Cascade Living Solutions Limited

Cascade Residential/Short Breaks

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 17 March 2016 and was unannounced. The service was previously registered as Cascade Residential and this was the first inspection since the service was registered as Cascade Residential / Short breaks.

The service is registered to provide accommodation and support for up to 8 people with a learning disability, specifically people with Autistic Spectrum Disorder. Some people have their own flat and others have a bedroom and share communal areas of the home. The home 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.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC). 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.

At this inspection we found that the service was safe. People's needs were assessed and comprehensive risk assessments put in place to reduce the risk of avoidable harm. Staff had received training on safeguarding adults from abuse and understood their responsibilities in respect of reporting any concerns.

Staff who had responsibility for the administration of medication had completed appropriate training. Medicines were administered safely by staff and the arrangements for storage and recording were satisfactory.

People were supported to make decisions and their rights were protected in line with relevant legislation and guidance. People were supported to access healthcare services. We saw that advice and guidance from healthcare professionals was incorporated into care plans to ensure that staff provided effective care and support. People's nutritional needs were met; their likes, dislikes and special diets were known by staff and were catered for.

The service had an effective recruitment process and this ensured only people considered suitable to work with vulnerable people had been employed. We saw that there were sufficient numbers of staff employed to meet the needs of people who lived at the home.

Staff told us they were happy with the training provided for them, and we saw that there were effective induction training and refresher training programmes in place.

We observed that staff were kind, caring and attentive to people's needs and that they respected people's

privacy and dignity. Staff encouraged people to make decisions and have choice and control over their daily routines.

Care plans were updated regularly and information shared so that staff were aware of people's changing needs.

We saw that a number of compliments had also been received by the service and that any complaints had been dealt with in accordance with the home's policy and procedure, and to the complainant's satisfaction.

Managers were proactive in monitoring the quality of care and support provided and in driving improvements within the service. There was clear organisation and leadership with good communication between the registered provider, registered manager, deputy manager and staff. We observed that records were well maintained.

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.

Staff had been recruited following robust policies and procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service that met their individual needs.

Staff had received training on safeguarding adults from abuse and this meant they were aware of how to refer any concerns to the safeguarding authority.

People were protected against the risks associated with the use and management of medicines. People received their medicines at the times they needed them and in a safe way.

The premises were being maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and they were either assisted to prepare their chosen meals with assistance from staff, or staff prepared meals for them.

People had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

We observed that staff were caring and that there were positive relationships between people who lived at the home and staff.

People's individual care needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

Privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, and their preferences and wishes for care were included.

There was a complaints procedure in place and we saw that any complaints received by the service were investigated thoroughly.

Is the service well-led?

Good

The service was well-led.

There was a manager in post and they were registered with the Care Quality Commission.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe care, and that the premises provided a safe environment for people who lived and worked at the home.

Cascade Residential/Short Breaks

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 17 March 2016 and was unannounced. The inspection team consisted of one Adult Social Care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as notifications we had received from the registered provider, information we had received from the local authorities who commissioned a service from the registered provider and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; 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 live at the home.

On the day of the inspection we spoke with a member of staff, the deputy manager, the compliance manager and one person who lived at the home. We observed people going about their day to day life and looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, such as staff training, quality assurance and maintenance of the premises.

Good

Is the service safe?

Our findings

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse. They were able to describe different types of abuse, and they told us that they would report any incidents or concerns they became aware of to the registered manager or a senior member of staff. Training records evidenced that staff had attended appropriate training.

We saw the folder containing safeguarding information; this included the organisation's safeguarding policy, the safeguarding adult's board procedures and information about the threshold tool used by the local authority. Use of the tool determined whether or not an alert needed to be submitted to the local authority. The folder included a summary of any safeguarding incidents or allegations, whether or not an alert had been submitted to the local authority and the outcome. We saw details of a medication error that had occurred in July 2015; this information was recorded in the person's individual records along with a copy of the notification submitted to the Care Quality Commission (CQC) and the alert submitted to the safeguarding adult's team. This showed that this incident had been dealt with in line with the organisations safeguarding policies and procedures.

We saw that care plans listed the risks associated with each person's support needs, and that these were divided into risks to self, risks to others, risks from others and risks relating to the property. Each risk assessment included sections to record the subject, the assessment, the identified risk or hazard and the action / support required. Areas covered included 'getting lost', transport (public and private), physical health, mental health, alcohol / substance misuse, 'hurting myself', gender, verbal aggression, physical violence, 'taking other people's things' and difficulties with relationships.

All staff working at the home assisted people to take their medication and we saw that they had completed training on the administration of medication. In addition to this, a member of staff told us, "We are all taking refresher training with [Name of pharmacy provider]."

People's care plans included details of their medical conditions and their current prescribed medication. The staff member on duty told us that medication was administered by one person but that two people checked the records and amount of medication held each day. Each person's medication was stored in a safe area; for one person this was in a locked facility within their flat, and for the other two people this was in a locked facility on the landing area outside their flat or bedroom.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs [CDs] and there are strict legal controls to govern how they are prescribed, stored and administered. We checked the storage of CDs and noted they were stored securely, although the CDs belonging to the person accommodated in the top floor flat were stored in the CD cabinet in another person's flat. The home had obtained a CD book but had not started to use it. The staff member told us that they had training scheduled for 23 and 24 March 2016 by their pharmacy provider on the monitored dosage system (MDS) and CDs. They planned to start to use the CD book following that training. The compliance manager contacted us after the inspection to tell us they had taken advice from the home's pharmacist,

who had confirmed that there was no legal requirement to store and record the drugs in the CD cabinet as controlled drugs. We saw that these medicines were recorded on medication administration record (MAR) charts along with other medicines prescribed and administered.

Each person had a medication folder that included Cascade MAR charts; we noted that the pharmacy had provided a spare label for each medication prescribed so that these could be added to the MAR chart. However, we noted that some handwritten entries had also been made on MAR charts and that these had not been signed by two people. This would have reduced the risk of errors occurring when transcribing information from the original label on to the MAR chart. The MAR chart included the staff signature, the actual time of administration and the number of tablets taken; we noted that one medication was required after meals and we saw that the staff member administered this medication when the person had eaten their lunch.

The medicines folder included a stock control sheet for each medication prescribed and a record of staff signatures so that the accuracy of recording on MAR charts could be monitored. 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. The arrangements in place for returning unused medication to the pharmacy were satisfactory.

The compliance manager carried out recruitment and selection audits and we saw that actions that were required had been recorded. These were identified improvements rather than shortfalls in the current system.

Employment checks meant that only people who were considered safe to work with vulnerable adults had been employed at Cascade Residential / Short breaks. We looked at the recruitment records for two new members of staff. An application form had been completed, references obtained and checks 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. We noted that some DBS checks and employment references had been received after the person's start date. The compliance manager assured us that these new members of staff undertook induction training and shadowed experienced care staff until these employment checks had been received. We discussed how it would be helpful to have clearer records of people's start dates and when they had commenced work on the rota unsupervised. The compliance manager told us that they obtained feedback from people who used the residential / short breaks service and the supported living service following new staff carrying out shadowing shifts. This helped managers to decide in which area of the service the new staff member should work.

We saw staff were provided with job descriptions; this ensured they were aware of what was expected of them.

We looked at staff rotas and noted that these were flexible so the needs of people who lived at the home could be met. One person was out for most of the day undertaking activities or employment, Monday to Friday. One person required minimum supervision and the other person required one to one supervision. A member of staff was on duty throughout the day to provide one to one support and provide supervision to another person. On occasions the person requiring one to one support needed to be accompanied to go out for a walk 'on demand' and this left the home unsupervised. The organisation's supported living service was located in the premises next door on one side, and their day centre was located to the other side. This meant there were other staff available if needed. Following our discussions on the day of the inspection, the organisation arranged for the deputy manager to be based in the residential / short breaks service so that there was always a member of staff on the premises.

The registered manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned. We noted that each person who lived at the home had an incident book where any accidents or incidents were recorded. The book included a full report of the incident and any action that needed to be taken. A report from staff was included when appropriate; this included records of de-escalation techniques used and the staff de-brief. The deputy manager explained to us how they were trying to reduce incidents for one person and that the person was taken to the community hospital for each event as part of this strategy.

We checked the service certificates for maintenance undertaken by contractors and found that they were up to date. This included a portable appliance test, an electrical installation certificate, a fire safety certificate, checks on emergency lighting and fire extinguishers and a gas safety certificate. There were fire safety procedures in place and a fire risk assessment. The fire risk assessment was displayed on the home's notice board along with the statement of purpose, health and safety policy and safeguarding adults from abuse policy. This meant that this information was freely available for people who lived at the home, staff and visitors to the service.

A fire officer had visited the premises in February 2016 and had noted some discrepancies. These included that the fire alarm needed to be tested weekly and that fire doors needed some attention. The compliance manager told us that work to rectify these faults had commenced on 23 March 2016.

Day to day repairs were carried out by the home's maintenance person. This included checks on emergency lighting, smoke alarms, fire alarms, fire extinguishers, door releases, hand dispensers and towels, torches, window opening restrictors and sensory equipment. We saw that any faults were recorded and a note was made of when repairs had been completed.

People had personal emergency evacuation plans (PEEPS) in place that recorded the assistance they would need to leave the premises in an emergency. In addition, there was a continuity plan in place. The plan included information about a variety of emergencies that could affect the safe operation of the organisation and home, including theft and the need to vacate the premises. The plan also included information about how people who lived at the home would be moved to a place of safety and how the business would be able to continue operating. This meant that the organisation had planned for and informed staff about how to deal with emergency situations to protect people as much as possible from the risk of harm.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that care plans recorded the decisions people were able to make and the types of areas that would require a best interest decision.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). None of the people who lived at the home had a DoLS authorisation in place.

We noted that the five principles of the MCA were displayed on the home's notice board so the information was available to people who lived at the home, staff and visitors to the service. Staff also had a small card with these principles printed on them to attach to their lanyard. Staff told us that they were in the process of developing case studies to be discussed at each staff meeting to enhance staff's understanding of these principles. We saw that staff had also completed training on the MCA and DoLS; we spoke with the deputy manager and they displayed a good understanding of their role and responsibility regarding MCA and DoLS.

Staff told us that restraint was not used at the home. People had positive behaviour support plans in place; these included proactive strategies, reactive / non-restrictive strategies, reactive strategies and post-incident support strategies. Areas covered included verbal abuse / aggression, damage to property and physical abuse. The strategies recorded the details of behaviours that could occur and advised staff about the support the person would require and how to speak to the person concerned to try to moderate their behaviour. They also included information about the need for a 'de-brief session' for staff following any incidents. From the information we saw it was clear that every effort was made to understand people's behaviour patterns and to help people to understand the consequences of their actions.

A member of staff told us, "We get lots and lots of training." Each member of staff had an individual list where their training achievements were recorded; these were stored with their personnel records. These evidenced that staff completed induction training that equipped them with the skills and knowledge they needed before they worked unsupervised. This included shadowing experienced staff and five observations of them administering medication to ensure that they were competent to carry out this task. The compliance manager told us that all staff were required to read the organisation's policies and procedures. These were now on-line and the system they used recorded how long people were on the site; this evidenced whether staff had actually read the policies and procedures.

The overall training record that we reviewed showed that staff had completed appropriate training. Recent training had included DoLS, person-centred care, epilepsy awareness, Buccal Midazolam (this is a drug that is administered to people who have epilepsy), food hygiene, autism awareness, fire safety, first aid, health

and safety, safeguarding adults from abuse, infection control and challenging behaviour. The compliance manager told us that training was only added to the full training record when she had seen the staff training certificate; this was to ensure that staff had actually attended and completed the training session.

Most staff had also achieved a National Vocational Qualification (NVQ) or equivalent at level 2 or 3. The head of house was undertaking NVQ Level 5 and the compliance manager had achieved this award. The service also had plans in place to ensure that all new staff completed the Care Certificate and they told us that two staff were already undertaking this award; the Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

The registered manager and financial manager attended regular meetings arranged by the local authority. These were information sharing meetings and as a result of information received at one of these meetings, the organisation had introduced a 'one page profile' to use as a summary of the person's personality, abilities and support needs within their care plan. The service was a member of the National Institute for Health and Care Excellence (NICE) and subscribed to the Community Care magazine. Managers also received the Skills for Care newsletter; Skills for Care is a nationally recognised training resource. These arrangements helped the organisation to keep up to date with good practice guidance.

Staff told us that they were well supported. The records we saw showed that staff had regular supervision meetings with a manager and an annual appraisal. We saw that a staff member's current performance, their future objectives, their learning and development needs and a learning plan were discussed at appraisal meetings. The compliance manager told us that they aimed to have staff supervision meetings every three months. Staff were also observed by a manager to check that they remained competent in their role, and these observations were recorded.

We saw that any contact with health care professionals was recorded in each person's consultation book, including the date, the reason for the contact and the outcome. Records evidenced that medical advice had been sought when people were unwell or were displaying 'unusual' behaviour, and that people were supported to see opticians, dentists and other health care professionals. These records also evidenced that people had an annual health check.

People had patient passports in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff.

We saw that the premises were suitable for the people who lived at the home. One person had a ground floor flat but the other two people lived on the first or second floors; both were very mobile and able to manage the stairs. There was a sensory garden attached to the home that was shared with the supported living service next door. The garden was enclosed and provided a safe area for people to walk outside unaccompanied. There were sea views from the rear windows of the property. Although two people lived in flats within the home, one person was accommodated in a bedroom and had the use of communal accommodation. We noted that the communal accommodation would be 'cramped' if the home was fully occupied; this was acknowledged by the managers we spoke with who told us they would consider how this could be adapted to provide more communal space if it were required.

We saw the menu book that was used to record one person's four weekly menu plan. This recorded that the person might go to the cupboard and take out what they would like to eat. When this happened the menu for that day would be changed, and this change would be recorded on the daily diary sheet. There was a code for staff to use to record the amount the person had eaten at each mealtime. This advised staff when they would need to contact the person's GP to report poor dietary intake. The menu book recorded that the

person liked curries but also suffered with 'tummy problems'; rather than take curry off the menu, staff had decided to prepare milder curries and chilli dishes. This showed that people's wishes had been taken into consideration when decisions were being made about their menus. Staff told us that this person's menu could not be changed too much "Otherwise they wouldn't be able to afford their weekly pub lunch, which they really enjoyed."

Some people attended the home for respite care; anyone who was accommodated in a bedroom had their own food cupboard in the kitchen and was supported / encouraged to help prepare their own meals.

Good

Is the service caring?

Our findings

The registered provider recorded in the provider information return (PIR), "Staff understand and promote respectful and compassionate behaviour, and these social skills are covered in the ASDAN programme." This is a programme of learning that is promoted by the organisation for people who live at the home. Certificates are given by the awarding body to evidence achievement.

We spoke with one person who lived at the home and they told us they were happy living at the home and with the support they received from staff. They showed us around their flat and said, "Yes, I am happy living here." We observed the interaction between people who lived at the home and staff and saw that staff were respectful of people's needs for support but also their need for privacy, and that there were positive relationships in place.

We saw that there was a board showing a photograph of each person who worked at the home and their role to help people to identify the staff who would be supporting them. The notice board also recorded the names of the dignity champion, the health and nutrition champion and the key worker champion. This included the person's background and why they had been chosen to champion this area of care practice. This meant that this information was available to the people who lived at the home and their visitors.

The PIR recorded, "All clients have access to a variety of spaces where they can meet their family and visitors. They have their own private bedrooms, some of which have locks (if appropriate) and they have sofas in their kitchen living space where they can make guests comfortable." The PIR also recorded, "Clients independence is promoted at all times and many clients have their own keys to the building so can come and go as they please." On the day of the inspection one person was out of the home undertaking work / educational opportunities and it was clear that this person's independence was promoted by staff.

We noted that one person's care plan stated, 'My parents can advocate for me but an independent advocate is available'. We saw that there was a notice displayed within the home that stated, 'If you have a problem with your housemates you can ring Hull and East Yorkshire Advocacy Forum or the Care Quality Commission'. This showed that people were made aware that they could be supported by an advocate if they felt they required this type of support. The registered provider told us in the PIR document that they intended to improve the availability of advocacy services for people who lived at the home.

Discussion with the staff and the deputy manager revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had diverse needs and that these were adequately provided for within the service; the care records we saw evidenced this and discussions with staff displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against.

We noted that there was a notice board in one person's flat; this was where staff spent their time as the

person required one to one support. The notice board included details of the staff rota for the home and for the supported living service next door, and the staff training schedule for 2015 / 6. This information was for the benefit of staff and not particularly relevant for the person who lived in the flat; we discussed with managers how this might not respect the person's personal space. The compliance manager contacted us following the inspection to inform us that an office had been set up within the home and all staff information would now be held in that office.

Good

Is the service responsive?

Our findings

People who lived at the home had care plans in place for areas such as health and well-being, diet and nutrition, medication, personal care and appearance, communication, mobility, leisure and recreation, education, emotional and psychological well-being, relationships, community participation, cleaning, social skills and religious requirements.

Care plans 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 thrive on my daily activities and need people to have lots of energy to keep up with me' and another person's stated, 'I like to travel, enjoy going on buses and trains' and 'I like to read a newspaper and keep up to date with the news'. Information about a person's life history was also recorded, as well as important dates for the person to remember such as family birthdays.

Details of people's strengths and needs were recorded in care plans. For example, one person's care plan recorded, 'Strength – I like privacy when dressing / getting ready for bed whether it be during the day or night' and 'Need – Staff to give [Name] privacy when it is clear he needs it'. It was clear that care staff knew people's individual personalities, wishes and care needs. Staff told us they got to know people by reading their care plans and talking / spending time with them, and by talking with their family and health care professionals. The information included in care records helped staff to understand people's specific needs and provide person-centred care and support.

Staff told us that they kept up to date with people's changing needs through handover meetings at the start of each shift. This included reading the communication book; we saw that this included day to day information such as visits from relatives and medical appointments. Staff were also required to check the daily checklist; this recorded that the daily diary, medication stock control, temperature recordings, service user monies and medication administration record (MAR) charts had to be checked each day. We saw that staff had signed to record that they had checked both documents when they started their shift. We saw that care plans, risk assessments and behaviour management plans were reviewed in-house every month. This meant that staff had access to up to date information that helped them to provide the care each person currently needed.

Care plans included information about people's personal preferences and choices, and things they enjoyed / did not enjoy. People had individual daily activities sheets in place that recorded their daily routines in respect of personal care as well as activities they took part in. These included visiting the library to change their books, photography and trips out to cafes, art galleries, the theatre and museums.

Staff told us about the activities people took part in. One person was saving money for a trip to Whitby, along with people they knew in the supported living service next door. They also went bowling and cycling on a regular basis. They had a rail card and a bus pass that enabled them and a member of staff to have trips out; staff told us this was something they really enjoyed.

We looked around the day centre that was next door to the home; this belonged to the same organisation and was used by people who lived at the home and people who lived in the adjoining supported living service. Activities at the day centre included life skills, creative arts, information technology (IT) and 'A way with words'. There was an IT room, a sensory room, a meeting room, a kitchen where people could take part in cooking and baking activities and a craft area. There was a 'movie' night at the day centre every Wednesday and we saw that the current activity in the craft area was the 'Coastal project'. People were also supported to work towards goals such as managing money, making their bed and cleaning their teeth effectively, and certificates were awarded when these goals had been achieved.

We saw that people had some choice and control over their lives. This was in respect of the way they chose to live and staff response to their requests (verbal and non-verbal) for support. People were supported and encouraged to live how they wished to live, with any identified risks being well managed.

Staff told us that people were supported to keep in touch with family and friends and the records we saw evidenced that staff encouraged this contact.

There was a 'suggestions / niggles' book in use and we saw that the complaints procedure was displayed in each person's flat. The staff member we spoke with told us that it was also included in the home's statement of purpose. We looked at the home's compliments, comments and complaints records and saw that there had been one formal complaint. This had been investigated thoroughly and a response had been shared with the complainant. There had been numerous positive comments received from health care professionals; one comment recorded, "First visit to Cascade for about two years. Warm atmosphere and very welcoming."

The most recent survey for people who lived at the home was in 2015 and another survey was due to take place. There was a service user forum that was available to people who lived at the home and the supported living service. The main topic of discussion was about people's chosen activities and we saw the activity programme for Spring that had been developed as a result of these meetings. The programme included a visit to Xscape, an Easter egg hunt and activities for Valentine's Day. We noted that the programme was in a picture / symbol format. Managers told us that they were moving towards people running their own meetings and organising their own activities.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) since the service was registered; this meant the registered provider was meeting the conditions of their registration. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection. We found that these were well kept, easily accessible and stored securely.

We spoke with the deputy manager on the day of the inspection and it was clear that they knew about the specific needs of people living at Cascade Residential / Short Breaks. The deputy manager carried out a weekly quality check and a further quality audit was carried out by the compliance manager each month in respect of service user records. These audits included checks on menus, temperature records, fire tests and drills, medical records, patient passports, advocacy, care plans, consultation records and appointment sheets. In addition to this, staff Disclosure and Barring Service (DBS) checks, staff training, supervision and appraisal meetings, meeting minutes, the management of medication and the safety and suitability of the premises were monitored. These audits included a summary of the findings and any action points.

Every three months the compliance manager carried out a 'mini CQC' inspection. She told us that any action points were raised and dealt with, and then discussed in staff meetings so that all staff were aware. We saw the minutes of the meetings held in February and March 2016 and noted that action points were discussed; these included information about 'champions', repairs, paperwork, staff rotas, feedback from the management meeting and information about specific people who lived at the home.

The local authority quality monitoring team had visited the service recently. They had made some suggestions for improvement and we saw that these were being worked on by managers within the service.

Staff meetings were held on a monthly basis and a member of staff told us, "We can raise issues at staff meetings and our views are listened to." The most recent staff survey had been carried out in February 2015. The survey included questions for staff on how the service could improve and the areas of care that were going well. Managers noted that there were three negative comments about the management of the service and a further survey was distributed to staff so that this could be further investigated. This showed that the service responded to staff comments and wanted to explore how these relationships could improve.

Surveys had also been distributed to health and social care professionals and to relatives in 2015, although response rates had been low. Surveys were planned again during 2016.

We asked if there were any incentives for staff. The compliance manager showed us a report they had

produced that suggested staff should receive additional pay for achieving National Vocational Qualification (NVQ) or equivalent awards, and that a new pay scale should be introduced that awarded people who worked in more senior positions i.e. who had more responsibility. This was still under consideration.

We were told that the organisation did thank people for their efforts; the organisation took staff out for a Christmas meal and staff received an Easter egg, as well as being thanked regularly for their commitment to the service.

In the PIR the registered provider described the culture of the service as "An open and transparent culture where staff are encouraged to give their views formally or informally [Suggestions Book / Meetings] and are supported to question practice with managers. Staff know that they could raise concerns about a colleague or whistle blow, and it would remain confidential. There is honesty and transparency, from all levels of staff and management, when mistakes occur." A member of staff told us, "I like working here. You have a sense of achievement at the end of the day as you can see you have made a difference to people's lives." This was the atmosphere that we witnessed on the day of the inspection.