Forget Me Not Caring Ltd

Forget Me Not Caring Limited

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Forget Me Not Caring is a domiciliary care agency registered to provide the regulated activity of personal care in supported living settings. The service currently supports 56 people with a learning disability and autistic people across 19 shared houses. People have their own tenancies and staff provide various levels of support depending upon people's needs.

People's experience of using this service and what we found

Right Support
Staff did not always support people to have the maximum possible choice, control and independence over their own lives. People were not always supported to make decisions following best practice in decision-making.
The provider did not always work proactively with people to plan for when they experienced periods of distress. Personalised support plans were not always in place and staff demonstrated a lack of understanding about how to support people appropriately at these times.
People were not always supported to plan and achieve their aspirations and goals. People's care plans lacked information about what was important to them and what they wanted to achieve in the future.
Staff supported people with their medicines in a way that promoted their independence; however, the provider's medicines processes did not always ensure people achieved the best possible health outcomes.
Staff supported people to play an active role in maintaining their own health and wellbeing, providing information and guidance about healthy eating and local sports facilities. Staff supported people to take part in a range of leisure activities in their local area.

Right Care
People's care and support plans did not always reflect their needs and preferences or promote their wellbeing and enjoyment of life. Information was not person-centred and records were not always completed in a dignified or respectful way.
People were not always involved in planning or reviewing their own care or in making decisions about the management of risk.
Staff did not always have the necessary skills to understand people who had individual ways of communicating such as body language, sounds, Makaton [a form of sign language], and symbols.
The provider did not always ensure the systems in place protected people from the risk of poor care and abuse.

Right Culture
The ethos, values, attitudes and behaviours of the management and staff did not always ensure people led inclusive and empowered lives.
The culture of the service was not always positive and staff did not always understand best practice in relation to the wide range of strengths and needs people with a learning disability and autistic people may have.
The provider had not effectively evaluated the quality and safety of support provided to people. The monitoring systems in place were not robust and had failed to highlight concerns found during the inspection.
People and those important to them were not always actively involved in making decisions about care.

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

Rating at last inspection
The last rating for this service was good (published 15 February 2021).

Why we inspected
We received concerns in relation to the oversight of the service, staff training and understanding of people's needs and the quality of people's care documentation. As a result, we undertook a focused inspection to review the key questions of safe, effective, responsive and well-led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement and Recommendations
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 safeguarding, dignity and respect and oversight of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Forget Me Not Caring Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 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 provides care and support to people living in 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service a short period of notice of the inspection to enable the provider to ask people for

consent to a home visit from an inspector and because we needed to be sure that the provider would be in the office to support the inspection.

Inspection activity started on 22 September 2022 and ended on 6 October 2022. We visited the location's office on 22 September 2022.

What we did before the inspection
We reviewed information we had received about 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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people whilst visiting them in their homes. We also spoke with eleven relatives about their experience of the care provided. We spoke with eleven members of staff including the registered manager, deputy manager, service support manager, senior carers and care staff. We also spoke with three health care professionals who have contact with the service. We reviewed a range of records. This included five people's care records, three staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider's safeguarding processes did not always keep people safe from avoidable harm and protect them from abuse. Staff had not always recognised or recorded incidents. For example, information of concern found during the inspection had not been escalated by staff within the organisation. This meant the registered manager was not aware of the concerns and was unable to take appropriate action to safeguard people.
- The provider did not always have robust oversight over incidents where people required support due to feeling distressed or upset. There was a lack of analysis about how staff communicated and responded to people at these times. Incident reports were poorly completed and demonstrated a lack of staff understanding which meant concerns about how people were being supported may not be promptly identified.
- The provider had a safeguarding log in place to record incidents and actions taken, however information was not always detailed and did not accurately reflect investigation outcomes.
- The provider had not always managed incidents affecting people's safety well. There was a lack of investigation into possible trends and themes to learn lessons, change practice and drive improvement.

The provider did not have effective systems in place to ensure people were protected from the risk of abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection took immediate action to implement more frequent audits and checks to monitor the completion of incident reports.
- People and those who matter to them had been provided with information on how to raise safeguarding concerns. This had been provided in a format suitable to meet their communication needs, including an easy read safeguarding information booklet with details about who to contact with any concerns.

Assessing risk, safety monitoring and management; Using medicines safely

- People's care records did not demonstrate how they were involved in managing risks to themselves and in taking decisions about how to keep safe.
- People's risk assessments were not always personalised, with many providing general information rather than detailed step by step guidance for staff to follow.
- The provider's systems to manage people's medicines were not always effective. During the inspection we found a person had been supported to take a medicine prescribed on an as needed basis twice daily which should only have been administered during periods of distress.

● People did not always have a protocol in place for staff to follow, detailing how and when they may need specific medicines. This meant there was a risk staff may not know when it was appropriate to offer people these medicines.

Risks to people's safety were not assessed appropriately and the provider had not ensured effective systems were in place to manage people's medicines safely. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider responded promptly once alerted to the medicines incident, seeking medical advice, arranging an investigation and retraining staff.
● People had storage space within their rooms to keep their medicines safely, which meant they could take them in private when appropriate and safe to do so.
● The provider ensured people's medicines were regularly reviewed by prescribers in line with the principles of STOMP (stopping over-medication of people with a learning disability, autism or both)

Staffing and recruitment
● We received mixed feedback about the consistency of staff support, with some relatives telling us about regular staff who had recently left and agency staff covering shifts. Comments included, "The staff leave quite frequently," and "There's been a change in staff." Despite this, people and relatives told us there were generally enough staff available to support people with their care needs, go out and take part in the activities they enjoyed.
● The provider's recruitment and selection process ensured the staff recruited were suitable to work with people who used the service. This included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

● Preventing and controlling infection
● The provider's infection prevention and control policy was up to date and provided staff with guidance about how to manage and minimise the risk of people and others spreading infections.
● Staff had completed training in infection prevention and control and food hygiene safety.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received relevant and good quality training. A recent audit completed by the local authority identified staff had not received training in understanding the needs of people with a learning disability and autistic people, including the use of communication tools and positive behavioural support.
- The provider had now introduced training tailored to understanding the needs of the people they were supporting. Staff were in the process of completing this training at the time of the inspection.
- The service checked staff's competency to ensure they understood and applied training and best practice. However, these checks lacked detail and did not focus on whether staff understood the specific needs of people with learning disabilities and autistic people.
- Where concerns were highlighted regarding staff communication and practice, the provider had not always ensured staff received supervisions in order to support them in understanding and addressing shortfalls.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- The provider could not evidence how they had considered people's capacity to make decisions. Where people possibly lacked the capacity for certain decisions around their daily care, the provider had not recorded any assessments or best interest decisions in their care plans.
- Despite the lack of documentation in place, staff were able to tell us how they supported people to make decisions through verbal or non-verbal means.
- People we spoke with confirmed they were able to make decisions about their care. One person said, "If I don't understand something, they [staff] will explain it to me. They listen to me."
- The provider told us they had scheduled more in-depth MCA training for the management team and were

in the process of implementing new care plan documentation which would more clearly evidence how people's capacity to consent had been assessed. We saw examples of these templates during the inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had completed an initial assessment of each person's physical and mental health and considered their protected characteristics, including any religious and cultural support needs. However, it was not always clear how people and those important to them had been involved in this process.
● The provider had implemented a policy of the month at their staff meetings to support staff knowledge and understanding. However, the provider was not able to demonstrate how they kept themselves informed of updates and changes to guidance specific to supporting people with learning disabilities and autistic people.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had health actions plans in place; however, these had not always been updated or cross referenced with people's care plans to ensure information remained up to date and relevant.
● People were referred to health care professionals to support their wellbeing and help them to live healthy lives.
● People were supported to attend health checks, screening and primary care services such as the GP and dentist.

Supporting people to eat and drink enough to maintain a balanced diet
● People were involved in choosing their food, shopping, and planning their meals.
● Staff supported people to be involved in preparing and cooking their own meals in their preferred way.
● People were given guidance from staff about healthy eating and were encouraged to eat a healthy and varied diet.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider had not always ensured people had high quality, personalised support plans and risk assessments in place to provide guidance for staff about how they would like to be supported.
- Staff were not always knowledgeable about how people communicated their needs and preferences. The terminology used by staff in people's care plans, daily records and incident reports was not always appropriate or respectful. Care records were not always completed in a way which promoted people's dignity.

The provider had not ensured people's care was dignified and respectful. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People's care and support did not always focus on their quality of life outcomes. People's care plans did not have meaningful goals documented and the provider was not able to evidence how people were encouraged to talk about their future wishes and aspirations.
- Despite these concerns, people generally told us they were able to do what they wanted to do, at times that suited them. Comments included, "I'm more independent living here" and "I'm able to go out when I want to"
- At the time of the inspection the provider was in the processing of redesigning people's care planning documentation with support from the local authority. The new template demonstrated an improved focus on personalised care and understanding people's needs and preferences. The provider told us the new template would also evidence how people were empowered to make choices about their current care and future goals.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Staff had not received specific training in understanding people's different methods of communication, such as Makaton.
- People's care plans did not always provide staff with sufficient guidance about understanding their communication needs, or how to facilitate communication when people were trying to tell them something.

● People were provided with information in formats they could understand including easy read versions of policies and guidance.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to participate in their chosen social and leisure interests on a regular basis. However, it was not always clear how they were involved in reviewing these interests to ensure they continued to enjoy them or how new possibilities were suggested or encouraged.

● People were in regular contact with friends and family. Relatives visited people in their homes and people also stayed in touch via phone and video calling.

Improving care quality in response to complaints or concerns

● The provider had a complaints log in place for recording when concerns were raised. However, outcomes and actions were not always clearly documented.

● People, and those important to them, were provided with information about how to raise concerns and complaints. The provider had recently updated their easy read complaints booklet to ensure people knew who to contact and when.

End of life care and support

● The provider was not supporting anybody with end of life care at the time of the inspection. However, the registered manager told us people's end of life care wishes and needs would be considered as part of their initial assessment if relevant.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders 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; 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's governance processes were not effective and had failed to hold staff to account, keep people safe, protect people's rights and provide good quality care and support.
- We identified concerns with the provider's oversight in a number of key areas such as incident reporting, medicines management, care planning and assessing people's capacity. Many of these concerns had already been highlighted during the local authority's recent audit.
- Following the local authority's audit, the provider had not always acted promptly to make improvements. Where concerns had been identified by the provider's own quality assurance systems, actions were not always followed through. This meant the necessary improvements had not been made to the quality and safety of the service.
- The provider had not invested in staff by providing them with quality training to meet the needs of all individuals using the service. The provider had not identified the importance of staff receiving training in understanding the needs of people with learning disabilities and it was unclear how staff were assessed to ensure they understood people's specific needs.
- The provider told us they had implemented an action plan and were also in the process of recruiting an additional service support manager to provide more support to staff and ensure management checks and audits were completed more regularly.
- The provider was aware of the duty of candour and the importance of apologising to people and those important to them, when things went wrong.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The culture of the service did not promote people's individuality and enable them to develop and flourish. It was not clear how people were being empowered to make choices or plan and achieve meaningful outcomes.
- People's relatives did not always feel the leadership and culture of the service was effective. Comments included, "I would not recommend Forget Me Not Caring to anyone," "It's not the ideal place for [person]" and "I've no idea who the manager is now."
- We received mixed feedback about the effectiveness of the provider's processes for requesting feedback from people and those important to them.

● People were supported to participate in house meetings; however, it was not clear how the provider monitored these to ensure they were taking place regularly in each of the houses.
● The provider told us they sent feedback surveys to relatives; however, some relatives told us they had not received these. Comments included, "No questionnaire has been sent out for a long time, if ever" and "I couldn't tell you when I've seen one."
● We received some mixed responses from staff about how comfortable they felt raising concerns with the management team. Despite this, staff generally told us they did feel able to give feedback. One member of staff said, "I have always felt comfortable talking to them [management] about any concerns or questions I have."

All of the above identified the provider did not have effective systems in place to monitor the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others
● The provider was receiving support from the local authority to monitor the completion of their improvement plan. The nominated individual told us they were committed to making changes in the service in order to achieve good outcomes for people.
● The provider worked in partnership with other health and social care organisations to meet people's needs and improve their wellbeing.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people's care was dignified and respectful. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's safety were not assessed appropriately and the provider had not ensured effective systems were in place to manage people's medicines safely. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have effective systems in place to ensure people were protected from the risk of abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to monitor the quality and safety of the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.