Cascade Living Solutions Limited

Cascade Supported Living

Inspection report

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Date of inspection visit:
11 May 2016

Date of publication:
29 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection of Cascade Supported Living took place on 11 May 2016 and was announced. This was the first inspection since the service registered as Cascade Supported Living in September 2014.

The Supported Living (SL) service is registered to provide personal care for people with a learning disability/Autistic Spectrum Disorder. People using the service live in their own flat located in a large property that is situated in Withernsea, a seaside town in the East Riding of Yorkshire. It is close to the sea front and town centre amenities and there is on-street parking.

There were eight people receiving personal care and support on the day we inspected. There was a registered manager employed at this service. 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.

The safety of people who used the service was taken seriously and the management team and staff at Cascade Supported Living were aware of their responsibility to protect people's health and wellbeing. There were processes in place to ensure people's safety, including risk assessments. These identified how the risks to people were minimised but also ensured people's rights to choice and freedom.

Where people required assistance to take their medicines there were arrangements in place to provide this support safely.

People told us that they were supported by a consistent team of support workers who they had developed good relationships with. People valued the relationship they had with the service's management team and support workers.

There were systems in place to ensure that people's rights to respect, privacy and dignity were promoted and respected. There were sufficient numbers of support workers to provide a flexible service and staff were trained and supported to meet people's individual needs.

Where people required assistance with their dietary needs this was planned for to ensure it was appropriate and safe. Where support workers had identified concerns around people's wellbeing, appropriate action was taken to contact other health and social care professionals to support people's wellbeing.

People and their representatives (where appropriate) were involved in making decisions about their care and support. People's care plans had been tailored to the individual and contained information about how they communicated and their ability to make decisions.

The service was committed to person centred care and ensured that people using the service were at the

centre of everything that they did. People's potential was recognised and they were supported to develop their skills and knowledge through learning. The registered provider was seen to constantly strive to ensure people who used the service were able to achieve their full potential and people's choices were acted upon by staff and management who went the extra mile to support them to live a fulfilled life and cared for them in a way they preferred. There was evidence of positive outcomes for people, and people had pursued new opportunities, progressed over time, gained new skills and increased their independence. There was a strong emphasis on person centred care and we found all staff and management were exceptionally kind and caring, very positive in their attitude to the organisation and their role and they said they were committed to the support and care of the people who used the service.

The service had developed and sustained effective links with professionals and this helped them have a multidisciplinary approach in supporting people. We saw written evidence from family members and health care professionals and the care files we looked at showed that people's needs were continually reviewed. The plans ensured staff had all the guidance and information they needed to enable them to provide individualised care and support. People were consulted and involved in assessments and reviews.

People who used and worked for the service felt able to express their views and opinions to influence service delivery. The management team provided an excellent support network for staff and acted on the views of people. People and staff without exception told us they thought the service was well managed.

Systems to continually monitor the quality of the service were effective. The registered provider gathered information about the quality of their service from a variety of sources including people who used the service, their family and professionals.

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.

People that used the service were protected from the risks of harm or abuse because the registered provider had ensured staff were appropriately trained in safeguarding adults from abuse and the registered provider had systems in place to ensure safeguarding referrals were made to the appropriate department.

Where people needed support to take their medicines they were provided with this support in a safe manner

People told us they trusted and felt safe with the support workers who supported them. There were enough staff to ensure people received a reliable and consistent service.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills required to provide care and support for people who used the service. They undertook training to learn new skills and keep existing skills up to date.

Where people needed additional support from health and social care professionals this had been accessed.

The staff were working within the principles of the Mental Capacity Act 2005.

Is the service caring?

Outstanding ☆

The service was exceptionally caring.

Without exception, people and relatives praised the service staff for their caring and professional approach. People valued the relationships that they had built up with the management and support workers and we found that they used their initiative and went beyond what was expected to support people.

People expressed a high level of satisfaction with the values and

culture of the service which were reflected in the kind, respectful and compassionate support they received.

People were supported by the registered manager and support staff who had high expectations of what people using the service could achieve. We saw the service was committed to a strong person centred culture which put people in the centre of the care and support provided.

Is the service responsive?

Good

The service was responsive.

Information about people's care and support needs was gathered before they went to live at the service. This information was used to inform care plans and risk assessments written to help keep people safe.

Staff recognised people's changing needs and they worked closely with other health care professionals in order to ensure good outcomes for people.

The service provided educational and social activities for people. The activity was meaningful and people told us that they enjoyed living at Cascade Supported Living.

People we spoke with told us they felt able to raise concerns and could make a complaint if they wished. There was a policy and procedure in place to support staff when dealing with complaints.

Is the service well-led?

Good

The service was well led.

There was a registered manager in post who was very keen to continually develop and improve the service. Audits had been completed to check the quality of certain areas of the service and a quality assurance system was in place which was in line with key lines of enquiry used by CQC.

People who used the service and staff we spoke with told us they felt supported by the registered manager who was approachable. There was a friendly welcoming feel at this service.

Cascade Supported Living

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

The inspection took place on 11 May 2016, was announced and carried out by one adult social care inspector; the registered provider was given 48 hours' notice because the location provides personal care and support and we needed to be sure that someone would be at the service that could assist us with the inspection.

Before this inspection we reviewed the information we held about the service such as notifications we had received from the registered provider. Notifications are when registered providers send us information about certain changes, events or incidents that occur. The registered provider also submitted a provider information return (PIR) prior to the inspection as requested; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who use the service. We sent out questionnaires to people who used the service, their relatives/friends, staff and community professionals; the collated information was used to assist us in planning this inspection.

On the day of the inspection, at the service office, we spoke with the registered manager, the compliance manager, the care manager and four support staff. We also spoke with two people in their own flats (with their permission) and one other person using the service to ask them for their opinions.

We also spent time looking at records, which included the care records for two people who used the service, the recruitment records for two members of staff and other records relating to the management of the service, such as safeguarding procedures and the complaints procedure. We looked at quality monitoring arrangements and other staff support documents including supervision records, team meeting minutes and individual training records.

Good

Is the service safe?

Our findings

The provider information return (PIR) we received told us, 'Clients understand what keeping safe means and are encouraged and supported to raise any concerns they may have about this within keyworker meetings or in an informal way with the staff on shift.'

People told us that they felt safe whilst support workers were in their home. Comments included, "I feel safe," "Yes I'm in good hands with the staff, I've been here for five years so of course I feel safe," "Sometimes I go out on my own and when I do I follow the green cross code. I stop, look and listen" and, "I let the staff know if I am going out."

We saw that people had risk assessments in place, covering several areas of individual need, to ensure risks to their health and safety were reduced as much as possible. The care files we looked at during this inspection included risk assessments for medication, transport, mobility, safety at home, getting lost, hurting myself and mental health and we saw these were reviewed regularly. Risk assessments helped to reduce the likelihood of accidents happening.

Each person's safety and welfare was considered. For example, accidents and incidents had been recorded and there was evidence of the actions taken documented, people had patient passports in place. These included information that could be taken to hospital in an emergency to help inform the hospital staff about how they should be cared for. Staff had been trained in first aid ensuring that people who used the service would receive appropriate emergency aid if necessary.

The service had made sure that people were able to access all areas of the service safely. There was a fire risk assessment and fire safety notices throughout the buildings. The communal areas of the service were free from obstacles to ensure there were no trip hazards and there was a secure door entry system in place in the houses to ensure unauthorised people did not gain entry to people's homes.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, portable appliances, the fire alarm system, emergency lighting and fire extinguishers. We saw that fire alarm checks were carried out every week and checks on emergency lighting and smoke alarms were conducted every month. This helped to make sure the fire safety arrangements in place at the home were robust.

We saw one person was not safe to go out alone and to help them understand this, the service had worked closely with a healthcare professional to create 'Social stories' with the person for 'Not opening the front door' and 'Having a safe outdoor badge' as well as other situations. The 'Having a safe outdoor badge' explained step by step why the person would not be safe to go out alone. Social stories helped teach social skills to people on the autism spectrum. These were short descriptions of a particular situation, event or activity which included specific information about what to expect in that situation and why. A staff member told us, "I am [Name's] keyworker and I have worked on social stories with [Name] for not opening the front door and having a safe outdoor badge. I work regularly with the psychologist on these and we are currently

writing one for running down the streets outside." This showed us the service were able to identify risks for people and support them to manage that risk appropriately in a way that they could understand.

Staff were trained in managing challenging behaviour and we saw where required, people using the service had an 'incident log,' 'mood' monitoring charts and behaviour support plans which recorded any periods of distress. These records were reviewed every month with the person to look at any patterns or strategies used to help reduce periods of distress. For example, one person's behaviour support plan said, 'I may put my teddy in the shower if I am distressed' and 'To use social stories to support me in choices and to help cope with my emotions.' Staff told us, "People have behaviour support plans in place and with [Name] we would revert back to their social stories. [Name] can nip or scratch you and we would encourage relaxation in their private room."

The staff we spoke with were able to tell us about how they reduced risk and kept people safe. One person told us, "We follow people's risk assessments such as making hot drinks and cooking food. We have fire doors in the building and some people have their own phones and take them with them when they go out." The compliance manager told us that most people had their own keys to the house and their bedrooms and one person had a 'Lifeline' system fitted through the East Riding of Yorkshire Council (ERYC), which consisted of sensors on the person's bedroom door and the front door to their flat; staff had an intercom system which we saw, that would alert them if the person had left the building. Lifeline provide a range of non-intrusive telecare sensors around the home which offer a comprehensive way of managing risks to a person's health and home environment.

During the inspection we found that there were procedures in place for protecting people from abuse and when safeguarding concerns had been identified, the safeguarding 'threshold' tool provided by the local authority had been used to identify whether the issue needed to be managed 'in-house' or whether an alert needed to be submitted to the local authority safeguarding adults team. Staff we spoke with told us they had completed safeguarding training and they demonstrated a good understanding of safeguarding awareness when we asked them to explain their responsibilities. Staff knew the types of abuse, signs and symptoms and knew the procedure for making referrals to the local safeguarding team. They had undertaken training in this area to keep their knowledge up to date and we saw records that confirmed this. One staff member told us, "I am trained in safeguarding and potential incidents could be financial, physical or emotional abuse" and another said, "We have information on safeguarding and whistleblowing up on the noticeboard in each flat. I have read the policy and completed training at levels one, two and three in safeguarding. If we see any changes in behaviour or any marks on people we would record and report it."

Staff were recruited safely and we checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Cascade Supported Living.

There were sufficient staff on duty to meet people's needs. The registered manager worked over five days and was supported by the compliance manager, care manager, heads of house and day and night support workers. The people using the service told us they felt there were enough staff to meet their needs. They said, "Yes there are enough staff" and, "Yes, people are nice." Staff told us, "Staff levels fluctuate; sometimes we have a lot and then only a few. No one is at risk because of lack of staff though" and, "It's a mixture we

have two staff on duty 8am until 8pm and in addition to that people have one-to-one hours. We have extra staff come in if we go out on trips." We saw pictorial staff duty boards on display in the houses highlighting which staff were on duty. We looked at the staff rotas from 11 April until 5 June 2016 and saw this demonstrated consistency in the number of staff on duty which included people's additional one-to-one hours each day.

There were systems in place to manage medicines safely and we saw from the training records held at the service that staff had completed medication training. The registered provider's medication policy had been reviewed in February 2016 and contained clear information on safe ways of managing medicines in line with best practice guidance; this included how medication was ordered, stored, administered, recorded and disposed of in the houses.

We saw that people's medication was ordered via a local pharmacy on a monthly cycle and each ordered prescription was seen and checked by staff. This meant there was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was stored securely in a locked cabinet in seven out of the eight people's own flats although we noted during checks of one person's medicines we noted that no temperatures were being recorded in any of the storage areas for medicines. The care manager informed us this was an oversight due to re-locating people's medicines into their flats in the previous week. The local pharmacy confirmed during this inspection that none of the medicines stored at the service would be unsafe to use due to temperatures not being recorded. The care manager told us the recording of temperatures where medicines were stored would be re-instated immediately.

We checked one person's medicine administration record (MAR) and we saw this included their name and date of birth and that two staff had signed for any handwritten entries on the MAR. There were no gaps in recording and staff had used the corresponding keys appropriately if a person did not have their medication. People had individual medication stock control sheets that included the name and dose of the medicine, the current stock, medicines administered and booked in and any medicines disposed of; these were audited regularly and signed by two staff members.

Good

Is the service effective?

Our findings

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The provider information return (PIR) we received told us, 'Staff have Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training. It is put into practice to protect clients and to ensure they have as much freedom to make their own choices as possible.' We saw from records held at the service that staff had received training on the MCA. Staff told us, "I have an MCA leaflet and I always assume people have capacity" and, "If we needed to make any adjustments for [Name] we would discuss with [Name], their parents and hold a best interest meeting."

Staff told us that they supported people to make decisions about their day-to-day lives. Comments included, "[Name] can do almost everything for themselves and [Name] has an objective which we encourage which is to get up at a reasonable time in a morning as [Name] likes their sleep. We try and guide people as much as possible to do things for themselves" and, "Part of our job is to develop people's life skills. [Name] has achieved so much, they used to just sit and didn't want to do anything and now [Name] will wash pots, make their bed, clean up in their own flat and do their own shopping."

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. For people living in their own home, this would be authorised via an application to the Court of Protection (COP). We checked whether the service was working within the principles of the MCA and found that at the time of this inspection records showed that one deprivation of liberty safeguard (DoLS) was in place and another application had been submitted to the COP.

People using the service had signed to show that they agreed with their plans of care and support. For example, one person had signed their care plan and it was recorded, 'A member of staff has talked me through my care plan and I understand what it means.' We saw that each care plan we looked at contained some information on a person's capacity to make decisions and what decisions had been made. For example, one person had consented to a dental treatment plan. One person using the service told us, "I make decisions about everything, what I want to eat and what I want to wear." This showed us that the service sought consent to provide care and support and that people's rights were protected in line with the MCA.

Staff had the skills and knowledge required to provide the care and support for people at the service. Staff received an induction when they started working at the service which included four shifts shadowing existing staff, recorded accounts of observed good practice and six medication competency checks. We saw the registered provider's induction followed the 'Skills for care' (SFC) workbooks and completion of the 'Care Certificate'. Skills for Care are a nationally recognised training resource and the Care Certificate is an

identified set of standards that health and social care workers adhere to in their daily working life. One staff member told us, "I did not start work until my DBS had come through. I did shadow shifts, read the service policies and procedures, looked at people's care plans and did a lot of training such as safeguarding, fire and first aid."

We saw staff at the service had undertaken regular training in a variety of subjects such as fire, safeguarding, first aid, medication, health and safety, equality and diversity, food safety and the MCA. All the staff we spoke with told us that training was on-going and had to be completed to help them to maintain their skills so they could care for people effectively. They told us, "Training is good at the moment. I have completed my NVQ level 2 and the nutrition mission." NVQ qualifications are now known as Quality Credit Framework (QCF) Diploma in Health and Social Care. These Diplomas have been created to enable staff in health and social care settings to have access to appropriate qualifications which support on-going development. Another staff member told us, "[Name] does lots of training with us. We are always getting updated with things we need to do and read."

People who used the service told us that they felt they were well looked after by staff, they said, "Yes they do have the skills. They help me with day-to-day things and I follow a plan" and, "I'm more independent and I go out on my own."

Staff were well supported by senior staff. Records confirmed staff had received regular supervision and staff confirmed this. Supervision is a one-to-one meeting with a senior member of staff where work related matters and training and development needs can be discussed. Staff told us, "In my supervision I discuss how I am coping at work and any training needs" and, "Every three months I have supervision and I know I can ask for one whenever I feel I need to. I meet with [Names] and talk about my objectives, the last one was about training and the ASDAN programme that some of the people living at Cascade attend." Award Scheme Development and Accreditation Network (ASDAN) is a curriculum development organisation and awarding body, offering programmes and qualifications that explicitly grow skills for learning, skills for employment and skills for life.

People told us that their individual dietary likes and dislikes were met. They told us, "I cook what's on my menu and choose what I want. Last night we did steak pie and chips and I help the staff prepare it. I love pizza and have this on a Saturday night," "I like mince and my favourite is stew" and, "I like to buy food and drinks and Ribena and pizza." We saw people's flats had an adequate sized kitchen and their chosen menus were visible. One person told us, "I do my own shopping on a Monday and Thursday and if I only need a few things I can go on my own."

People using the service had their nutritional needs assessed where appropriate. Information about people's preferred foods and drinks, food allergies, likes and dislikes was recorded. If any needs were identified with eating or drinking people were referred to the appropriate health care professionals for advice and support and we saw evidence of guidance from the speech and language therapy team (SALT) in one person's records.

The PIR told us, 'They [People using the service] are supported to make doctor's appointments if necessary, and everyone has regular routine access to a dentist or chiropodist. Some clients have involvement with a Community Team for Learning Disability (CTLD) and a nurse visits the facility and support clients to appointments.' People using the service told us they saw other healthcare professionals when they wanted to. One person said "I see my GP and go to the dentist every six months. Staff make the appointments for me." We saw evidence in people's 'consultation books' that there were health care professionals in regular contact with the service to support people. This included GP's, dentists, optician, community nurses, CTLD

and SALT. The details of the visits or appointments had been recorded and any actions taken as a result. For example, we saw it was recorded that one person's relative had raised concerns about them not eating their breakfast when at home and the person had lost two pounds in weight. The service had sought advice from the dietician, CTLD and their GP due to symptoms of lethargy and not eating. This resulted in the person visiting the dentist for treatment. This demonstrated that the registered provider had systems in place to ensure that people were supported to access healthcare services where necessary.

Outstanding ☆

Is the service caring?

Our findings

Everyone we spoke with, without exception, told us that they were treated with kindness and compassion by all the management team and support staff. One person said that all the staff were "All really good and they care and don't want anything bad to happen to me." Others told us, "Yes they care, they try to encourage me to go out and about" and, "Cascade is a palace." We saw written feedback that had been given to the service by people who used it. One person's comment said, "Cascade is one of the loveliest places to live. It is full of friendliness and happiness bursting out of the roof."

Family members were equally pleased about the care their relative received. The provider information return (PIR) we received told us, 'Cascade visits all families regularly at home to support them emotionally and help them to maintain strong links with the person who is living with us.' The managers explained the service took a holistic approach to care by ensuring the wellbeing of both people and their families. People were encouraged to go out with their relatives whenever they wished and some went to visit and on holidays. We saw the service had done a lot of work on relationships and nurturing with one person who used the service and the person now regularly went out with their family. We spoke with the person during this inspection and they told us of their love of Disney and all the characters and the registered manager told us the person was going with their family on a trip to Disneyland sometime in the future. Another person using the service told us, "I've got my [Relative] and I have friends at Cascade. [Relative] comes sometimes but they are busy with their job. I always see them around Christmas time and I speak to [Relative] on the phone."

We saw that the service met regularly with people's relatives and comments during these discussions included, "Cascade is the best thing that could have happened for [Name]. [Name] has come on in leaps and bounds. We are glad [Name] is here and the staff are brilliant and [Name] loves them all; [Name] is so happy. [Name] has been here three years in July and we have seen such a big improvement. They [Staff] are so caring." We saw another example where the service had worked with a person's family through frustrations and worries about the person going home to visit. The service had offered solutions for the person to stay at Cascade and for the relatives to visit at their own pace to help ease everyone's anxieties and we saw evidence of these family visits at the service. This meant both people and their families were supported to maintain regular contact.

We found that the service made a real difference to people`s lives. Staff talked with kindness and compassion about people. They told us they were fond of people and supported them through happiness, sadness and achievements. For example, one person was underweight when they started using the service and wouldn't eat in front of others and had very little social interaction. Staff worked with the person and helped them to overcome their fears. Staff knew the person liked fish and chips and encouraged them to eat whilst walking with them in the paper. When this was successful the staff encouraged the person to eat the fish and chips from a plate in a public house and eventually the person had a different meal on the plate. This meant the person was able to be out in a social setting and feel relaxed when eating in front of others.

We saw the registered manager had worked avidly to ensure everyone who lived at the service received a

'bus pass' to allow them to travel for free with support and had developed strong links with a local retailer as part of their 'Fare share' initiative project which donates surplus ambient foods to their beneficiaries. People who used the service would be able to collect surplus ambient foods from the retailer twice every week with no charge. Shelf-stable food (sometimes ambient food) is food of a type that can be safely stored at room temperature in a sealed container.

We saw people who had difficulty communicating verbally had 'Social stories' within their care plan. These were pictorial and outlined in detail the important things for people to follow to help them communicate in an appropriate manner in different situations. We were able to see one person's social story called, 'The shaking hands story'. This encouraged appropriate ways to greet people in a social setting. We were introduced to the person during this inspection and they shook our hand upon meeting. A staff member told us, "Part of [Name's] morning routine is that they look at the social story for what they are doing that day." This helped the person express themselves in an appropriate way that they could understand.

Links with health and social care services were used to improve the effectiveness and quality of service people received. For example, the service and its staff had worked closely with the Speech and Language Therapy Team (SALT) to support one person with their communication. We saw the person used a Picture Exchange Communication System (PECS). PECS is a form of alternative communication that can be used with a wide variety of learners, from children to adults, who have various communicative, cognitive, and physical impairments. We saw the person's photo cards were organised and stored in their bedroom where they were easily accessible to both the person and the support staff. This meant the person was supported to have the skills to communicate their wants and needs.

We saw another example where the service had worked closely with the person, their social worker and the local safeguarding team in order to provide advice and support to the person during personal relationships. The service had liaised with other professionals and agreed interventions such as a chaperone and sexual education classes at the service, with the agreement of the person, so that they could continue to attend a community activity in a safe way. This supported the person to explore personal relationships whilst being aware of boundaries, their safety and that of others.

Staff celebrated people's achievements with them and we found that recently five people using the service had won an award and appeared in the local newspaper after completing a 'Coastal project' that had seen their art work exhibited. The coastal project work had included research into local history and coastal themes and learning for life creative crafts which explored 2D and 3D art forms using paint, crayons and Mod-roc. Mod-roc (or mod roc) is another name for plaster impregnated bandage, and it can be used to make sculptures.

Staff talked about people in a respectful manner and they told us they respected people's privacy and dignity. For example, when we asked staff to talk about people's needs they obtained assurance from us that the information they gave us was confidential and protected people's right to privacy. One staff member told us, "[Name] was new to the service and was trying to undertake all their personal hygiene themselves. I spoke with [Name] about this and asked if they wanted any support. [Name] has the door closed and now shouts when dressed so they are covered up at all times. [Name] also requested a female member of staff to help with personal care and the shifts have been changed around so [Name] always has a female to help."

All of the people who used the service told us staff respected their privacy by knocking on their doors before they entered their bedrooms for example. They told us, "They [Staff] always ask my permission before they come in my room," "They knock on my door" and, "Staff respect me and are very kind." One person's care

plan recorded, 'I like staff to knock on my door before entering,' and we saw this was respected during the inspection. The noticeboard in the service showed that one staff member was designated as a 'Dignity champion.' Their role was to promote good practice within the service. This showed that staff were keeping information about people confidential and they were vigilant in protecting people's right to privacy.

We saw staff supporting people throughout the day with understanding and compassion. Staff recognised people's needs because they obviously knew them very well. One staff member told us, "No decisions are ever made without the client's agreement. I am very proud to work here, I have been here a couple of years now and they always go the extra mile. You sit and have a cup of tea and we feel proud and you can see it in people's faces."

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs but these were adequately provided from within people's own family and spiritual circles. One staff member told us, "We support one person who has religious needs and we remind them of this if they forget." We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

We asked the registered manager about advocacy services. They told us, "Each person's flat has details of advocacy services visible and we have access to Independent Mental Capacity Advocates [IMCAs] and the Hull and East Yorkshire Advocacy forum. We have currently requested advocacy support for one person in relation to their care planning." We saw from the records we looked at that one person who used the service was waiting for advocacy support to be allocated to help them with their day-to-day decisions in relation to their care planning and details of advocacy services were available in the flats we visited and on the noticeboard in the entrance hall. An advocacy service is provided by an individual who is independent of the provider and social services and who is not part of the person's family or friends. Advocates support individuals, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them and will make sure the correct procedures are followed by the registered provider and other health professionals.

People's needs towards the end of their life (EOL) were being considered by the service. There was no one receiving EOL care at the service but some people had been supported by the service for several years. Because of this, the registered provider had started to look at how the people using the service could be supported in the future. We saw the service was currently working on 'Just in case' plans with people to help them and their families understand decisions and choices in relation to severe illness and EOL without scaring people unnecessarily. The plans included six stages and this was in progress when we inspected.

Good

Is the service responsive?

Our findings

We were told by people that used the service that they knew about their care files and we saw that people had actively contributed and consented to information held about them. One person told us "I've got a care plan and [Name of staff] said I can change it anytime I want. I have signed it."

Assessments were undertaken to identify people's support needs and individualised support plans were developed outlining how these needs were to be met. The care files we looked at were written in a person centred way and identified the person's individual needs and abilities as well as choices, likes and dislikes. Care files included an in-depth 'Life story' on the person, their family, education and any passions they had. We saw one person's care files recorded that they were passionate about 'trampolining.'

Each care file had individual care plans in place to support the person and we saw these recorded the person's strengths and support needs in that area. The care plans we saw included, health and wellbeing, diet and nutrition, medication, cooking, personal hygiene and appearance, communication, mobility and physical development and advocacy. Records evidenced that the information had been gathered from the person themselves and people had signed their care files to show they agreed to the contents. We saw these were appropriately reviewed and updated to ensure a person's current needs were known and met. These systems ensured that staff had up-to-date information enabling them to provide responsive care as people's needs changed.

Each person had a 'monthly workbook' that comprised of an objective for the month and several different areas of information which was completed on a daily basis. We saw one person's workbook that recorded their morning and evening routine, sleep, menu, behaviour/mood and appointments/visitors. All of these areas corresponded with the person's individual care plans and an overview of the workbook was completed at the end of every month with staff and the person. We saw this overview contained any notable achievements reached for example; one person's workbook had recorded during the month of May, '[Name] made their bed very neatly without staff prompting or any help.' This was the person's overall objective for the month. During the overview the staff and the person discussed if the person was keeping their home to an acceptable standard, if any incidents had occurred and if there were any patterns or strategies that had worked, if the person had any health concerns and how well they thought they were progressing.

Care files included a one page profile that recorded, 'What's important to me', 'What people like about me and who I am' and 'How to support me'. One person's profile stated, 'Help me stick to my routine, I will sometimes choose not to do the things that help me keep healthy, such as my daily routine' and another person's stated, 'Speak to me like a grown up and distract me away from my fixations' and 'Make sure you allow time in your day to listen to my concerns.' A one-page profile captured all the important information about a person on a single sheet of paper under three simple headings. These helped staff to understand the person and provide appropriate support.

Care files included information about people's personal preferences and choices, and things they enjoyed and did not enjoy. For example, one person's records said, 'I enjoy the [Name of games console],

trampolining and playing solitaire' and, 'I don't like flies, wasps and any changes to my routine.' People had their daily routines in respect of personal care recorded as well as activities they took part in. The records we saw included, watching DVDs, going out for lunch and going to the library.

The service had an activity planner that was visible on the noticeboard that showed events that were available for people to take part in, these included, ASDAN budgeting and money skills, social development, health and nutrition, cookery skills, pottery, sensory room and a disco every six weeks. We also saw a 'Summer fun' calendar of events that had been requested by the people living at Cascade Supported Living; this included a day trip to Whitby, Eden camp, Scarborough, Dalby forest and the Yorkshire wildlife park.

During this inspection we saw people going out for their lunch at the local public house and attending education classes in the day centre (which was located inside the service). We saw the day centre had computer equipment for people to use during their classes and one person told us, "Once a week I do computers and my maths and English" and, "I like to read, write and play games. I like fantasy stories and I have written my own book and it's been published, it's a story about gods, goddesses and magic. I have a [Names of games consoles] and every Tuesday I go to the library and recently we went to Whitby." Another person told us, "Swimming is fun. I go swimming with [Name of staff]."

We saw that two staff who worked at the service were trained to deliver the Award Scheme Development and Accreditation Network (ASDAN) and the registered provider was a registered centre to deliver the ASDAN programme from September 2015 to September 2016. ASDAN offers a wide choice of activity-based curriculum programmes that can be used in mainstream and alternative educational settings with learners working at a range of levels. We spoke with one staff member who delivered this learning to people using the service, they told us, "ASDAN helps people to develop their life skills." The compliance manager told us that the ASDAN sessions were held two to three times per week at the service and incorporate an educational scheme of work that was specifically designed to support people with learning disabilities and autism. We saw evidence of people's participation in these learning sessions in their care files that included, shopping worksheets, safer social networking, body language for managing social relationships, identifying money and calculating, storing food safely and certificates people been awarded for completion of modules such as, developing skills in looking after your home and washing and ironing clothes.

Staff told us that they knew people's interests from reading their care plans and from talking to them. One staff member told us, "We get to know people by spending time with them and adjusting yourself around the clients. For example, [Name] we are quiet and promote independence and [Name] is a joker and likes a laugh" and, "I sat down not long ago with the person I key work and we talked about if they wanted to be prompted to get up earlier." This demonstrated the service listened and learned from people's views and experiences.

The registered provider had made information available about how to make a complaint. People told us they knew who to talk to if they had any complaints or worries. One person who used the service told us, "I have never had to do it but I know how to. I would talk to the staff and there is a sheet in my kitchen telling me how to do it." We saw that the complaints procedure was available in the service in an easy read format. Easy read refers to the presentation of text in an accessible, easy to understand format.

We checked the complaints log and saw that it contained the registered provider's complaints policy and a monitoring log for recording any complaints and the actions taken. The service had not received any formal complaints in the last 12 months.

Staff told us they would listen to a person's complaint or concern and would deal with the complaint

immediately if they were able to do so. Otherwise, they would report the issue to the management. One member of staff said, "[Name] comes to you with niggles every so often, recently a workman had been into [Name's] room and fixed a repair and [Name] was not happy as they weren't home. It has been discussed and agreed that in future if workmen are coming then they will give 24 hours' notice." This showed that people's concerns had been listened to and that action was being taken.

Meetings were held regularly for people who lived at the service and we saw the most recent 'resident' survey and the analysis of the returned surveys. Comments included, "I am happy" and, "I need a bigger television." We saw the comments were evaluated and we were able to see a consultation that was held with one person to address their requests for a new TV. We saw from the discussions that the person was able to make their decisions and were supported to do this by staff who offered alternatives. The person made their own decisions and was supported to purchase a new television and to move rooms in the service. This meant that people who lived at the service were being given opportunities to comment on the care and support provided.

Good

Is the service well-led?

Our findings

We sent the registered provider a 'Provider Information Return' (PIR) that required completion and return to the Care Quality Commission (CQC) before the inspection. This was completed and returned with the given timescales. The information within the PIR told us about changes in the service and improvements being made.

As a condition of their registration, the registered provider is required to have a registered manager in post. There was a registered manager in post on the day of our inspection. The registered manager for Cascade Supported Living had been in post for a number of years and this had provided consistency for the service. They told us that they kept themselves updated about any changes through their own internal systems and training and by using the provider guidance on the CQC website and attending CQC workshops. They said the service received regular updates from the Social Care Institute for Excellence (SCIE) and the National Institute for Health and Care Excellence (NICE). NICE provides national guidance and advice to improve health and social care; and that this helped them to keep up to date with any changes in legislation and with good practice guidance.

The registered manager was on duty and along with a compliance manager and a care manager; they supported us during the inspection and were knowledgeable about all aspects of the service and were able to answer our questions in detail.

Management knew about their registration requirements under their registration with the CQC and were able to discuss notifications they had submitted. The Health and Social Care Act 2008 (HSCA) requires providers to notify CQC of certain incidents and events.

During our inspection we observed an efficient administration office with support workers and management interacting well. There was a clear management structure in place and staff appeared to understand their roles and responsibilities. We asked staff if they felt able to discuss things with the management and we received positive responses. One member of staff said, "It is good. There are a lot of managers but they all bring something to the service, [Name] takes the lead with staff, [Name] does a lot of training and [Name] looks after the environments. We have communication books and meetings, they are here and on hand" and another told us, "Everyone respects the managers and they do take on suggestions." We saw written feedback from a member of staff that was new to the service with comments that included, 'I feel I have been supported, made welcome and I feel all the managers and staff are professional and approachable. The service users are treat within the legal, agreed ways of working but more important as individuals and not numbers.'

Staff described the culture as, "We are open. It is really fun and every day is so different," "Everyone is approachable, they [Managers] are always asking if any support is needed. We have a lot of information and we are progressing since I started last year; the paperwork has developed and daily diaries and routines have changed" and, "I know I can approach the managers. [Name] is really laid back, supportive and knows their stuff." Comments from people who used the service included, "Nowadays I can talk about anything and

everything with people and I think they are doing a good job."

We saw a staff meeting minutes folder that included minutes from meetings between heads of house, managers and staff. We also saw staff de-briefs conducted following any major incidents and key worker monitoring sheets. One staff member told us they had brought up at a staff meeting that the key worker monthly monitoring sheet contained lots of duplicated information in differing areas and the staff had suggested this was brought together on one sheet that was completed every three months. We saw this had been agreed and the new monitoring form implemented. Staff told us that they had the opportunity to ask questions, make suggestions and express concerns at staff meetings and that they felt they were listened to. They told us, "At staff meetings we can talk about anything and get it off your chest," "Staff meetings are regular, we talk about any issues and any updated information we need such as training. [Name of manager] will send us group text messages and we use the communication book, supervisions and staff meetings to keep up to date" and, "Staff meetings are regular."

There was a statement of purpose and an easy read tenancy and tenants handbook in place. These were given to all new users of the service. The statement of purpose included details of the agency's aims and objectives, the staffing structure and provisions of service. The tenancy included clear information about the expectations of people whilst they lived in their property which included, paying rent, keeping the property clean and tidy and accepting support as part of the persons plan.

The registered manager monitored the quality of the service by regularly speaking with people to ensure they were happy with the care and support they received. We saw that the registered provider had a comprehensive quality assurance framework in place. This was linked to each domain of the CQC's regulations and set out how the service would meet these and what audit tools would be used to do this, the timescales and any outcomes and evidence. A quality assurance planner was in place for 2016 which indicated which audits would be completed and when.

We saw additional audits were completed and covered areas such as medicines, service user files, admissions, safeguarding, risk assessments, health and safety and infection control. Overall assessments of the audits were completed. This was so any patterns or areas requiring improvement could be identified. We saw an audit of recruitment had been completed with an action point of 'review the induction of new staff with a view to improvement.' We were able to see the new induction process during this inspection. We concluded that this was an effective system for monitoring the quality of care and support provided and driving improvements with the service.