Perennial Investment Limited

Infinite Care

Inspection report

Cams Hall
Cams Hill
Fareham
Hampshire
PO16 8AB

Tel: 01329227436
Website: www.myhomecare.co.uk

Date of inspection visit:
18 January 2019

Date of publication:
21 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:

Infinite Care is a provider of community home care services. It provides personal care to people living in their own houses and flats in the community. It provides a service to younger and older adults. At the time of the inspection they were providing personal care to 26 people across Hampshire.

What life is like for people using this service:
•People did not always receive a service that provided them with safe, effective and high-quality care.
•The management of risk was not always ineffective and placed people at risk of harm.
•The management of medicines was not always effective which meant people were at risk of harm.
•People's human rights were not always upheld as the principles of the Mental Capacity Act 2005 were not understood by care workers.
•People were not always provided with support that was personalised to them.
•The service was not well led and there was a lack of robust and effective quality assurance processes in place.
•People told us that care workers were very good and that they were happy with the service being provided.
•More information is in the detailed findings below.

Rating at last inspection:
The service was first registered with the Care Quality Commission on 14 March 2018. This was their first inspection since registration.

Why we inspected:
This was a planned comprehensive inspection. Newly registered services are inspected within a year of their first registration.

Follow up:
At this inspection the service has been rated 'Inadequate'. Therefore, the service is now in 'Special Measures'. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

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

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.

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 not safe

Details are in our findings below.

Inadequate

Is the service effective?

The service was not always effective

Details are in our findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive

Details are in our findings below.

Requires Improvement

Is the service well-led?

The service was not well-led

Details are in our findings below.

Inadequate

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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection Team: The inspection team consisted of two 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 older people, with varying needs, living in their own homes.

The service did not have manager registered with the Care Quality Commission. A registered manager is legally responsible for how the service is run and for the quality and safety of the care provided. An acting manager was in post who told us they would be applying to become the registered manager.

Notice of inspection: This inspection was announced. We gave the provider 24 hours' notice of the inspection site visit to ensure the acting manager would be present, and to ensure people's consent was gained for us to contact them for their feedback. We visited the office location on 18 January 2019 and met the acting manager, office staff and to review care records, policies and procedures.

What we did: Prior to the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

This inspection included speaking with ten people, three relatives, three members of staff, the acting manager, the provider and a director. We reviewed records related to the care of five people. We reviewed

recruitment files for four staff. We looked at records relating to the management of the service, policies and procedures, quality assurance documentation and complaints information. We asked for further information following the inspection including the end of life policy and additional care plans, and these were received.

Inadequate

Is the service safe?

Our findings

People were not safe and not protected from avoidable harm. This was because risks to people had not been managed effectively.

Assessing risk, safety monitoring and management:
• People told us they felt the provision and delivery of care was safe. One person told us, "I am well looked after, it's good to know that I can stay in my own home rather than having to go into full time care." A relative told us, "We are so pleased our relative is safe and someone is taking care of them and keeping them safe."
• However, risks to people had not always been assessed, monitored or mitigated effectively. One person's daily care notes identified that they had fallen on two occasions. This demonstrated that they were at risk of falls. However, a falls risk assessment was not in place and their care plan failed to provide guidance on how to manage and mitigate the risk of falling. This person also smoked and had a history of accidently causing small fires within their home. Input had been received from the local fire service. However, the provider failed to implement a risk assessment. Therefore, guidance was not available to care workers on how to manage the risks associated with burns. Documentation also reflected that care staff noticed this person had recently sustained a burn to their finger which had been documented in their daily care notes however was not reported the management team. This meant no medical assistance had been sought to review the burn and it subsequently became infected. The environmental risk assessment identified smoke alarms to be tested weekly however there was no documentation to evidence that this took place. Care workers told us they would look in people's care plan to identify risks to people.
• The risks associated with insulin controlled diabetes and catheter care had not been assessed or mitigated. One person, who started receiving care on 4 July 2018, was living with diabetes, however there was no diabetes care plan or risk assessment available. There was no information available on the signs or symptoms which might indicate that the person was experiencing high or low blood sugar levels which might need medical attention. One person received support from care workers to manage the care of their catheter. There was no information in the care and support plan to guide care workers on how to do this safely whilst also reducing any risks of infection.
• Where people lived with specific health conditions, such as Parkinson's Disease, detailed risk assessments and guidance were not in place to guide care workers on how to provide safe care and support. For example, one person's care plan states, 'Assist [Person] to the bathroom' however there was no further information to say how to assist this person. The acting manager told us it had been difficult to get risk assessments done prior to the deputy manager starting a few weeks ago. One of the directors told us when the last manager left, "There was a big backlog, we employed the deputy manager and we are just catching up with what hasn't been done."
• Daily care notes demonstrated that one person had been tearful on staff arrival and said they had fallen. Documents demonstrated they were low in mood and tearful on the day and in low mood for several days. After six days they were complaining of pain and struggled to stand up, they were still complaining of pain on the seventh day, no medical support was accessed for this person.
• The system to record accidents and incidents was ineffective. Documents demonstrated that there had only been one recorded incident since the service began operating in March 2018. However, care records demonstrated that although accidents and incidents had occurred, these had not been recognised as

incidents or accidents and therefore not recorded appropriately. This also meant that further investigation did not take place to ensure all remedial actions were taken to manage any new or emerging risks and learning was not identified. For example, a care worker found a person on the floor when they visited on two occasions. The failure to identify this and record this as an incident and accident meant there was no oversight of this person's falls and no learning derived.
• The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:
• Most people managed their own medicines, although care workers did administer or support some people with their medicines. Where this was the case, care plans lacked guidance on the level and type of support required.
• Where people were being supported with 'as required' or PRN medicines, there were no protocols or risk assessment in place to guide staff on how and when these medicines should be administered. For example, one person's care plan stated, '[Person] self-medicates apart from their Oramorph Liquid. It is a Pro Re Nate (PRN) and is to be taken orally to relive pain. [Person] will need assistance with the drawing up of this medication. Follow GP/pharmacy instructions.' This meant that care workers did not have clear guidance which increased the potential risk to people who were being administered medicines.
• One person required support with topical creams, their care plan stated that they could become disorientated which meant they could not always be relied on to inform staff where the topical cream should be applied. There was no guidance or body map to guide staff where to apply the topical creams. This meant that with a lack of guidance there was an increased risk of creams being applied to the wrong area.
• The acting manager told us that when care workers supported people to administer their medicines, this was recorded on a medicines administration record (MAR) chart. The service had been in operation since March 2018 and no MAR charts had been returned to the office for oversight or auditing. The provider was therefore unable to demonstrate that people had received their medicines as prescribed and that MAR charts were being completed accurately and correctly. This posed a risk to people because the provider did not have any oversight and would not be able to pick up on potential medicines errors in a timely manner.
• Staff had received medicine administration training and the deputy manager told us competencies are assessed during observations however there was no documentation to support this.
• The failure to ensure the proper and safe management of medicines was a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Safeguarding systems and processes:
• A detailed 'safeguarding service users from abuse or harm policy,' was in situ. However, this policy had not been followed. For example, on the 18 December 2018 a care worker emailed the deputy manager, acting manager and provider to raise a safeguarding concern. Despite these concerns being raised with the management team, a safeguarding referral was not made and this was not reported to CQC (Care Quality Commission). This meant this person was at risk of harm in their home and the provider did not share this information with anyone. The provider failed to follow their policy and safeguard the individual from the risk of potential harm and/or abuse.
• We talked to the management team about how they ensure care workers are aware of abuse and how to report it and the acting manager told us that it is part of care workers inductions that care workers are encouraged to report concerns. He told us, "Meetings would make a huge difference, and us auditing on time." Despite staff training, safeguarding concerns had not consistently been raised with the local authority.
• A 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) regulation 2014.

Staffing levels:
• The provider had not always ensured there were enough care workers so that people received support in a timely way. The provider had taken on additional care packages without being confident that they had the staff in place to provide the care and were therefore having to regularly cover care visit themselves. There was an electronic call monitoring system in place which meant the management team were able to monitor care workers attendance and length of visit however this was not monitored outside office hours. This meant that if a care worker did not turn up for an evening visit or weekend visit the management team would not be aware of it until they next logged on unless the person was able to contact the out of hours number. The acting manager told us they were planning an upgrade to the system which would then alert them if care workers had not attended a call.
• People and their relatives said they would recommend the service although Infinite Care do not have enough staff, relatives said, "Infinite are recruiting." One person told us, "The manager comes and washes me as I have no shower facilities."
• The provider had followed safe recruitment practices.

Learning lessons when things go wrong:
• Risk assessments and care plans were not always reviewed following incidents. For example, records demonstrated that one person had fallen twice while but there was no falls risk assessment in place.
• The provider had a system to record accidents and incidents. However, an analysis of accidents and incidents had not taken place, themes and patterns had not been identified and preventative measures had not been put in place.

Preventing and controlling infection:

• People told us care workers practiced good infection control measures and records showed staff had been suitably trained. The acting manager told us, "We provide gloves, aprons, hand towels, foot covers and uniforms, care workers pick up stocks from the office or I will drop them off."

Requires Improvement

Is the service effective?

Our findings

People's care, treatment and support does not always achieve good outcomes, doesn't promote a good quality of life and is not based on best available evidence.

Ensuring consent to care and treatment in line with law and guidance:

• The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
• Despite having received training, care workers were not able to talk confidently about the principles of the MCA 2005. When asked about their understanding of the MCA 2005 was, one care worker told us, "I have two ladies that have dementia, they can be wearing but you have to encourage them to be independent and help them do things," another staff member said, "I don't know." When care workers were asked when they would seek consent form a person, their responses included, "When you go there and if they can't [give consent] their family will tell you," and, "If they are not able to consent it would have to come from their immediate family." These responses did not demonstrate that staff understood the principles of the Act. We spoke to the acting manager and they told us they only supported one person who lacked capacity and their relative had power of attorney however, there was a risk that staff sought consent from family members for other people without following the correct MCA and best interest process. People told us that care workers sought their consent before supporting them. One person told us, "The carers always explain what they are going to do before they do it and ensure I am OK with that."
• The acting manager understood the MCA 2005 and how this might impact on people's care and support, however, there was no evidence that this was always being implemented in practice. Some care plans did not include evidence of consent from people. The provider was unable to demonstrate that people consented to their care.

A failure to provide care and treatment of people without the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff skills, knowledge and experience:

• People told us that care workers were competent, knowledgeable and carried out their roles effectively. One person told us, "My care is second to none and I cannot fault any part of my care it is excellent." A relative told us, "As a relative I can only comment on my observations and I have only seen professionalism and quality care." Despite these positive comments staff had not received training in specialist areas such as catheter care and Parkinson's, only one person had attended diabetes training and risk assessments were not available to guide staff which meant although staff were kind they did not have the necessary information required to provide care which met the holistic needs of people. This meant there was a risk that staff would not know how to support people appropriately and know when medical assistance was

required.
• Staff had received training in the administration of medicines however there was no documented evidence that medicines competency assessments were undertaken. The deputy manager told us, "We need to develop better documentation around ensuring staff medicine competencies, we do it through observations." They told us that they had already identified this as an area for improvement and showed us a new medicines competency form they were going to introduce.
• Staff had completed an induction which included three days of mandatory training and a one-day information day at the office. A director told us, "We let staff shadow until they are 100% confident." However, staff had not been receiving supervisions or appraisal and there had been no staff meetings. This meant that staff did not receive ongoing support and development in their role and had no opportunity to review their past and current performance. Staff told us that if they had a problem they would pick up the telephone and would be supported. The acting manager told us, "We plan to schedule [supervisions] before the end of the month." A director reiterated that the previous manager had left a back log and they were just catching up with what hadn't been done. The providers policy states, 'From April 2015 staff new to care work will receive a Care Certificate if they complete successfully their 12 weeks introductory training programme, which will allow them to work without being under direct supervision.' However, staff had not had the opportunity to complete the Care Certificate and Infinite Care was first Registered in March 2018. This certificate was designed for new and existing staff, setting out the learning outcomes, competencies and standards of care that are expected to be upheld. The provider was unable to demonstrate that staff had an understanding of the care certificate requirements.

The failure to ensure staff receive appropriate support and training 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 - Staffing.

Eating, drinking, balanced diet:

• Where people needed support with their nutrition and hydration needs, this was provided. Care workers supported with basic preparation of breakfasts and checked people were having enough nutrition and fluids. Any main meals were pre-packed and microwaved with choices for people.
• One person told us, "I usually get the same carer and although I don't get my food made for me she makes a good cup of tea if she has time". One person's care plan identified that they would like a flask of hot water in their bedroom and milk so they could make their own tea between visits. Care records demonstrated that this was provided.

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

• There was no documented evidence that people's needs were assessed before the service began to provide support. This was important in order to provide assurances that the service had suitable numbers of staff with the right skills and knowledge to meet the person's needs. We spoke to the acting manager about this and they told us, "The assessments are normally completed on a blank care and support plan, these are disposed of when the care and support plan was written." We spoke to the acting manager about this and they told us they would make sure assessments were recorded and kept in future. The provider did carry out a home safety visit which was clear and detailed for one person. General care plans that were in place lacked detail and did not address the whole person, including their physical, mental, and emotional health, while taking social factors into consideration. There was a risk that people did not receive holistic care that was specific to their needs.

Staff providing consistent, effective, timely care:

• Where people required support to access healthcare professionals this was not always organised. One person told us, "Sometimes the care worker will ring the GP and arrange an appointment but I can usually do this myself." We saw evidence that staff had not always called for medical advice in a timely manner and this led to people experiencing prolonged pain. This has been written about further in the safe domain in relation to falls. An assessment of needs in their care and support plan in relation to pain stated 'No support needed at this time.' The acting manager and deputy manager were not aware of this fall, they told us it had not been reported to them by staff and they had not reviewed the care records as they were stored in the persons home and had not been taken to the office or reviewed. There are several entries describing this person as crying and in pain however no documentation to demonstrate if this was looked into or medical support sought. The acting manager and management team informed us that they will be collecting all daily care notes at the end of each month to review them. They also told us they would speak to staff about the importance of informing them of any incidents to reduce the risk of this occurring again. There was evidence that in an emergency situation staff had contacted an ambulance in a timely manner.

• Care plans did not cover a full range of people's needs. They lacked person centred detail and guidance for staff. For example, one care plan states 'I need support with dressing and undressing due to my limited mobility.' However, it does not detail how their mobility affects them and what support is required. Another care plan states, 'Assist [person] into the bathroom.' but does not go on to say what assistance is required. This meant that staff did not have the information required to support a person effectively.

• Staff told us they handover process where they information to each other about people's changing needs by recording on the intervention sheets.

A failure to assess, monitor and mitigate risks relating to the health and safety of service users was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance.

Requires Improvement

Is the service caring?

Our findings

The provider did not always involve and treat people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported:

• People spoke positively about the support they received from their care workers. Comments included, "What can I say, they are so good all the time," "My carers are very kind but they are just so busy getting everything done. I know they would like to stay and chat but there isn't time," and, "My carers are exceptional, I don't know about training but patience, care and kindness always." Despite these positive comments we found concerns with the management of medicines, risk and governance which meant that people were not always treated well and supported according to their needs.

Supporting people to express their views and be involved in making decisions about their care:
• Staff recognised what was important to people and respected this. One person told us,
"I do like a routine and the carers are happy with that so we all know what the plan will be when they arrive."
• Staff supported people to express their views and maintain their independence. One person said,
"Sometimes if I feel ok I make some tea when the carers are with me and it feels good to do something useful". A care worker told us, "I am very friendly, try not to be too pushy, I encourage them to talk to me about their life," and, "I have a really good relationship with my clients, in the summer I encourage them to go out in the garden, I try to make sure I am not rushing and they know I care."
• The provider started involving people in their care reviews from December 2018 and this was appreciated by those who had had reviews to date. A relative told us, "My spouse would not be able to deal with the care plan reviews on their own so we do it together." Another relative told us, "I appreciate the involvement in my relative's care plan and feel very reassured because of that inclusion." The deputy manager told us they intend to invite all people to a review of their care going forward.

Respecting and promoting people's privacy, dignity and independence:
• Care workers told us how they protected people's privacy and gave examples such as closing doors when assisting with personal care and keeping them covered when supporting people to transfer. One person told us, "The carers understand the need for privacy and avoiding any awkward moments."
• People told us they were treated with respect. One person told us, "The carers always explain what they are going to do before they do it and ensure I am OK with that." Care workers comments included, "I encourage [people] to do as much as they can, they help me with their dressing, I encourage them to drink and eat," and, "I encourage them to do things themselves, they do things with you."
• The Equalities Act 2010 was designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. The care planning process included a section to record information divulged by people with regards to gender, sexual orientation, marital or partnership status, disability, creed, colour, race or ethnicity among others. This demonstrated that staff gave consideration to the characteristics defined under the Act. The acting manager gave an example or someone they supported who had needs in this area.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that responded to their needs

Personalised care:
• People's likes, dislikes and preferences were documented in their care plans however, care plans were not always dated or did not contain sufficient detail to ensure people received personalised care. For example, one person's care plan stated, 'WendyLett sheets in place, ensure there are no rips or tears.' however, there was no information on what a 'WendyLett Sheet' was or how, when and where to use this. A WendyLett sheet is a satin sliding sheet which allows sliding in one direction, but not in the other. Another care plan stated in the medical history, 'COPD, Ankylosing Spondylitis, Psoriatic Arthritis, nerve damage, fractured coccyx bone, damage to the lower front pelvis' however, the care plan lacked detail as to how these conditions impacted upon the person or their support needs. This was a common theme throughout the care plans looked at. The care plans lacked person-centred detail, for example, one care plan stated, 'Fill the basin with water and give [Person] a shave,' there was no information if this person preferred a wet shave or electric shave and it did not guide staff to ask if they preferred a shave, another care plan stated, 'ask if I need my creams applied, and assist if required,' however there was no indication on what creams may be required, where they should be applied and under what circumstance. One care worker told us they administer medicines, "If it is in a blister pack, we have no competency assessments." This meant that if an unfamiliar or new care workers was asked to carry out support they would have very little idea of the specific needs of people, which could put them at risk.
• When asked their understanding of person centred care one care worker said, "To make sure they are clean and they are all nice and tidy and fresh and happy," and another said, "Well I think it is just important to make sure every aspect of their needs is met and privacy kept confidential." Person-centred care is care that is tailored to the needs and aspirations of each individual, not standardised to their condition. It means that the things that are important to the person receiving care and their family are discussed and form the basis of their care. There was a risk that people do not receive person centred care when the people supporting them are unsure what it is.
• The Accessible Information Standard is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Some consideration had been given to providing care plans in an accessible format. A care worker told us that they used pictures identifying night and day for one person who had no concept of time. They said, "Audio feedback is available for people who need it." However, another care worker told us they hadn't heard of the Accessible information standard. The acting manager said they would look into other ways of providing people with information that they could access and understand.

A failure to maintain securely an accurate, complete and contemporaneous record in respect of each service users was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance.

Improving care quality in response to complaints or concerns:

• People and their relatives told us they knew how to make a complaint; A relative told us, "Yes, we know how to complain, it's not been necessary to call yet," and another relative told us, "I would speak to the carer before escalating anything". However, one relative told us they had cause to complain and that it had taken a call to a different authority before any action had been taken. They were not satisfied that their complaint had been effectively dealt with. We spoke to the acting manager about the complaint, they told us it had been dealt with to the satisfaction of the complainant however, there was no documented evidence to support this. We could not be confident therefore that the complaint had been investigated thoroughly and used as an opportunity to drive improvements and manage risks.

The failure to establish and operate effectively an accessible system for identifying receiving, recording, handling and responding to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activity) 2014 – Receiving and acting on complaints.

End of life care and support:
•The acting manager informed us no one was receiving end of life care at the time of our inspection.
• The provider had a policy, based on national guidance, in place to provide support to staff about the actions to be considered when a person was approaching the end of their life.
• Staff had not received training in end of life care. The service was not supporting anyone with end of life care at the time of the inspection however, the policy states, 'Induction training involving end of life care is developed in relation to the Care Certificate framework that is being introduced in 2019.' The acting manager told us that they would like to introduce the care certificate within the next six months.

Inadequate

Is the service well-led?

Our findings

Leadership and management did not consistently assure person-centred, high quality care and a fair and open culture:

• It is a condition of registration to have a registered manager in post. Infinite Care has not had a registered manager in post since 3 May 2018. This meant that the provider was been in breach of their registration for eight months at the time of the inspection.
• The provider did not have effective systems and processes in place to ensure they had a good oversight of the service. There were no quality assurance audits and no action plans to demonstrate how they planned to improve the service. We found the quality assurance processes that were in place to be ineffective and did not pick up on the issues identified during our inspection. These included concerns with records: risk management, and a lack of person centred care. Care plan audits were not in place. The acting manager told us that a shortage of staff and resources had made this difficult.
• We could not be assured that systems and processes were continually reviewed to make ensure they remained fit for purpose.
•The provider had not ensured that there were effective systems in place to monitor and assess the quality of the service, to drive improvements and to ensure compliance with the Regulations. Risks to people had not always been fully assessed or planned for. Throughout this report, we have made several references to records relating to peoples care and support which were not always sufficiently detailed to support staff to meet people's needs.
• There was a failure to maintain accurate and fit for purpose care records. These included missing or incomplete, care plans and risk assessments that were not detailed. There was a risk, if accurate and contemporaneous records were not in place, that this could negatively impact on people's health, safety and well-being.
• This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• We spoke to the providers and management team about the areas for development we had noted such as record keeping, monitoring care records and incidents and accidents, audit processes and risk management most of which the provider did not have adequate oversight of. The provider told us that they will start to do monthly audits to improve this and to check that the managers audits are taking place. The deputy manager told us, "I have planned to do staff file audits every six months," They showed us the paperwork they intended to use. One of the management team told us, "We want to make sure we are running an excellent service." They told us that they were committed to improving the service and added, "We have focussed more on delivering the service rather than documenting things." The acting manager told us, "I feel we are a work in progress with hearts in the right place."

Engaging and involving people using the service, the public and staff; Working in partnership with others:
• Support for staff from managers was poor. Care workers told us they had not had the opportunity for supervisions and appraisal. The 'Supporting Workers' policy talks about specific policies including 'Staff Supervision' and, 'Staff Appraisal' however one of the directors told us, "We do not have a supervision policy." The 'Supporting Workers' policy states, 'Through these policies and corresponding procedures

Infinite Care is able to show how it supports its staff by providing:' things such as induction, training, staff protection from harm as well as, 'defined programmes of staff appraisal and supervision.'
• The acting manager told us of some examples of how they had worked with other agencies to meet people's needs. For example, they said, "[Person] has an advocate and a social worker, we have had a number of meetings with them as a team to discuss their wishes and how best to care for them and [person] has visits from the district nurse for diabetes."
• People told us they had been involved in decisions about their care. One person said, "I think the office people are helpful they take my call and pass on message.
• Surveys to gain feedback about the service had been completed in December 2018. Feedback from people was positive. People's comments included, "Best in six years of care," and, "[Carer] is brilliant." There was one concern with regard to staff changes. Although a review had taken place there was no evidence to demonstrate how this had been followed up. The acting manager told us that they try to use consistent care workers however with staff sickness and recruitment difficulties this was not always possible.

Continuous learning and improving care:
• The provider failed to improve care and demonstrate continuous learning. We noted several areas for development such as record keeping, monitoring intervention sheets, audit processes and risk management most of which the provider did not have any oversight of.
• Despite being registered since March 2018; a lot of the providers paperwork had not been updated to remove the predecessor providers name.
• Incidents did not prompt learning to improve care. For example, there was a lack of communication between care workers and the management team which resulted in accidents and incidents not being picked up on in a timely manner. The care workers failed to escalate some of these accidents, incidents and concerns to the management team. There were no actions identified due to the lack of audits which meant improvements could not be made.
• Daily care records and medicines administration record (MAR) sheets were not taken to the office therefore managers could not audit and review them or offer guidance to staff on improved ways of working.
• The acting manager told us, 'We have focussed more on delivering the service than documenting things," and, "I feel we are a work in progress with hearts in the right place."

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 11 HSCA RA Regulations 2014 Need for consent A failure to provide care and treatment of people without the consent of the relevant person was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The acting manager understood the MCA 2005 and how this might impact on people's care and support, however, there was no evidence that this was always being implemented in practice. Care plans did not include any evidence of consent forms. The provider was unable to demonstrate that people consented to their care

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The failure to establish and operate effectively an accessible system for identifying receiving, recording, handling and responding to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activity) 2014 – Receiving and acting on complaints.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff receive appropriate support and training 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 - Staffing.

Lack of meetings
Lack of appraisal
Lack of supervision
Lack of care certificate which is in contradiction of their policy

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Not accessing primary health care for people Not recognising accidents and incidents Unsafe management of medicines

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of the service and to send a report to the Commission monthly.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A 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) regulation 2014. Failing to report a safeguarding concern to the local authority and to CQC

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of the service and to send a report to the Commission monthly.

Regulated activity	Regulation

Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance A failure to assess, monitor and mitigate risks relating to the health and safety of service users was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance. A failure to maintain securely an accurate, complete and contemporaneous record in respect of each service users was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) 2014 – Good Governance. There was a failure to maintain accurate and fit for purpose care records. These included missing or incomplete, care plans and risk assessments that were not detailed. There was a risk, if accurate and contemporaneous records were not in place, that this could negatively impact on people's health, safety and well-being

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake audits of the service and to send a report to the Commission monthly.