staff and updates their practice accordingly. This was a repeat recommendation from the previous inspection. At this inspection we found the provider had made some improvements but systems to ensure records were in place prior to staff going into people's homes were inconsistent.

● Recruitment practices were not always robust. On the first day of our inspection, one staff member had no records of recruitment recorded on the providers electronic system. For example, there were no references from previous employers to demonstrate good character, no disclosure and barring check (DBS) and no photographic identification. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. We raised significant concerns with the registered manager about the safety of this staff member and they confirmed they had not seen any recruitment records for them. Following this, the provider was able to demonstrate they did have the required records for this staff member, which had been stored at another location. However, the registered manager had allowed this staff member to support people on their own, without being assured the required checks were in place.
● People who were most at risk if a visit was missed, were identified, contingency plans were in place and records demonstrated people did not have missed visits. However, this was partly due to the registered manager and deputy manager providing care visits to people. This had impacted on their ability to carry out their management roles.
● Records demonstrated people received their scheduled visits, staff were frequently on time and people told us they were supported by regular staff. One person told us, "I know all of them and know their names. They are all very good." Another said, "I usually know who the carer is, and they are on time most of the time, but sometimes they are held up."

Learning lessons when things go wrong
● When things went wrong, lessons were not always learnt to support improvement, and this was evident from our findings at this inspection and in all previous inspections. This meant the service did not demonstrate learning, reflective practice and improvement.
● Safeguarding events were not always recognised or recorded. The provider and registered manager were unable to demonstrate if accidents, incidents and safeguarding events were analysed to identify if any themes or trends were occurring. We could therefore not be assured if action would be taken to address any recurring patterns.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
At the last inspection we found the provider had failed to work within the principles of The Mental Capacity Act 2005. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider continued to be in breach of this regulation.

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's consent to general care and treatment, had been sought and recorded. However, we found some people's care records indicated they had a diagnosis of dementia and their relatives had signed the consent form on their behalf. Although we found one person had a record to demonstrate their relative had a power of attorney for health and welfare, giving them legal power to consent on their behalf, other people's relatives who had signed the consent form, did not. If people are unable to consent to their care and support needs, another person cannot consent on their behalf unless they have the legal right to do so. We discussed this with the registered manager who told us they would review people's records.
● Mental Capacity Assessments and Best Interest decision had not been completed where care records indicated they were needed. For example, one person's medicine's assessment stated they, 'Can't read the label and will forget their medications.' Staff administered their medicines. There was no MCA completed to demonstrate if the person's capacity had been assessed for this decision. We discussed this with the registered manager who confirmed the person would forget their medicines and may lack capacity, which is why staff administer. Another person's care plan identified there were known risks around their medicines. The assessment stated they, 'Can sometimes refuse to take medicines or forget, staff to encourage.' There

was no MCA or best interest decision in place.
● Two people's care plans identified they had bed rails in place. They both had a diagnosis of dementia. There was no MCA or best interest decisions for these restriction on their liberty.
● At the last inspection we found people did not have MCA assessments where needed and had raised this with the provider and previous registered manager, who gave assurances these would be completed. At this inspection, the registered manager and provider gave us further assurances they would review people's care plans and complete MCA assessments and best interest decisions where required.
● Staff had not always received MCA training. At the last inspection we received assurances from the provider all staff would complete this training. A staff member told us, "If the person hasn't got capacity, we refer to the care plan, contact the power of attorney (POA) or advocate." However, people's care plans did not demonstrate assessments were being completed when required. This meant we were not assured all staff would recognise if a person required a mental capacity assessment. We discussed this with the provider and registered manager who gave us further assurances all staff would complete this training, to ensure they understood the principles of the MCA.

The provider and registered manager had failed to work within the principles of The Mental Capacity Act 2005. This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
At the last inspection we made a recommendation the provider review their training and supervision guidelines and seek reputable guidance to ensure all staff receive supervision and training in line with their policy. We found the provider had failed to act on this.

● Staff had not received sufficient training to enable them to carry out their roles safely. The provider had a list of mandatory training staff needed to complete, but not all staff had done so and were providing care to people. For example, some staff had not completed training, including but not limited to, dementia care, medicines administration, safeguarding, first aid and moving & handling practical assessment. Furthermore, regular agency staff used, did not have records to demonstrate they had received detailed training to equip them in their roles. For example, one agency staff had completed a list of 13 different training subjects in one day. We were not assured areas such as safeguarding, food hygiene and moving and handling could all be sufficiently covered within one days training.
● Some staff who had been employed for over a year, had completed training workbooks in some of the providers mandatory training in 2020. However, there was no evidence these staff had achieved the stated pass rate of 75%, there was no signature of an assessor or trainer and workbooks were only partially completed.
● Furthermore, there was no evidence staff had been assessed to safely use specific equipment with people, such as hoists, slide sheets and stand aids, all of which were evidenced to be in use within people's care plans. Staff had completed online moving and handling training in 2022 with no practical assessment of the use of equipment. One staff member said, "In my role up to now I feel confident, but I've done lots training face to face in previous roles [previous employment]. No, I wouldn't feel confident if I hadn't done this as it's not the same online [training] as actually doing it."
● Additionally, staff had not completed training in other areas such as diabetes care, catheter care and pressure care. This was important as people's care plans identified they had these additional needs. We raised this with the provider as a matter of urgency and they took action to ensure staff completed this training. However, we were not assured staff had received all the training they needed to enable them to provide safe care to people and understand how to mitigate associated risks.
● The provider told us they had an induction process for new staff which included completing their

mandatory training and shadowing other staff on visits to people. However, we found staff were delivering care without having their induction period reviewed and completed. One staff member told us, "I didn't get an in-depth induction because I had worked before in a care home." Another said, "I haven't had an induction. I went to the office, met the managers and they put me straight onto a call out [care visit]. I have read policies and procedures."

● Although some staff had basic competency checks for using equipment to move people safely, the staff signing them off as 'competent', had not completed any higher level of training such as a 'train the trainer' course themselves. We were not assured staff completing these competency checks had the skills and knowledge to assess other staff as competent.

● Staff were not receiving consistent and effective supervision to provide support, identify any training needs or consider ongoing development. Although some staff had supervisions recorded, these were not regular. We discussed this with the registered manager who told us they were reviewing all staff and booking in supervisions, which we saw evidence of following our visit to the office.

The failure to ensure all staff receive appropriate support, training and an induction to enable them to carry out their duties was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to our concerns about staff training during the inspection. They provided evidence that staff had completed some of the required training. However, we were not assured this training gave staff the skills they required to mitigate risks to people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were not always fully assessed prior to the service providing support. This was important to ensure the service had suitable numbers of staff with the right skills, knowledge and any equipment required was in place to meet the person's individual needs. For example, initial assessments completed were not detailed, were not person centred and failed to identify all risks associated with people's health needs or mobility. We discussed this with the registered manager who told us they would review all people's care assessments to ensure they had the required information. However, we were not assured systems were in place to ensure essential information was recorded within people's electronic care record prior to receiving a service and this placed people at risk of harm.

● Care plans did not cover the full range of people's needs. They lacked person centred detail and guidance for staff. The electronic care records the provider used, asked questions about people's needs. These were answered using a drop-down option. However, they lacked detail about how each person wished to be supported. For example, one person's care plan asked if they could dress themselves. The answer recorded was, 'Yes, independently (with or without equipment). Needs encouragement to change their clothes.' There was no detail about how staff should encourage the person, such showing them a choice of clothing or laying clothes out so they could put them on easily. Another person's care plan asked if they could wash themselves. The answer recorded was, 'No, fully dependent. Will require assistance to complete a full body wash.' There was no detail about how staff should support this person, such as if they liked to use a flannel or a sponge, if they could wash some areas themselves, or where they liked to wash such as in the upstairs bathroom, or using a bowl of water in the bedroom. We raised these concerns with the registered manager and following our inspection, people's care plans were reviewed and updated to reflect more person-centred information.

● People did not have paper copies of their care plans in their homes. We discussed this with the registered manager and provider, who told us people could have access to the electronic care records system. However, consideration had not been given to people's right to have access to their own care plan and their individual ability to access an online system.

The failure to assess people's individual needs, including their health, personal care, emotional, social and cultural needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The Equality Act 2010 is designed to ensure people's diverse needs in relation to age, disability, sex, marital status, gender reassignment, pregnancy, race, religion and sexual orientation are met. People's care records demonstrated these protected characteristics had been explored and documented for people.

Supporting people to eat and drink enough to maintain a balanced diet

● Most of the people we spoke with said they, or a relative prepared their meals. Those people whom staff prepared meals for, were happy with the way this was done. One relative said, "They [staff] prepare [person's] meals. My [person] has cornflakes in the morning, they make a sandwich and put it in the fridge." Another said, "Yes, [staff] get their [person's] lunch. They [staff] will ask them [person] what they want."

● However, we found care plans lacked detail about people's nutritional needs. For example, one person's care plan identified they were, 'impaired when swallowing.' There was no information about what this meant for the person and the associated risks. We discussed this with the registered manager who confirmed, "[Person] does cough and can choke." The registered manager took immediate action to update the person's care plan to reflect this risk with guidance for staff on how to mitigate it.

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

● Care plans, medicines information and risk assessments were not up to date. We have reported more about this in the safe domain of this report. If these were shared with healthcare professionals in an emergency, they would not have relevant and up to date information. This was important to ensure people's needs were met if they moved between different services and meant people were at risk of harm.

● Staff contacted healthcare professionals to ensure people had access to health services and had their health needs met.

● Records confirmed people had regular access to GPs, district nurses, continence teams and other professionals. One relative told us, "One time [person] was on the floor in the kitchen and they [staff] called an ambulance for them. They called me to let me know." A person said, "When I needed an ambulance, they [staff] waited until the ambulance had come."

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created 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
At the last inspection, the provider had failed to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and the provider and registered manager continue to be in breach of this regulation.

● The service was not well managed. The registered manager and provider had limited and ineffective quality assurance processes in place, to monitor and review the overall quality and safety of the service provided to people.
● At our last inspection, the provider audited care files, this was not effective. They told us they would review their audits and add detail about what was being looked at, to enable them to identify any areas of concern and take action. At this inspection, we found this had not been effective. Some audits had been completed but they did not identify the issues found during the inspection or drive the necessary improvement. Systems and processes failed to identify care plans did not reflect people's current needs and did not contain all the necessary guidance for staff to support people safely. We have reported more about this in the safe domain of this report.
● Quality assurance processes in place failed to effectively monitor and drive improvements in relation to recruitment processes, staff training, infection control, accidents and incidents including safeguarding concerns. We found concerns in all of these areas.
● Effective systems and processes were not in place to recognise safeguarding concerns. This meant action had not been taken to keep people safe. The provider and registered manager failed to make records of concerns raised and any subsequent investigations they may have completed. Furthermore, they failed to take action to safeguard people from the risks of further harm. Where records were made these lacked detail and transparency.
● Systems and processes in place failed to ensure staff had completed the providers own mandatory training. Staff had not always received specific training to be able to safely meet people's needs which led to people being put at risk of harm. In addition, systems and processes in place to monitor staff recruitment, had failed to identify where staff had a legal limit on the number of hours they were permitted to work. We discussed this with the providers who told us they would review their systems and ensure staff did not work over any permitted limits. We shared this information with the relevant legal body.
● Policies and procedures were in place to aid the running of the service. For example, there were policies in

relation to safeguarding, whistleblowing, equality and diversity, and infection control. These were accessible to staff. However, we were not assured these were being robustly implemented or understood, due to the concerns we found.
● Although the registered manager and provider told us they were committed to making improvements at Infinite Care, this was the fourth inspection where the provider had failed to make the changes required and attain a rating of good.

The ongoing failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager and provider had not notified CQC about all incidents, safeguarding concerns and events that were required. Although, we were notified of one event, this was after we raised concerns in relation to that event with the registered manager and provider.

The failure to notify CQC of significant events without delay was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At the last inspection we recommended the provider review ways to engage people and their relatives to seek their feedback and strengthen their processes for enabling people to contact them. At this inspection we found although some improvements were made, this was not consistent and people, their relatives and external professionals were not given regular opportunities to provide feedback about the service.

● People's views were not consistently sought. Although, some people had reviews of their care, most of these had occurred since we started our inspection. Prior to this we found only three people's views had been actively sought by the registered manager and provider. Systems in place to enable people using the service to have the opportunity to give feedback, were not consistent or clear.
● People's relatives and external professionals were not asked for feedback on the service provided. One relative said, "No, I've not been asked for feedback. I am not sure if they have called my [relative], but they haven't called me." We requested records to demonstrate feedback is sought from people, their relatives and external professionals but these were not received.
● People and their relatives told us they knew who the provider or registered manager were and how to contact the office if they needed to. Comments included, "I think they [management] do the best they can, on the whole they are not bad at all", "I have spoken to the [registered] manager, who came when they first started" and "It probably could be managed a bit better."
● Support for staff from the management team was poor. Staff meetings were not regularly held. A staff member said, "We have never had one [staff meeting] since I have been there." Although spot checks had been completed to monitor staff competency, these were done by staff who had not received additional training to do so. Staff were not consistently getting the opportunity to receive support, raise concerns, or identify their training needs. This led to poor outcomes for people. We discussed this with the registered manager who told us they were working to ensure staff had regular opportunity for support and to feedback.

● However, staff felt they could receive support from the registered manager if needed. A staff member said, "I have always found [registered manager] to be extremely capable and approachable. Another said, "[Registered manager] is helpful. They are there, but I don't go into office much or have a lot of dealings with them."

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

● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. The providers policy stated they would, 'undertake to put in writing what has happened and the apology, keep full records of the incident, including all associated correspondence and the actions that have been taken to carry out the duty of candour with the service user and / or representatives.' However, we found this policy had not been followed when safeguarding incidents had occurred. Records had not always been made and mistakes were not identified and apologised for in a timely way.

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

● People were not always receiving person-centred care and support. People's care records lacked detail and did not fully capture their individual needs and wishes. We discussed this with the registered manager, who took action to update people's care plans.

● People were not empowered because there was a lack of understanding of the MCA process. You can read more about this in the effective section of this report. However, people and their relatives told us they were happy with the care provided. Comments included, "I have always been happy [with the service], I am very happy with them, but they seem to vary [managers]", "They [management] seem reasonable. The main ones we deal with are the carers who come in, they have never let us down yet" and, "If they [staff] have to do anything they say, 'is that alright, is there anything else you want doing'. They are very caring."

● Many of the staff had only worked at the service for a short time. However, they demonstrated a commitment to the people they supported and told us they wanted to provide good care. One staff member said, "I tend to go to the same clients every day, I know them." Another said, "We have the time to provide people with the care they need. I have a nice regular round in one area."

Continuous learning and improving care

● Shortfalls identified at previous inspections had not been addressed. Where we made recommendations, these had not been followed so that improvements were made where required.

● Despite the service receiving a rating of requires improvement at the last inspection and the provider having a condition on their registration, requiring them to take monthly action to make the improvements needed, there was no ongoing improvement plan in place. Systems and processes in place to monitor the effectiveness and safety of the service had failed to identify the concerns we found. We were therefore not assured that there was a culture of learning and development within the service. The provider completed an action plan following concerns raised with them during the course of this inspection.

Working in partnership with others

● The provider and registered manager told us they were open to working with external professionals and seeking advice and support where needed.

● The registered manager told us they worked in partnership with external professionals to seek advice and support, so people's needs were met. Records demonstrated staff raised concerns with health and social care professionals, including community nurses and GP's, although we were not assured staff always understood risks or had received the training to consistently recognise when to do so. This is described in the Safe and Effective domains of this report.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of significant events without delay which placed people at continued risk of harm.

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 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager failed to assess people's individual needs, including their health, personal care, emotional, social and cultural needs.

The enforcement action we took:

We have cancelled the provider's and the registered manager's registration

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider and registered manager had failed to work within the principles of The Mental Capacity Act 2005.

The enforcement action we took:

We have cancelled the provider's and the registered manager's registration

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had continued to fail to assess the risks to the health and safety of people to mitigate risks, failed to provide safe medicines management and failed to ensure there was an up to date infection control policy and staff had received sufficient training in infection control.

The enforcement action we took:

We have cancelled the provider's and the registered manager's registration

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager failed to

	protect people from abuse and improper treatment and to have effective systems and processes in place to prevent abuse of people.

The enforcement action we took:

We have cancelled the provider's and the registered manager's registration

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager failed to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and contemporaneous records.

The enforcement action we took:

We have cancelled the provider's and the registered manager's registration

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager failed to ensure all staff receive appropriate support, training and an induction to enable them to carry out their duties.

The enforcement action we took:

We have cancelled the provider's and the registered manager's registration