Amber Case Management Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an announced inspection which took place on 13 and 14 October 2016. The inspection was announced to ensure that the registered manager or another responsible person would be available to assist with the inspection visit.

This was the first comprehensive inspection of the service following their registration with the CQC in November 2013.

Amber Case Management Limited is registered with the Care Quality Commission to provide personal care to people living in their own home. At the time of our inspection 23 people were using the service.

The service is registered to provide personal care to both adults and children. Amber Case Management provides specialist services and coordinated services on behalf of people who have an acquired brain injury or other complex, life changing injury such as spinal cord injury. It accepts referrals from Clinical Commissioning Groups (CCG's) medical consultants, and solicitors acting on behalf of people where legal proceedings for compensation are taking place. . Awards are made, so that funding is available to pay for people's care. All the people supported by this service have had their case heard at the Court of protection and have Appointed Deputies to make decisions on their behalf.

The support each person received was unique to them and bespoke packages of care were delivered by staff recruited though the service but employed directly by the person themselves or a deputy appointed by the court of protection to manage the persons financial affairs.

The service will assist with the assessment of need, and the role of the case manager included attending litigation meetings, court proceedings and case conferences to draw up a comprehensive assessment of needs, and develop care plans based on the specific and individual needs of individuals.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

People who used the service received good quality care from competent staff, who understood how to provide safe care. The service had policies in place to protect people from abuse. Where necessary staff would advocate on behalf of people who used the service to ensure their rights were protected.

There was a high staffing ratio to ensure that people's needs were met, and staff had opportunities to help people to manage risk and develop skills and competence, whilst ensuring their safety.

People were supported by skilled and competent staff who were recruited safely and had received training to manage their complex health and social needs. New staff completed a thorough induction including shadowing more experienced staff to get to know the individuals they would be working with, and received ongoing training to maintain their competency.

Staff received regular supervision and they told us that they found this informative and instructive. They told us that the registered manager was helpful and was available to speak to if they had any concerns. The service operated an on call system to allow staff to contact a member of the management team in case of any emergencies.

We saw that staff had undergone training in the Mental Capacity Act 2005, and were able to demonstrate a good understanding of mental capacity and consent issues.
Staff were trained in safe handling of medicines. There were clear systems in place for ordering, storing and administering people's medicines.

People were encouraged to eat a healthy diet. Care plans paid attention to good nutrition. Where necessary, weight charts were kept to monitor weight and fluid charts monitored drinks to ensure people did not become dehydrated.

Amber case management was a caring organisation. One person who used the service told us, "we are very well supported and I am very happy with my care." People were consulted about the way their care was delivered, and they were involved in selecting the staff who would support them.

We saw that people were supported and encouraged to make their own decisions, and staff respected the choices they made. Working in small teams meant staff could provide on-going and consistent support to individuals so they were able to get to know them well, understanding their background, culture and history.

Staff treated people with kindness, and supported them to take measured risks, respecting their right to do so. One member of staff told us, "We encourage people to make their own decisions, we might think them unwise but we are there and can step in to ensure the result is not too chaotic."

The service respected people's rights to privacy. Where staff rotas reflected round the clock care, staff would withdraw when it was safe to do so to allow people their personal space, remaining close by to provide support if needed.

Care records provided detailed guidance about how to offer good care based on individual needs and preferences. People were supported to maximise their independence. However, we saw one care plan which did not reflect the way the service was being delivered.

Staff were vigilant to people's needs and used innovative techniques to assist people who used the service. Where changes in people's needs were recognised, appropriate referrals to health care and other professionals were made to ensure an appropriate response was provided.
People were encouraged to take greater control of their lives, and the service used assistive technology to good effect. For example, they had begun to use 'eye gaze' technology to assist a person without speech to communicate. Although in its early stages, this demonstrated an ambition to support people to maximise their potential and become more autonomous.

The manager and service were held in high regard by all stakeholders. Overall governance was good with systems in place to monitor people who used the service as well as day today management of the service.

Care records were reviewed on a monthly basis but systems for tracking and recording information were sometimes over elaborate. There had been no breaches of data protection or confidentiality.

The registered manager had adopted an inclusive management style that supported staff and increased their confidence in working with people who had complex health and social care needs. Staff felt well supported. The staff turnover was low which meant that people who used the service were supported by people who knew them well.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff to meet people's needs.

Staff understood their responsibilities to protect people from harm.

Risks to health and well-being had been identified and were appropriately managed.

There were effective systems in place for managing medicines.

Is the service effective?

Good

The service was effective.

People were supported by knowledgeable and skilled staff who had received training to meet their specific needs.

People had access to other healthcare services to manage their health needs.

People were supported to make their own decisions and staff respected their choices.

Is the service caring?

Good

The service was caring.

Privacy and dignity were valued, and the service respected people's right to a family and private life.

Personal information was maintained securely.

People were treated in a caring and compassionate manner.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's needs.

Staff looked for ways to maximise people's independence and supported people to take greater control.

The service looked to maintain people's lifestyle and sought innovative ways of meeting need.

Is the service well-led?

Good

The service was well led.

Systems were in place to monitor service user needs and review care records.

There were systems in place to monitor the quality of the service to help make sure people received safe, effective and responsive care.

Staff felt well supported and understood their roles and responsibilities.

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Detailed findings

Background to this 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 was planned to check 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.

The inspection took place on 13 and 14 October 2016 and the first day was announced. The inspection team consisted of one adult social care inspector. The provider was given 48 hours' notice before our visit and advised them of our plans to carry out a comprehensive inspection of the service because the location provides a domiciliary care service and we needed to be sure that someone would be in the office.

Before this inspection, we reviewed the previous inspection report and notifications that we had received from the service and contacted the Local Authority Adult Care Services to ask them if they had any concerns about the service, which they did not.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

During this inspection, we spoke to two people who used the service and two relatives. We spoke with the registered manager, a case manager and two support workers. We visited one home where we could observe how staff cared for and supported people. We spoke with three professionals who had direct contact with the service, such as .We reviewed five people's care records, three medicines records, six staff records, the staff training plan and records about the management of the service, including policies and procedures, staff rotas, audits, service user questionnaires and other records.

Good

Is the service safe?

Our findings

People told us that they felt safe. One person who used the service told us, "Yes, I am safe here." A relative of a person who used the service told us that they had peace of mind, because their relative was supported by a consistent staff team who knew them well, and delivered care in a way that was safe.

The staff we spoke with demonstrated a good understanding of the need to protect people from harm, and were able to indicate different types of abuse. One support worker discussed with us the signs that would alert them to potential abuse and the actions they would take if they suspected a person was being abused. They said, "We are their voice, we have to stand up for them". Another member of staff told us that when they suspected that a person who used the service was at risk of financial exploitation by his acquaintances, they took appropriate steps to inform the relevant investigatory authorities and explained to us the protective measures they considered to minimise the risk.

Staff had access to the service's safeguarding policies, which provided guidance on their responsibilities to protect vulnerable children and adults from abuse. Staff told us that they were aware of these procedures and understood how to use them. They told us they had received training about protecting people from harm and we saw in the training matrix that all staff had completed training in this area. We looked at the service's safeguarding files and saw that where alerts or concerns had been raised, appropriate action had been taken to protect the individuals concerned.

We saw in staff records that where issues of poor conduct were raised either by staff, people who used the service and their relatives, or through observation of practice, these were dealt with appropriately through the whistleblowing and disciplinary procedures.

The service had a positive approach to managing risk. One person who commissioned services from Amber Case Management said, "The service deals with some very vulnerable people. They recognise and safeguard against excessive risk and support people to identify and measure the risks involved in their activities".

When we looked in care records we saw that comprehensive risk assessments were carried out to recognise potential hazards. Assessments, which identified risks to people, and care plans that directed staff on how to minimise these risks, were thorough and robust. Generic risk assessments - such as risks within the environment - considered use of equipment, personal safety and spatial considerations like the placement and height of furniture. Plans to mitigate the risks included specific details to enable support workers to respond quickly, such as the location of fuse boxes and water stop taps. We saw in care records that risk was monitored and assessments reviewed, so for example where there was a change in staffing levels at one location, it was recognised that this might impact on the fire evacuation procedures, so the service contacted the Fire and Rescue Safety Officer to check, and revised procedures accordingly. The impact of subtle changes in service delivery was noticed and appropriate steps were taken to reassess risk to take these changes into account.

Initial assessments were detailed and identified any potential risk individuals might encounter, either

through activities of daily living, their physical condition or cognitive ability. Measures to minimise the risk were costed and put into place, with detailed instruction where necessary.

Risk assessments were comprehensive and took into account the complexities of the person's needs, the wider social context and views of other people involved in the care provision, including specialist advice such as speech and language therapists, physiotherapists and psychologists, as well as family members. Risk assessments established the hazard, level of risk, potential harm and how the risk could be mitigated. For example, where a service user was at risk of falling or moving down the bed whilst sleeping, appropriate aids and equipment was provided to ensure their safety. There was clear instruction provided for support staff on how this was to be used, and any precautions they needed to take to maintain the person's safety.

The service recognised that people had a right to self determination and supported people to live in the way they wished. Where this involved risk, the service supported people to make choices and supported them to manage the risk. All risk assessments were reviewed monthly.

The service operated an on call system for emergencies, so arrangements were in place at all times of the day and night to ensure the continuity of care and support. The registered manager told us that the on call officer was rarely called upon, but support staff would call for advice or to provide information such as an unscheduled admission to hospital.

Amber Case Management did not employ staff directly but worked with a small number of care agencies and with financial deputies of people who used the service to interview, supervise and train staff directly employed by the person. Staff worked in individual teams supporting one or two people who used the service. We looked at the recruitment procedure and saw this was based specifically on the needs of the people supported by the service. Individuals who used the service were invited to form a part of the selection process. One person who used the service told us they had been involved in "hand picking" their staff.

Appropriate checks were made on all candidates including references, criminal records checks, and proof of address, identification and rights to work in the UK. This meant that only suitable people were employed to work with vulnerable people.

Staff rosters reflected the individual needs of people who used the service and support provided was based on assessed needs. For example, where two people were living together there was a large staff team of twelve people providing support over a twenty-four hour period. Three staff worked throughout the day, either individually or in pairs. This allowed enough time for people to explore their individual needs, or to spend time together, and allowed for extra care for supervision or to meet any identified needs such as for manual handling or support on trips out.
A member of staff stayed awake at night to meet people's needs and assist with repositioning and other night time duties. Another roster showed a smaller team of five people worked with one individual. Built in to the rota was "family time" to allow the person to have time away from their support staff, and be supported by members of their own family. People told us, and we saw that staff supporting them respected their right to a family life and rights to privacy. Staff would withdraw to the staff room to allow time alone, but were in close proximity should they be needed.

When we looked at past staff rosters we saw that staff teams had remained consistent, with the same people supporting individuals who used the service. This meant that they were supported by people who knew them. We asked one support worker about cover for staff sickness and annual leave, and they told us that generally staff would try to cover any gaps on the roster themselves. The registered manager told us that as

a small agency they could be flexible and respond quickly to any emergencies. If necessary, they could use trusted agencies who knew their systems and processes and had worked with the service previously.
The service had policies and guidelines in place to prevent the spread of infection, and staff training included annual refresher training in infection control, health and safety, and food hygiene. We saw staff followed the guidelines when supporting people with personal care and food preparation.

We looked at how the service ensured the safekeeping and administration of medicines. Staff were trained in safe handling of medicines and we saw at one location that a list of authorised medicine handlers was kept up to date. There was also a copy of the Royal Pharmaceutical Society guidelines for handling medicines in social care. There were clear systems in place for ordering, storing and administering people's medicines. Medicines were delivered in dosettes which ensured the correct dose could be administered when they were required. They were checked and stored in a locked room. The temperature of the room was checked on a daily basis. Similarly, the fridge temperature was recorded on a daily basis for any medicines which required to be kept cool. If medicines are stored at the wrong temperature they can lose their potency and become ineffective.

We did not witness medicines being given but we asked a support worker about how they did this. They were able to give a good account of the process of checking the right dose according to the prescriber's instruction and placing the medicines in a pot for the person who used the service to take. They would offer a drink and observe them taking their tablet before recording this in a Medication Administration Record (MAR). The support worker we spoke to was knowledgeable about the medicines they were giving, the dosage and why they were required.
We checked three MAR records and saw that they provided a detailed list of all the medicines prescribed, and when they needed to be taken. Staff signed when people had taken their medicine and there were no gaps indicating missed signatures on the MARs. This showed us a clear audit trail was maintained to monitor people's medicine administration.

Due to the complex health needs of the people who used the service, some were prescribed a high number of medicines to be provided frequently with as many as eight or nine tablets being given at one time. When we checked we saw that care was taken to ensure that medicines were given correctly and we were told that no errors had been reported. Some people who used the service would need medicines as part of an intervention strategy, for example to control seizures. This is sometimes referred to as rescue medication. We saw that where this was the case staff were trained in appropriate procedures to administer this medicine.

When we reviewed one care plan we noticed that there was a covert medication plan in place. Covert medication is where a medicine is given to a person without them knowing, for example by disguising the medicine in food or drink. There was a letter from the person's general practitioner (GP) authorising that tablets could be crushed and sprinkled over food. However we saw no evidence that this had been considered as being in the person's best interests. When we raised this with the registered manager, she agreed to review this process and to arrange a best interest meeting.

Good

Is the service effective?

Our findings

The registered manager told us that when she was supporting people who use the service to find suitable staff to support them she looked for a 'can do' attitude. She told us, "I like skilled reliable staff who can pick up a care plan and know what to do". The nature of the service meant that staff had to deliver a highly specialised service tailored to individual needs. Staff told us the level of training offered was, "Superb; anything we need to do the job better, they will find the right person to train us".

Once recruited all new staff would undergo a thorough induction into the service and serve a probation period of between six and nine months. Staff completed a new starter questionnaire to gauge their level of competence, and the service would seek appropriate training to meet their requirements, such as National Vocational Training (NVQ) or the Care Certificate. There was an expectation that staff would commence NVQ level 2 within six months of commencing employment.

Staff were given sufficient support and training to provide safe care and to help them understand and minimise risk to people they were supporting. For example, staff underwent extensive training focussed on the specific requirements of the person who used the service, such as nebuliser training, PEG feeding, handling and cleaning suction machines, and handling specific equipment such as electric wheelchairs, tracking hoists or profiling beds.

Initial training would be provided away from the workplace and provide an introduction to the service. Staff would be issued with a staff handbook and introduced to the company policy and procedures. We saw in staff files that they signed to say that they had read and understood policies and procedures, including any amended versions. This meant that service delivery would be consistent and in line with up to date policies. This was followed up by an on- site induction where staff were introduced to the person who used the service and spend time shadowing more experienced staff to learn about the role through on the job training pertinent to the service user. They were signed off when both they and their supervisor felt that they were ready to complete the necessary tasks.

New starters had completed the mandatory awareness course covering topics such as health and safety, safeguarding adults and children, food hygiene, infection control, RIDDOR (i.e. Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations) and COSHH (Control of Substances Hazardous to Health). Other mandatory courses that staff are required to attend before being allowed to work with people who used the service included medication administration, emergency first aid and brain injury awareness. Further training delivered to staff related to the specific needs of people who used the service, such as suction/tracheostomy care and introduction to brain injury. Staff were required to complete the mandatory awareness course every twelve months, and repeat the other training modules every three years. The service kept a training matrix which recorded all training completed by staff, including the date completed and the date they would need refresher training. This was colour coded to show when staff required further training and alerted managers to the need to organise refresher courses. This was kept up to date.

All employees had a supervision session every three months. This was normally conducted by the team

leader, or the nominated supervisor, who in turn was supervised by the case manager. This ensured that relevant information was shared across all employees. The registered manager received litigation supervision appropriate to their needs.

When we spoke to staff about their supervision, they told us they found their regular supervision sessions to be useful and informative, and provided an opportunity to increase self-awareness and learning. We saw that supervision was recorded with notes signed by both the supervisor and the person being supervised.

We looked at supervision records in six staff files. All showed good discussion and a wide range of issues considered, such as issues or concerns about the people who used the service, concerns about working practices, updates on the service and identifying learning opportunities. For example, we looked at one record, which showed good discussion about a specific issue relating to a person who used the service, with practical advice offered and consideration of methods of alleviating the issue. Action points were noted and updates were noted at the subsequent supervision session. Good practice was praised and key action points noted.

All staff were given an annual appraisal. However when we looked at appraisal notes they did not reflect the progress or otherwise of the staff member, nor did they consider goals for the coming months. When we spoke to the registered manager about this, she agreed to review the appraisal system to make this a more meaningful activity for staff.

Staff had received training on, and were able to demonstrate an understanding of the Mental Capacity Act, and show how the service was performing within the scope of the ACT. We observed that staff offered people choices about what they wanted to do, and worked with them in an inclusive way. Examples were given to us about how staff supported people in all areas of their lives and empowered them to make decisions by giving them the confidence and tools to help effective communication. For example, where a person had communication difficulties staff had identified the use of assistive technology and had provided an 'Eye Gaze' machine: by focussing her gaze on a specific answer this would allow the person to make choices about things that were important to them. Mental capacity assessments were completed as appropriate and the agency worked in conjunction with the legal sector and other health care professionals as appropriate. The agency told us everyone using the service had initial assessments in regards to capacity.

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 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

People who used the service were assessed as lacking the capacity to consent to care and treatment. Where possible, people had signed their care plans to confirm they were able to make some decisions about meaningful choices and aspects of their daily lives. A psychologist who worked closely with a number of people who use the service told us "[The service] is not risk averse – it's never 'they can't do that'. They try to consider how to minimise risk, helping people to take measured risks to enable them to learn and develop." The service promoted personal growth and aimed to give control to the people who used the service. We saw that staff supported people through robust assessments, which highlighted the risks and actions taken to support the person whilst respecting the person's right to choose how they lived their lives.

We looked at six care plans each of which paid attention to good nutrition. Staff were given training in

healthy eating and encouraged a good diet. People who used the service were supported with all aspects of meal preparation and staff assisted them with shopping. When we visited one location we saw that a person who used the service was being helped to prepare the evening meal, with attention paid to the nutritional content to allow a balanced diet. We saw that where necessary weight charts were kept to monitor changes in weight and a malnutrition universal screening tool (MUST) was completed. This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan, and referrals were made as required to speech and Language therapists (SaLT) and dieticians for advice on diet.

Drinks and rehydration were not overlooked; one member of staff told us they noticed a person who used the service was not drinking, so they monitored their fluid intake. Risk assessments showed that on some days the person would only take 500 – 600 ml of fluid, so staff have identified ways to increase this, for example, offering more choice of drinks; prompts, such as sitting with the person and drinking together , or looking for alternative ways to meet hydration needs such as extra milk on breakfast cereals.

The service supported people to find appropriate accommodation, and worked with architects, physiotherapists and occupational therapist to draw up and design homes which were adapted to meet the needs of the pole who lived in them. For example, rooms were fitted with tracking hoists where necessary; this prevented risk of obstructions or cluttered walkways. Widened doorways to ensure safety of people using wheelchairs, and rise and fall work surfaces to accommodate people working at different heights.

Good

Is the service caring?

Our findings

When we spoke to people who use the service and their relatives, they told us that Amber Case Management was a caring organisation. One person who used the service told us, "we are very well supported and I am very happy with my care." A relative told us that that a previous care agency had not cared for their relative very well, but now their relative was "happier and well settled; properly looked after". People who used the service were cared for by staff who supported their independence and promoted their privacy and dignity.

A specialist health worker told us "the service is very person centred; [people who use the service] are fully involved and consulted. We have regular meetings and they are always involved in a way they are comfortable with. Sometimes they will attend the meeting but usually they will be involved in a discussion beforehand. All plans are developed in consultation with them". We saw that the needs of the people who used the service were considered before other considerations and people were treated with kindness and patience.

Staff were recruited carefully to meet the needs of the people who used the service and attention was paid to selecting the appropriate candidates who could develop a rapport with individuals. People who used the service were involved in the selection of staff. The staff we spoke with were able to describe the individual needs of people who used the service and how they wanted to be supported. Guidelines for support workers stated, "The person you assist will probably have preferred ways of doing things. Listen to their wishes and follow their preferences for as long as you can do so safely". We saw that this was followed, with activities and plans centred on the person and people's individual choices and preferences were clearly documented in the care records.

People told us and we saw in practice that they were supported to make their own decisions and staff would respect their choices. One support worker told us "we are here to support them to live their life. We are their entourage, and are here to assist, not take over". Although they staff were clear about their professional boundaries. They told us that they had developed close working and friendly relationships with the people who used the service, but understood that the relationship was on a professional basis. They understood the right to a private life and respected their privacy and confidentiality.

We saw this extended to records and personal information held about people. Staff had signed confidentiality agreements and information held about individuals was stored securely in locked cabinets in people's homes. Information held centrally was equally secured on password controlled electronic systems with further security for more sensitive data.

Staff knew and understood the residents. We observed interactions at one home where two people were supported. Both appeared relaxed and comfortable, and we saw that staff were kind and caring, treating the people who used the service with courtesy and respect, laughing with them and sharing jokes. One of the people had difficulty with speech but they were not excluded from the conversation. Staff had learned to understand them, interpret their wishes and reiterate their requests.

Because they worked closely with individuals on a one to one basis, support staff had time to get to know them and find out what was important to them. When we spoke to staff, they were able to demonstrate a full understanding of the people they supported, their background and history. Where people had suffered severe brain trauma staff were able to show an understanding of the impact this had on their life. Where possible staff would work to maintain a previous lifestyle and this could involve positive risk taking. One member of staff told us, "People had a previous life and we respect that, and respect their choices. We won't wrap them in cotton wool. We encourage people to make their own decisions, we might think them unwise but we are there and can step in to ensure the result is not too chaotic."

Staff supported people to maintain their independence as much as possible. We saw that people were encouraged to do as much as they could for themselves, for example, preparing meals with assistance. We saw that personal choice was encouraged, so for instance, people had chosen their own decorations and furniture and staff respected personal taste. Family members were encourage to play an active part in the lives of people who used the service, and we saw that this was built in to staff rotas to allow time for people to spend with their families.

Although staff had time to sit and talk with people they recognised the need for privacy and time alone. Staff told us that they would recognise when people needed to be on their own and would retire to the staff room so they were on hand to provide support if needed. When we talked to staff they told us the needs of people who used the service were paramount but their needs and wishes could sometimes be compromised by the demands of people close to them. They demonstrated a good understanding of the need on occasion to advocate on behalf of people when conflicting demands between support and self-interest occurred, and we saw they would support the individual to resolve these conflicts, and ensure their rights were protected.

Good

Is the service responsive?

Our findings

A healthcare professional who worked with a number of people who used the service told us she believed Amber Case Management provided, "An excellent service, which responds to people's needs and delivered high quality care."

The service recognised that people had varying needs and provided a person centred approach to care provision responsive to need. Prior to receiving a service, care managers would undertake a thorough and broad based initial assessment covering a spectrum of needs, with consideration of how best to manage risk. This was then used to cost out service provision and form the basis of a robust and comprehensive care plan covering twenty separate activities of daily living. The Registered Manager told us that, "Care plans are not just a paper exercise. People will develop and grow, and the care plan will adapt with them.

We looked at six care records. These identified and recorded people's individual needs, providing detailed guidance for staff about how to provide consistent, safe and person centred care to ensure the well-being of each person. For the staff team, getting to know the people who used the service was a continuous process, and as they learnt more about a person, the new information was shared and added to the care documents. One support worker told us "we are constantly revising the care plan. We learn more each day from [named person] and this influences how we work with them".

Care plans were broken down to provide staff with clear and detailed instruction to ensure that the delivery of care was in accordance with people's preferences and wishes. For example, one care plan we looked at detailed plans to assist a person to wash, and made reference to deodorant, talc, aftershave and moisturiser if using a wet shave. Another had detailed plans for moving and handling, with specific reference to different types of transfer required.

There was evidence that staff monitored people's health care needs and liaised with a range of other health care professionals. One support worker told us "we get loads of input: the OT (occupational therapist) is here every week, and we get regular visits from the Speech Therapist. We are also working with the physiotherapist, and try to encourage movement and dexterity. If I have a problem I know who to call and they are always receptive." Where specific health risks had been identified staff were given appropriate training and knowledge to manage risk or refer to other health care professionals as required. For example, staff were trained to an appropriate level in tracheostomy care, bowel and bladder management and other specialist issues. Care records documented regular consultations with a variety of healthcare specialists to ensure that people were supported to maintain good health and ongoing healthcare support. These plans were updated monthly, and action points noted, for example, refer to speech therapist, with the specific reason documented.

The registered manager agreed that learning about individual's tastes and preferences was an ongoing process, and the service remained flexible and responsive to changing need. We saw that care records and daily notes were reviewed on a monthly basis and information collated to provide regular reports to present to interested parties such as court appointed solicitors. Where reviews identified changes in need there was

evidence of liaison and referral to relevant health professionals, for example, requests for a Speech and Language Therapist review, or referral to an orthodontist.

We saw one care plan which did not provide an accurate reflection of service delivery. This care plan identified a need to ensure full support of two staff to assist with the person's evening routine. When we checked the staff duty rota, we noticed that this person did not receive support on two evenings each week. When we enquired about this the registered manager informed us that this was time the person spent with their family, who would manage the routine, but this was not noted in the care plan and could lead to ambiguity or confusion. The registered manager agreed to amend the care plan to reflect the time the person spent with family members.

In addition to providing good personal care and support Amber Case Management supported people to live the life they wanted, supporting people to gain confidence in their abilities and helping them to overcome the obstacles faced by people with severe brain injury. The service acknowledged people's independence and encouraged people who used the service to take greater control over their daily lives. A key part of the support provided was to help people to maintain or increase their independence and attempt to regain any skills they might have lost. Care plans reflected this for example, identifying for example, opportunities for learning or supporting people through college, or taking greater control of financial affairs. We saw in one care record how a person had taken greater control of their life and become less reliant on support staff to meet his needs, and this had led to a reduction in care provision.

The service recognised that the extent of peoples injuries meant some people would have great difficulty to achieve their goals, such as returning to driving, but would not rule possibilities out, considering innovative ways to meet need or use of assistive technology to help people. A member of staff told us "we won't rule anything out". The service supported people to pursue their hobbies and interests and to develop new pastimes and activities. For example, we were told that a number of people who used the service regularly used the indoor ski centre, and for one person this had increased their confidence and self-esteem, as they had begun to ski unassisted. People had regular therapeutic activities to assist with their mobility and dexterity, such as hydrotherapy.

The agency had a complaints procedure, but when we asked to look at a log of complaints and compliments, we were told that there wasn't one. However, the registered manager also told us that they had never received any complaints about the service.

Good

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act (2008) that the manager of a service like Amber Case Management is registered with the Care Quality Commission. When we visited the home had a registered manager who has been registered since January 2015. The registered manager was present throughout the inspection.

All of the people we spoke with were positive about the registered manager and felt supported in their work. One member of staff told us "She is very supportive and nothing is a problem. She is there when we need support. I have worked in some really challenging situations but with her support and supervision I've come through".

A service commissioner told us the registered manager "Gets on well with our clients. The service under her direction is alive to improvement, so we get good value. I have seen a lot of improvement in people's abilities and confidence."

We saw that the manager had adopted an inclusive management style that empowered and supported staff. Regular supervision assisted personal growth and access to good and bespoke training increased staff confidence in their abilities. The registered manager was ambitious to expand the service but recognised the need to do this incrementally. A member of staff told us, "Demand for the service exceeds supply, but the manager won't overstretch. It is important we work within our limits so that we can maintain the quality. The service is very well led; [the registered manager] knows the staff, she is personable and she is there when we need a sounding board. She can be firm, and if there is an issue she will address it." When we spoke to the registered manager, she told us, "My reputation is at stake. I need to ensure that the service is operating at the best level."

Another staff member talked about the teamwork within the service, explaining that the staff understand their roles and responsibilities to work for the benefit of the people who use the service. We saw that staff rotas reflected stable staff teams with very low turnover, meaning that people worked well together. Staff confirmed that they were willing to cover any sickness or leave to provide continuity in support, so reliance on unfamiliar staff was minimised. This ensured continuity of care which was delivered by staff who were familiar with the people who used the service. Staff told us that there was good communication and support from the registered manager and case manager, and that they would regularly visit them at work.

There were effective systems in place to monitor the quality of the service. We saw a recent audit of audit of medication, which checked medicines were appropriately ordered checked, stored and administered. Checks were thorough but demonstrated adherence to the correct procedures. All care plans were audited every month to ensure safe and appropriate delivery of care. Reviews and audits were thorough and comprehensive, involving information from staff and people who used the service, observations and analysis of records.
The registered manager told us that she was keen to seek feedback form stakeholders, and had commissioned a survey for people who used the service to comment on how they felt about the way their

care was delivered. This survey was conducted in July and August, and from returns provided there appeared to be a high satisfaction rate. However, they were disappointed at the low level of returns and when they enquired about this were told by people who used the service and their representatives that the survey was over elaborate and unsuitable. Using this information, they had designed a new questionnaire, which they were preparing to distribute to people who used the service.

The registered manager was responsible for reporting back to various stakeholders and interested parties, including people who used the service, consultants, commissioners and court appointed deputies, and provided regular reports as required. Information held in various folders about each person was thorough and detailed, and the service had good systems to store this information securely. However, we saw some duplication, which could lead to leaking of confidential data by sending the wrong information to third parties. Elaborate systems for checking information were overcomplicated for example, systems to review care plans were signed off on a 'support plan review form', a 'case management and risk assessment review' and a 'case management and risk assessment review template'. When we reviewed one case record we saw that the latter template had not been competed although both the earlier forms were signed off. This could lead to further confusion and misreporting.

Copies of the company's policies were available to staff, and we saw that these were based on good practice guidance and up to date legislation. These included a communications policy, advocacy policy and study assistance policy, indicating a willingness to support staff to further their understanding and provide a better quality service. All policies were checked and reviewed annually. This demonstrated to us a desire to ensure staff had the most up to date guidance to ensure they supported people as well as they could. Where changes were made, staff would sign to say that they had read and understood the amendments. When we spoke with staff they showed a good understanding of the policies, especially the medication policy and safeguarding policies.