AKA Case Management Limited

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 announced inspection took place on 5 and 9 July 2018. This service provides case management, support with rehabilitation and personal care to adults and children who have sustained traumatic injuries or are living with long term health conditions. Not everyone using AKA Case Management Ltd receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided. At the time of our inspection, 16 people were provided with personal care by AKA Case Management Ltd.

The service had a registered manager at the time of our visit. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's health and safety arising from their health condition or home environment were identified and assessed. However, improvements were required to ensure that risks were kept under regular review and decisions about people's care were clearly recorded. Staff supported people to take medicines if required, but improvements were required to ensure the management of medicines was fully safe.

There were enough staff to meet people's needs and staff were recruited safely. Systems and processes were effective in ensuring people were protected from the risk of abuse. People were supported by staff who understood their responsibilities for maintaining cleanliness and hygiene and to report accidents and incidents.

Staff had sufficient skills and knowledge to meet people's needs. People were supported to eat and drink enough and to maintain their health. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice.

People were involved as partners in their care and were treated with kindness and respect. Staff used appropriate means of communication to aid people's involvement and understanding. People were treated with dignity and respect by care workers and to maintain relationships that were important to them.

People received a comprehensive assessment before they started using the service and staff had sufficient guidance and knowledge to provide personalised care. Staff supported people to maintain and develop their independence, partake in activities and pursue their interests. The service considered whether people had any needs in relation to their disability, sexuality, religion or culture and these were incorporated into care plans if required.

People were provided with information about how to make a complaint about the service and people told

us they were able to raise issues or concerns and these were responded to. The registered manager provided opportunities for people to provide feedback on the service they received.

The service was well managed. The registered manager was supported in their role by other senior members of staff. Checks were carried out on staff performance and staff felt well supported and involved in the running of the service. Other quality assurance processes were in place and the management team were in the process of refining roles and responsibilities in relation to monitoring the quality and safety of the service. The management team had strong links with external organisations and health professionals and staff were supported to develop in their roles.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were supported by staff who knew how to keep them safe. Improvements were required to ensure that risks to people's safety were kept under regular review and decisions about people's care were clearly recorded.

Staff supported people to take medicines if required, but improvements were required to ensure the management of medicines was fully safe.

There were enough staff to meet people's needs and staff were recruited safely.

People were supported by staff who understood their responsibilities for maintaining cleanliness and hygiene and to report accidents and incidents.

Is the service effective?

Good

The service was effective.

Staff had sufficient skills and knowledge to meet people's needs.

People were supported to eat and drink enough and to maintain their health.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice.

Is the service caring?

Good

The service was caring.

People were involved as partners in their care and were treated with kindness and respect.

Staff used appropriate means of communication to aid people's involvement and understanding.

People were treated with dignity and respect by care workers and to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People received a comprehensive assessment before they started using the service and staff had sufficient guidance and knowledge to provide personalised care.

Staff supported people to maintain and develop their independence, partake in activities and pursue their interests.

People were provided with information about how to make a complaint about the service and people told us they were able to raise issues or concerns and these were responded to.

Is the service well-led?

Good

The service was well led.

The registered manager provided opportunities for people to provide feedback on the service they received.

Checks were carried out on staff performance and staff felt well supported and involved in the running of the service.

Quality assurance processes were in place and the management team were in the process of refining roles and responsibilities in relation to monitoring the quality and safety of the service.

The management team had strong links with external organisations and health professionals and staff were supported to develop in their roles.

CareQuality Commission

AKA Case Management Ltd

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 provider was given two days' notice to ensure someone would be available at the office to assist us with the inspection. We visited the office location on 5 July 2018 and 9 July 2018 to meet with staff, review care records and policies and procedures. We made telephone calls on 6 July 2018 to people who used the service, and their relatives. One inspector and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses care services.

We used information the provider sent us in the Provider Information Return. This is 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.

During our inspection, we spoke with two people who used the service and five relatives over the telephone. We also spoke with three care workers, one team leader, one assistant case manager, one case manager, the operations director and registered manager. Following our site visit, we sought feedback from four external healthcare professionals and received two responses.

We looked at all or some of the care records of five people who used the service, staff training records and the recruitment records of three members of staff. We also looked at policies and procedures, records of accidents and incidents and returned satisfaction surveys.

Requires Improvement

Is the service safe?

Our findings

Some people required support to take their medicines. One person told us, "Medication is popped out the packet (by care workers) but I take it myself." Another person's relative told us, "[Relation] is not independent taking (medicine) so staff administer this."

Records showed that people received support with their medicines if required and this was recorded on medicines administration records (MARs). The registered manger told us that regular checks of MARs were carried out by case managers to ensure people were provided with the support they required. We also saw evidence that staff had received training in medicines administration and had their competency to support people with medicines reviewed.

Despite the above, we found that records did not contain sufficient information for staff to fully ensure the safe administration of medicines. For example, it was not always clear from records the support people required to take their medicines, some topical medicines (such as creams) were not included on the MAR and there was a lack of information about some medicines, which had been prescribed 'as required'. In addition, when medicines had been hand written on MAR's these were not routinely signed or checked for accuracy. This presented a small risk that people would not receive medicines as prescribed.

Risks to people's health and safety were identified through initial assessment with the person and their family if appropriate. These included risks arising from the home environment and what action staff should take in the event of a fire and security arrangements within the home. Specific risk assessments were in place in relation to people's health conditions, such as what action staff should take in the event of a seizure and specific activities, such as going out in the car.

Although specific risk assessments were in place, it was not clearly recorded that some assessments had been regularly reviewed. The operations manager told us that this had been identified during an audit of care plans and they had spoken with staff to assure themselves these were regularly reviewed and had advised this needed to be clearly documented. Despite this, staff were knowledgeable about the risks to people's safety and the measures required to keep people safe. For example, one staff member described the risk of a startle seizure and how they minimised this by explaining what was about to happen and trying to minimise sudden noises.

People were involved in managing risks to their safety. On persons relative told us, "My [relation] feels safe with AKA carers as they help with physio, rehabilitation, toileting, walking frame and driving the car." The registered manager told us that some people who used the service wanted to partake in activities, which contained an element of risk, such as driving and riding a bike and that different safety measures were explored, such as attending a driving assessment centre.

Some people who used the service displayed behaviour that could present a risk to themselves or others. The staff we spoke with were knowledgeable about possible triggers for behaviour and described how they sought to minimise these. We looked at the care plan of a person who could display harmful behaviour and

saw this contained clear guidance from external healthcare professionals, which had been incorporated into their care plan.

People and their relatives told us they felt safe with the support they received from AKA Case Management Ltd. One person told us they had, "no concerns" about their safety and would raise any issues they had with a member of staff. A relative told us, "[Name] feels safe with care workers. I have no concerns to raise with AKA." Another relative told us, "My [relative] feels safe with AKA care workers. There is no cause for concern."

People were supported by staff who understood their responsibility to protect people from possible abuse. Staff were able to describe different types of abuse and the signs and symptoms to look for. One staff member told us, "For example, physical abuse I would look for uncommon bruising or marks on their body. Any marks are always documented and this is always looked at. If I suspected abuse I would go to the team leader, if no action (was taken) I would go above to manager and follow the whistleblowing policy if needed. I have no concerns."

A safeguarding policy was in place which supported staff in ensuring people were protected from abuse and neglect. Records showed that staff had received training in safeguarding adults and children and that referrals had been made to the relevant local authorities when required. This meant that systems to keep people safe were robust.

People told us they were supported by a sufficient amount of staff to provide them with reliable and consistent support. One person told us, "Missed calls have been in the past but very rarely." Another person said, "I have round the clock care. Staff have never not turned up with is really helpful; especially when I need my medicines." A staff member told us of the action the provider took to try and maintain staffing levels during periods of bad weather or staff sickness, such as rearranging shift times and working alongside relatives to ensure people were safe.

People and their relatives were involved in the recruitment of staff. Staff did not work unsupervised until they had 'shadowed' experienced staff and felt confident. One person's relative told us, "As [name's] mother, I'm involved in the interview stage before they meet [name]. I look at the application form and interview along with AKA and team members. Shadow staff observe and see how others interact. We don't throw them in the deep end straightaway."

People could be assured recruitment checks were carried out to ensure that staff were suitable to work with them. Recruitment records included references and showed that checks were carried out on staff member's identity and through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People were supported by staff who understood their responsibility to protect people against the spread of infection. A relative told us, "They (Staff) wear protective clothing, for example, gloves." Another relative told us, "Staff do personal care and make sure [relation] is clean as is doubly incontinent. AKA provide gloves." Staff were aware of the action they needed to take to reduce the risk of spread of infection, for example by washing their hands and wearing protective clothing, such as gloves and aprons. One member of staff told us, "We have a plentiful supply of gloves and aprons and only need to say if need some more. We have yellow bags to dispose of clinical waste. We get yearly updates in infection control and have completed training in food hygiene."

People were supported by staff that were aware of their responsibility to report any accidents or incidents.

Staff felt confident to raise concerns and admit mistakes and felt these would be responded to appropriately by the registered manager. We reviewed accidents and incidents that had been reported by staff in the six months prior to our visit. Records showed that appropriate action had been taken, for example by seeking the advice of an external healthcare professional. The registered manager also provided an example of systems being changed to help prevent a reoccurrence following an incident.

Good

Is the service effective?

Our findings

People received support from staff that had the knowledge and relevant skills to carry out their roles and responsibilities effectively. One person told us, "Staff are most definitely competent and I'm able to tell them what to do, however all training is up to date." A relative told us, "[Care worker] is trained in moving and handling, communication and occupational therapy. There are more training opportunities commencing soon." Another relative said, "Quite a lot of training is needed to suit my [relation]. Staff have the mandatory one led by a physiotherapist so moving and handling is specified."

Staff told us they received an induction when they started working for the service, which prepared them for their role. One member of staff told us their induction was "impressive" and "included opportunities for shadowing (more experienced staff) and lots of training." Staff files showed that an induction checklist had been completed with new staff, which ensured they were familiar with policies and procedures.

The registered manager told us in their Provider Information Return (PIR) that, 'All staff undertake induction training, mandatory training and service user specific training where appropriate.' Staff told us they had received a range of training in areas such as moving and handling, infection control and first aid and training records showed this to be the case. In addition, staff told us they were able to request additional training and supported in their professional development. Staff gave examples of requesting training in relation to people's specific health conditions and being supported to undertake nationally recognised vocational qualifications, such as the Care Certificate or Diploma in Business and Administration Management. This meant that staff were supported with their professional development.

Staff told us their competency in relation to areas of care provision such as medicines and moving and handling were kept under review by senior members of staff. One member of staff described receiving training in the use of a percutaneous endoscopic gastrostomy (PEG) by an external healthcare professional. A PEG is a medical procedure in which a tube is passed into a patient's stomach to provide a means of feeding when someone cannot eat orally safely. They told us their competency was kept under review by senior staff who worked alongside them at least every three months. All of the staff we spoke with told us they received supervision from a more senior member of staff and received feedback on their performance.

People and their relatives told us that staff provided support with eating and drinking, if required. One person told us, "Carers prepare meals but I get choices of what to eat as I do shopping online and get it delivered." A relative told us, "Food has to be of a smooth consistency, staff are aware and mash it up. This is followed by loading the spoon and encourage either verbal or prompting to open [name's] mouth." Another relative said, "[Name] needs support with feeding and chooses what to eat with plenty of time, no rush."

People's care plans contained information about the support they required to help them eat and drink. This was personalised to reflect people's specific needs and risks. For example, one person had a detailed food regime from an external health professional. The staff we spoke with were aware of this regime and measures required to reduce the risk of choking. Daily records showed the type and amount of food and drink the person had consumed whilst support was being provided. This meant people were protected from

the risks of poor nutrition, dehydration and choking.

People were supported to maintain their health and receive appropriate health care support. People and relatives told us that staff understood their/ their relations health needs and responded appropriately. A relative described staff following the advice of an external healthcare professional and told us, "Staff listen and follow care plans."

The service had strong links with a range of external health professionals, such as psychologists, speech and language therapists, occupational therapists and physiotherapists. People's care records contained clear guidance from health professionals to ensure effective support. Staff were aware of the guidance in care records and described how they followed this to ensure effective care. Care records included details of the action staff should take if they observed a deterioration of people's specific health conditions. One staff member told us about a person they worked with who was able to monitor changes in their health and contacting the doctor on their behalf when the person was concerned. This meant that staff supported people to monitor their health and responded to any changes.

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 and their relatives were involved in decisions about their care/ their relations care. A relative told us, "I am involved in the care plans organising trips. I sit with [relation] to discuss options. There is a care worker present and we pre-arrange what day and hours are required. Myself and care workers try our best to motivate and have [relations] best interests at heart." Another relative told us although their relation could not make some decisions, staff communicated with them using a specialist type of equipment to try to ascertain their wishes.

Staff told us they had received training in the MCA and were able to describe how they worked in accordance with its principles. One staff member told us, "I have worked with people who have lacked mental capacity to make some decisions. You still ask choices, for example about what to wear. Some people you can read their body language or facial expression. You act in best interests by choosing a jumper if cold and t-shirt if warm, but always give a choice."

Mental capacity assessments had been completed by external health professionals if there was doubt about a person's ability to consent to their care. 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. Records showed that an application had been made to the Court of Protection in relation to one person who may be deprived of their liberty. Whilst records showed that a best interest meeting had been held with the person's family and relevant professionals, the outcome of the best interest meeting was not clearly documented. Despite the above, we spoke with an external health professional who was complimentary of best interest's discussions and meetings and told us, "AKA go above and beyond" to ensure they are acting in people's best interests.

We recommend that the system to record mental capacity assessments and best interest's decisions be reviewed. This is to ensure that information about mental capacity and best interests decisions are clearly recorded in care plans in relation to different aspects of care provision.

Good

Is the service caring?

Our findings

People were treated with kindness and respect by staff. One person told us, "I'm really happy and have no qualms. Staff are doing so well here." Another person said, "AKA staff are lovely; they're very good at what they do." People's relatives also described a friendly and collaborative approach. One person's relative told us, "Staff are certainly motivating and help to ensure this is a happy workplace for all." Another relative said, "I describe carers as friendly, trustworthy, brilliant people skills. The one we've got now is unbelievable; a great addition." Staff we spoke with were all highly motivated and enthusiastic about their work and committed to providing compassionate care to the people they supported.

People and their relatives told us that staff had the time and skills to get to know them and meet their individual needs and choices. One person's relative told us, "We all interact well as a team" whilst another told us, "Care worker is getting to know [relation], doing simple activities, talking to [relation]. At the moment, we are getting [relation] used to a care worker at different times of the day, playing with hours and outings. The care worker has already taken [relation] for a short walk." Staff described providing care and support that met people's needs and preferences. For example, one staff member told us, "It's all about [name] who wants it done in a certain way."

Staff used appropriate means of communication to aid people's involvement and understanding. A relative told us that care workers used the same 'objects of reference' and words to aid their relations understanding as much as possible. Another relative said that staff communicated with their relation effectively through the use of a communication book containing words and symbols. A member of staff described the signs that a person they supported was in distress and the action they would take to try to alleviate their distress, for example, by the use of objects that provided comfort to the person.

People and their relations were provided with regular opportunities to discuss the support provided and whether it was meeting their needs. A person told us, "Two care workers handover which helps everyone keep in touch at all times. The case manager speaks to me whenever changes need to be made." One relative told us, "We have meetings once a month. Case manager and care workers mediate if problems arise; if there's anything to tackle we do it together."

The registered manager was aware of independent advocacy provision and considered whether people required the support of an independent person to speak on their behalf or represent their best interests. These people are called advocates. They provided an example of when an independent advocate had been used to ensure that the person was able to express their views and wishes about their care without the influence of relatives, professionals or care workers.

People were treated with dignity and respect by care workers. One person told us, "Staff listen very carefully; they give me a shower and dress me respectfully. I'm very good with personal hygiene so I'm grateful to staff because I would do it myself if I could." A relative said, "[Name] can do bit but needs help getting dressed and the toilet. Staff treat [name] with respect and use towels for modesty."

People were given choices about whether they wished to be cared for by male or female care workers and staff were recruited to match people's individual needs and preferences. One person told us, "AKA suggested having a male carer. I was willing to give it a go but I prefer females once I tried it." A relative told us, "We employ all female staff because [name] is vulnerable. We have a strict policy not to employ males." Another relative said, "We want [name] to enjoy their life to the fullest. That's why it's important to employ a care worker with a young vibe." People and their relatives told us their preferences regarding care workers were respected.

People's social needs were understood and they were supported to maintain relationships that were important to them. For example, a relative told us that family time was important to them and told us that staff respected this. We saw that this was reflected in the person's care plan and daily notes, which showed that the person was given opportunities to spend time with their family.

Good

Is the service responsive?

Our findings

The provider told us in their PIR that once a referral was received; the case manager met with the person and their family so they could decide whether to use the service. A needs assessment was then completed and the person's wishes and goals were recorded in a case management plan and individual support plans produced. Records showed that people's individual goals were recorded and that progress against these was regularly monitored. For example, records showed that one person's goals included eating normally and developing their communication. Reports from external healthcare professionals showed that two years after the person started receiving a service they were able to feed themselves and make choices.

People and their relatives were actively involved in planning and reviewing their care and support. One person told us, "AKA carry out regular reviews and they are 'on the ball'. Staff are also provided with supervision, any problems I can get in touch with [registered manager]." People's relatives also confirmed that annual reviews were carried out with regular meetings and home visits throughout the year. Staff told us they found care plans contained sufficient guidance for them to provide personalised care. One staff member told us, "It is very rare there is a change (in person's care plan). The team leader would inform the case manager and the care plan would be updated. Care plans give the guidance you need." The staff we spoke with were very knowledgeable about the people they supported.

People told us they received personalised care that was responsive to their needs. A relative told us, "Times vary because it depends on what [name] is doing." Another relative said, "At the moment care worker is working alongside [family] learning the routine and [name's] likes and dislikes. Forms must be completed, for example what care worker has done on shift and how [name] was." We looked at daily recording sheets, which had a good level of detail about the support provided by care workers. These contained information about needs specific to each individual, for example, whether the person had been assisted to reposition, checked during the night and supported with personal care.

People were supported to maintain and develop their independence. A relative told us, "We have to encourage [name] to go out on activities. [Name] loves shopping and needs a push but we will get there soon enough. They encourage independence, they take [name] out socially to the cinema, concerts, shopping, make meals." Another relative said, "[Name] has a choice whether to shop for items of clothing or buy ingredients as baking is a favourite. Still very good life skills experience in the community. Care workers keep an eye but [name] hand the money over to the till and waits for the change."

Any needs in relation to people's disability, sexuality, spirituality or culture were identified during the initial needs assessment. If applicable, people's care plans contained information about how they should be supported with any identified needs, such as expressing their sexuality. The registered manager told us they ensured people were able to receive information in a format that was accessible to them. They told us that one person required information in a large font and routinely liaised with speech and language therapists to ensure people were supported with their communication.

People were asked to give feedback on the service they received and knew how to raise any concerns or

issues they had. One relative told us they had a recent review of their relations care and "we had no complaints or niggles. These can be raised and documented in our special book if needed." Another relative told us they had raised queries with care workers, which had been responded to so had not needed to raise with the management team.

The registered manager confirmed that no complaints had been received since they registered the service but that people were provided with information about how to make a complaint and a complaints procedure was in place. None of the people or relatives we spoke with had needed to make a formal complaint and felt confident any concerns or issues would be responded to. Records showed that when issues had been raised, for example as part of an annual review, these had been responded to and actions agreed to address these with staff.

At the time of this inspection, the provider was not supporting people with end of life care, so therefore we have not reported on this.

Good

Is the service well-led?

Our findings

People and their relatives told us they believed AKA Case Management Ltd to be a well led service. One person told us, "Overall opinion of AKA is that they are an excellent service," Whilst another person described the service as, "top notch." A relative said, "My partner and I can't fault AKA," whilst another relative told us, "The service is managed and run to a standard of excellence." Relatives told us that staff were motivated to provide high quality care and support and they would recommend the service to other people.

AKA Case Management Ltd had a clear aim to 'empower individuals to adapt and develop a meaningful lifestyle after a devastating injury.' The registered manager told us in their PIR that the the values of uniqueness, professional, integrity and caring were embedded within the service and printed on the back of each staff members identity badge. People were complimentary of the values and attitude of staff and described them as motivated. Staff were passionate about their role and the support they provided to people to enable them to live fulfilling lives.

The service had a registered manager who was supported to manage the service by the operations manager, consultant case managers, case managers and team leaders. Staff told us they received regular supervision and were invited to team meetings and felt supported. One staff member told us, "AKA are fantastic. I have never worked for a care company before that cares about its staff. I have regular supervision and appraisal and the opportunity to attend regional meetings. They (management team) really care about your input." Another staff member told us, "We have regional meeting three or four times a year. We are encouraged to put our views across and I feel that our ideas are acted upon." Staff told us they were supported to develop in their roles and undertake further training and qualifications. This meant staff were provided with leadership, supervision and support.

Staff described the challenge of lone working and the large geographical service the service covered. One staff member told us they did not always know whom to contact if their line manager was not available. The registered manager was aware of the concerns of some staff who felt isolated and told us about initiatives being introduced to address this issue, such as staff focus groups and a buddying system to reduce feelings of isolation. Records showed that these initiatives had been suggested by staff and were in the process of being developed. They told us they would ensure that staff were provided with a point of contact on occasions when their line manager was not available.

The registered manager was aware of their responsibility to notify us of specific events that occurred in the service. Records showed they routinely contacted external agencies and professionals, such as the local authority and psychologist, if they were concerned about people's safety. Records of accidents and incidents were kept and reviewed by relevant case managers to ensure that sufficient action had been taken to reduce the risk of a reoccurrence. Whilst action had been taken to keep people safe, it was not clearly recorded these had been recently reviewed by a more senior member of staff to identify any trends or to evidence oversight. The operations manager explained there had been a change in personnel and they would ensure these were reviewed by a member of the management team in future.

The views of people, relatives and staff in relation to improving and developing the service were sought and acted upon. A relative told us, "I'm asked my thoughts on the service." We looked at completed satisfaction surveys from people and relatives, which showed a high level of satisfaction with the service provided. Relatives told us that when issues did arise they were able to discuss these with case managers and resolve them. A relative told us, "AKA are approachable even when offloading, they ask 'what do you think about one, two, three options?" Records showed that issues and concerns were discussed at reviews and action agreed to address these. This meant people were encouraged to give their views about the service and that any changes or improvements required were acted upon.

Other quality assurance processes were in place. For example, we saw evidence of medicines audits, which had been completed by team leaders. Whilst these were effective in identifying whether people had received their medicines they had not identified other issues, such as topical medicines (such as creams) not being recorded or lack of protocols for medicines prescribed 'as required'. A review of client files had been carried out and this had been effective in identifying issues such as the need for risk assessments to evidence regular review and need for capacity assessments. We saw evidence that some improvements had been made following the audit. The registered manager told us there had been some recent staff changes and they were in the process of refining their quality assurance processes.

We recommend that the provider implement a robust continuous quality monitoring process that evidences regular reviews of care plans, risk assessments and medicines administration records to ensure these are comprehensive and contain up to date information.

The care records we looked at in the office were stored electronically. It was not always easy to find information about the support that people required with different aspects of care or clear confirmation of decisions. This was because some aspects of care were informed by professional reports, which were stored separately from care plans. This meant that information about people's care needs and decisions about their care were not always easy to find or review. We spoke with the operations director and registered manager who showed us a report they had recently commissioned of IT systems. They told us they would implement recommendations to ensure information was easy to find. Staff told us that information was kept in paper format in people's homes, which was easier to navigate.

The service has strong working relationships with external organisations and professionals. The service worked with a range of healthcare professionals on a regular basis. The healthcare professionals we spoke with were complimentary of the working relationship they had with AKA Case Management Ltd. One healthcare professional told us, "I feel like a valued member of the wider team when working with AKA and they seek out my professional opinion and make use of it to benefit the clients that they work with. They are not afraid to deal with the difficult issues and ensure that the standards are high and maintained always with a professional approach."

The registered manager and operations manager had links with research projects and other professional bodies. For example, the registered manager was chair of The British Association of Brain injury and Complex Case Management (BABICM). BABICM is the representative body for the continued professional advancement of case management and promoting best practice to address and manage the needs of people with brain injury and other complex conditions.