Insight Specialist Behavioural Service Ltd

Moordean

Inspection report

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Date of inspection visit:
17 August 2017

Date of publication:
13 December 2017

Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

The inspection was carried out on 17 August 2017 and was announced.

Moordean is a care service providing personal care and accommodation for six adults with complex learning disabilities, mental illness and behaviours that may cause harm to themselves or others. People were at risk of being socially excluded due to their behaviours. This service is one of a group of seven care services owned by Insight Specialist Behavioural Service Ltd. The person centred positive social support people received prevented them from becoming isolated and enabled people to fully participate at service and within their local community.

People had transferred to Moordean within the last year from another service also run by Insight Specialist Behavioural Service Ltd. The move to Moordean had resulted in people living in a more homely setting designed to reduce people stress and anxiety levels. Moordean had been adapted to suit the individual complex needs of the six people who lived there. The building was spacious and airy and has been designed with input from people themselves and the specialised behaviour support team to ensure it met people's specialist and individual needs. Everyone had access to an on-suite shower room and some people had their own kitchenette facilities. The service also had a communal kitchen, bathroom with a bath, dining/lounge room, and secure garden. One person was learning to be more independent and lived in their own self-contained annex on site.

The providers had fully embraced the principals of Positive Behavioural Support (PBS). PBS is recognised in the UK as the best way of supporting people who display, or are at risk of displaying, behaviour which challenges care services. The providers had resourced and modelled people's care in accordance with current PBS best practice principles.

Staff clearly understood their roles in minimising risk. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. One member of staff said, "The behavioural management training we get shows us how to minimise risk for each person to keep them safe."

The appropriate positive responses were delivered through individualised behavioural strategies which consistently reduced the instances, severity and intensity of harm or potential harm to people, staff and others. This created an improving picture of life experiences and choice for people, whom, in the past, may have been excluded, marginalised and isolated from wider society.

Person centred care and people's safety was at the heart of the care people experienced. The provider's shared their vision and values with staff and others so that they were understood and acted on. Staff told us that the positive culture and providers values were embedded from the first day of their induction training. Staff saw themselves as enablers, promoting people's rights and participation.

Positive Behaviour approaches supported social inclusion and was used in maintaining contacts with family

members. The providers maintained their own professional knowledge and understanding of best practice in learning disability services.

People were protected from institutionalisation. People's lives were based on person centred circles of support. (A circle of support is a group of key people that can help someone with a learning disability, mental illness to make decisions about their life.) The providers and staff worked with families to overcome some of the challenges they faced in maintaining contact with their loved ones who may not always respond to them positively. Key family members were involved in planning positive behavioural therapies.

To promote exceptional outcomes for people who may otherwise be excluded the providers led by example and visited the service every week, chairing clinical meetings and overseeing the detailed planning and daily operations of the service.

A health and social care professional commented about the qualities at Moordean. They said, "The service provides a positive and safe environment, staff have great knowledge of the people they care for, are person centred, take positive risk and are empowering of individuals by supporting them on their pathway with a holistic approach to individual care."

The providers were innovative and creative and constantly strived to improve the quality of people's lives, consistently implementing positive behavioural therapies, using research and gathering individualised data to assist people with different and often challenging communication styles to develop skills and positive experiences. For example, people's challenging behaviours were declining. When challenging behaviours did occur, these were being increasingly managed by staff using verbal interventions rather than physical interventions.

The providers, registered manager and staff participated in research and the collection of behavioural data aimed at improving the quality of outcomes for people. They recognised that harmful behaviours were also a form of communication.

Staff were consistently supported to understand how people communicated their needs, how to meet people's needs and how to respond calmly when people's challenging behaviours escalated, either at service or within the community. Staff received specialised training based on each person's conditions.

Each person had access to a member of staff called a mentor with enhanced training in Positive Behavioural Therapies (PBT). Incidents and accidents were recorded in such a way as to provide data to the Positive Behaviour Therapist who met with the person involved, with staff, the registered manager and the provider's to see what steps could be taken to prevent incidents happening again. When people presented negative responses to experiences, they were not excluded, but the approach to the activity by staff was adapted to try and turn negative responses into positive outcomes. Changes in behavioural strategies were supervised by the head of the Insight Positive Behaviours Service (PBS) team who was a Dr in Counselling Psychology. Additional Specialist support was also provided by psychiatrists and mental health nurses.

Positive Behavioural Therapies enabled staff to use data collected about people's moods and behaviours to identify trigger points that indicated people may be unwell. Staff making prompt referrals and enabling access to medical care via GPs supported people to maintain their health and wellbeing. Information about health monitoring and communication was appropriate collected and shared with external health care services, for example ambulance and hospital staff. Staff had been trained to assist people to manage the daily health challenges they faced from conditions such as epilepsy and diabetes. Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to

eat and drink. People were supported to make healthy lifestyle choices around eating and drinking.

All the staff were involved in monitoring the quality of the outcomes based care people experienced. Audits systems were connected to the providers risk based management system which fed back into clinical reviews and quality development. The provider shared their learning with all the services in the group.

Positive risk taking was promoted and safety systems were consistently reviewed and audited to reduce the risk of harm. Risk assessments were extremely detailed and were seen as working documents. Risk levels were constantly reviewed and changes to interventions and staffing levels were linked to individual risk levels from hour to hour.

The provider gave people the opportunity to share their views by training staff to understand people's communication styles, for example using objects of reference and collecting detailed data about people's moods, facial expressions and body language. Actions taken by the provider and planned improvements were focused on improving people's quality of life, based on the research and in partnership with external experts. People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences.

The training and supervision staff received enabled them to recognise and respond to communications and behaviours to reduce the risk of violence and aggression occurring. Staff consistently implemented responses that were tailored to the individuals needs and that had been planned by behavioural analysis and specialist behavioural therapist and external health and social care professionals.

Staff provided friendly compassionate care and support. The providers valued their staff and understood they needed additional management support to manage stress and work intensity. Staff were kind and calm at all times. People were encouraged to get involved in making decisions about their everyday lives. People had choices about what activities or routines they wanted to follow. Staff were deployed to enable people to participate in community life, both within the service and in the wider community.

The registered manager produced information about how to complain in formats to help those with poor communication skills to understand how to complain. This included staff understanding people's moods, behaviours and body language. Staff frequently checked with people if they were unhappy about anything in the service. If people complained, they were listened to and the registered manager made changes or suggested solutions that people were happy with. The actions taken were fed back to people.

Staff had received training about protecting people from abuse. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

Recruitment policies were in place. Safe recruitment practices had been followed before staff started working at the service. The registered manager recruited staff with relevant experience and the right attitude to work well with people who had learning disabilities and challenging behaviours. New staff and existing staff were given extensive induction and on-going training which included information specific to learning disability services.

There were policies and procedures in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to

make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded. This impacted positively on people as they were achieving more independence and less restrictive lives.

A registered manager was employed at the 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 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 very safe.

Individualised positive risk taking practices minimised the risk of harm and improved people's life experiences. The registered manager and staff were committed to preventing abuse.

Staff using positive behavioural interventions reduced people's anxieties and subsequent challenging behaviours.

Risk management systems in the service were comprehensive and used as live working documents to minimise risk.

Staff were recruited safely. People's safety was maintained through the consistent deployment of the right numbers of staff based on the levels of risk.

Medicines were administered safely by competent staff.

Is the service effective?

Good

The service was effective.

People were cared for by staff who understood their communication styles, moods and needs well.

Staff met with their managers to discuss their work performance and had attained the skills they required to carry out their roles.

The registered manager and staff had completed training in respect of the Mental Capacity Act 2005 and understood their responsibilities under the Act.

Staff understood their responsibly to help people maintain their health and wellbeing.

Is the service caring?

Good

The service was caring.

People could forge good relationships with staff so that they were comfortable and felt well treated.

People were treated as individuals, able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

People experienced care from staff who respected their privacy and dignity.

Is the service responsive?

Outstanding ☆

The service was very responsive.

Personalised care and flexible support methods were used to keep people and those close to them involved in planning the care and support.

Important aspects of people's care was clinically reviewed at least weekly. Positive behavioural therapist and external health and social care professionals used proactive interventions based on published research to consistently expose people to positive life outcomes.

The providers and staff innovatively used research based data collection methods to gather information about people's lifestyle preferences and likes and dislikes.

Before changes were made, the providers and staff took time to process analysed data and used professional planning to consider what the impact of changes might be on people.

Staff used engaging techniques to monitor if people may be unhappy about any aspect of their care. Details about people's moods and responses to situations were used innovatively to monitor their satisfaction. Complaints and concerns were listened to, taken seriously and responded to promptly.

Is the service well-led?

Outstanding ☆

The service was very well led.

The provider's followed their own philosophy, vision and values and made sure that these were shared and used by staff in their daily work. This resulted in a culture that prevented social exclusion and valued people's individual experiences and aspirations.

The provider's worked closely with the registered manager and

staff at Moordean and other external specialist services to promote community inclusion, person centred care and positive risk taking.

The providers used externally verifiable data to measure the impact of the positive behavioural interventions they used to show improvements in people's lives.

The management of risk was overseen by the providers on a weekly basis. The registered manager and all staff understood the structures in place to monitor and review minimise risks.

The providers monitored staff health and wellbeing and responded to the challenges staff faced due to the intensity of their work.

Moordean

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.

This inspection took place on 17 August 2017 and was announced. We gave short notice of the inspection so that people may be less anxious by our presence in their service. The inspection team consisted of two inspectors and an expert by experience. An expert by experience was a person who had personal experience of caring for someone who uses this type of care service. The expert by experience observed care and talked to people and visitors to gain their views of the service provided.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place at the service, which the provider is required to tell us by law. We used this information to decide which areas to focus on during our inspection.

People used a range of communication styles and their abilities to verbally tell us about their experiences was limited. However, people communicated with us, either by us observing how they responded to staff when care was delivered or by them talking to us about things that were important to them. We spoke with three people about their experience of the service. Two people invited us to view their bedrooms and we asked them about their experiences of the care. We spoke with three relatives and four staff including the registered manager, a team leader, a shift lead and a support worker. We received feedback about the service from a commissioner at the NHS Swale Clinical Commissioning Group and an external Psychiatrist.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at four people's care files, three staff record files, the staff training programme, the staff rota and medicine records.

The service had been registered with us since 05 September 2016. This was the first inspection carried out

on the service to check that it was safe, effective, caring, responsive and well led.

Good

Is the service safe?

Our findings

A relative said, "They've [staff] worked hard with him. At his last service his life was more restricted by the environment. He's a much calmer young man now and I think it's due to more space and the staff understand him. He's more relaxed and a happier man." Another relative said, "I have no reason to believe my son is unsafe, the staff know how to meet his needs which keeps him safe." And, "Safe, yes very safe, It's great and beautiful here, I feel he's now in his proper home and the space works to his advantage."

Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and by talking about people's experiences, moods and behaviours at shift handovers. Staff signed care plans and risks assessments to acknowledge they understood them. Records detailed the information shared between staff about risks within the service.

Staff had specialised behaviour intervention training to maintain people's safety. Staff were exceptionally vigilant with people's safety. We observed one person trying to push an object into their ear. Staff calmly took away the object whilst distracting the person to help make a cup of tea. This protected the person from injury and harm. Enough staff were deployed to enable people's individual needs to be met and for care to be delivered safely in the service and in the community. People benefited from 1-1 staffing input, additional staff were made available to enable people to access their local community safely. Staff had the skills to recognise and respond to people's needs to minimise their exposure to harm. They understood how each person communicated their needs such as, if they were in pain, anxious, upset or unhappy. For example, staff explained how they minimised risks to individuals by understanding their behavioural triggers and avoiding them. Staff said, "We know when people do not like loud noise or crowds so in those situations we redirect them away to keep them calm."

The registered manager followed policies about dealing with incidents and accidents. Should any incidents occur they were fully investigated by the registered manager and steps would be taken to minimise the risk of them happening again. Actions needed were checked by the registered manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. For example, the risks of a person presenting behaviours that could harm themselves or others had been reduced by a change in their routine. The management actions following incidents minimised risks across the service and meant that safe working practices were followed by staff.

A health care professional said, "I am immediately alerted of any potential safeguarding and follow-up investigations and actions taken going forward." Staff were trained and had access to information so they understood how abuse could occur.

The registered manager understood how to protect people by reporting concerns they had to the local authority and protecting people from harm. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities

for reporting abuse.

Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. One member of staff said, "I would make sure that any allegations of abuse were reported." Staff gave us examples of the tell-tale signs they would look out for that would cause them concern. For example, bruising or mood changes. Staff understood that they could blow-the-whistle to care managers or others about their concerns if they needed to. (Blowing the whistle enables employees to contact people with their concerns outside of the organisation they work for, like social services.)

The registered manager protected people's health and safety. Safe working practices and the risks of delivering the care were assessed and recorded to keep people safe. Environmental risks and potential hazards were assessed and equipment was checked by staff before they used it. There was guidance and procedures for staff about what actions to take in relation to health and safety.

Fire systems were maintained and tested. Each person had a personal emergency evacuation plan (PEEP) with detailed information about their ability to escape fire and the support they needed from staff to do this safely. Fire evacuation practice demonstrated that the registered manager monitored how staff responded to people's PEEP's to maintain people's safety.

The provider had a 'business continuity' policy which was being reviewed. This gave information to staff about how people's care should continue safely immediately after an emergency, and the arrangements that had been made disruption to staffing levels during periods of severe weather.

The service was clean and free from odours. The risks of infection and cross contamination were minimised by health and safety control measures based on an up to date infection control policy. These controls included, the testing of water systems for legionella bacteria, water outlet flushing and temperature monitoring, infection control training for staff, safe systems of cleaning, and the provision of personal protective equipment. For example, daily, weekly and monthly cleaning schedules were followed by staff. We sampled these and they showed cleaning was up to date. These safe systems of work protected people from potential infection.

Staff followed the provider's medicines policies. The registered manager checked that staff followed the policy and remained competent by checking staff knowledge and practice when they administered medicine's. Medicine audits were carried out. Staff administering medicines were provided with training so that they understood the broader principals of medicine's safety and record keeping. Staff we talked with gave us details of how they supported people safely when dealing with medicines.

People were protected by staff who understood their responsibility to record the administration of medicines. The medicine administration record (MAR) sheets showed that people received their medicines at the right times and as prescribed. The registered manager confirmed there was a policy regarding the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. The system of MAR records allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff. MAR sheets and these were being completed correctly by staff. Medicines were audited monthly by the registered manager.

People were protected by safe recruitment practices, minimising the risk of receiving care from unsuitable staff. The registered manager followed a policy, which addressed all of the things they needed to consider when recruiting a new employee. Recently appointed staff gave a detailed account of how they had been recruited in line with the provider's recruitment policy. Applicants for jobs had completed applications and

been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity, written references, and confirmation of previous training and qualifications relevant to the role. Gaps in employment were explored to provide a consistent record of work history. Staff confirmed, "At interview I was asked about my motivations, experiences and we discussed gaps in employment." All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Good

Is the service effective?

Our findings

We observed people were supported with their agreed and recorded daily routines by staff. People's health needs were monitored by staff and comprehensive information was provided about people's conditions. For example, people with epilepsy had treatment guidelines in place which staff knew how to follow.

A relative said, "Very happy with staff, they are dedicated, hardworking and clued in to his needs."

A health care professional said, "When reviewing individuals' healthcare needs it has been my experience that any recommendations made by myself are actioned as goals from the service. In the interim between reviews I receive any follow ups from my recommendations and any further actions that have had to be taken and outcomes for the individual."

People were assisted to access other healthcare services to maintain their health and well-being, if needed. People had been seen by a variety of healthcare professionals, including a GP, nurse and dentist. Referrals had also been made to other healthcare professionals, such as Speech and Language Therapy and Psychology. For example, one person informed us that a few days ago their 'head was spinning'. They had been taken to their GP who was monitoring the person's health. Staff told us that whilst the person's health issue was being investigated by the GP, they had changed the intensity of the person's routine so that it was less demanding. Having input from a wide range of professionals gave staff the information they needed to meet people's needs.

Food preparation areas were well presented and clean. They were accessible to people at any time. Members of staff were aware of people's dietary needs and food intolerances. Staff used observations to assess if people enjoyed or left their food to build up a picture of people's individual food and dietary preferences.

People were encouraged to make their own drinks and foods. People had storage areas in the kitchen for foods that they preferred to eat. A relative said, "I think he has choice and they try to have healthy meal options and treats."

People had household jobs that were rotated and adjusted according to their ability which included helping with food preparation. One person helped cut up vegetables and, another got an egg from the fridge when it was their turn to prepare lunch. People were encouraged to make themselves drinks and staff used subtle intervention techniques to enable people to complete the task in hand. For example, one person was making their own tea in main kitchen. Staff assisted the process by prompting, 'Use your own cup' and staff helped person place kettle back on stand with hand on hand support on the handle of the kettle. Staff used visual prompts to encourage the person to place their spoon in the dishwasher. The member of staff then accompanied the person as they carried their cup of tea to their seat.

Staff supported people to avoid foods that contained known allergens people needed to avoid. One person told us that yellow (Spicy) foods upset their stomach, but they still liked to eat it, but "staff encouraged them

not to."

Staff told us that there was a training programme in place and that they had the training they required for their roles. This included specialised training to a recognised national standard in the management of challenging behaviours. It was clear that new and existing staff had a good level of skill and training to manage people with challenging behaviours. Staff patiently implemented safe distraction techniques, understood how and when to escalate their interventions if needed and they ensured that everyone was kept safe. New staff described their induction by saying, "My induction was really good, I feel happy about how the induction was managed, I spent time with clients slowly building working relationships."

Staff learning was provided in a number of ways, including by e-learning, distance learning courses and face to face training and this was supported by records we checked. Additional training was provided in relation to person centred care planning for people with learning disabilities and managing people's behaviours if they may harm themselves or others.

Staff also told us that they received supervision and felt supported in their roles. Records showed that when new staff started they would begin training using the Care Certificate Standards. These are nationally recognised training and competency standards for adult social care services. Records showed that supervision meetings with staff were held with senior members of staff. One member of staff told us, "At supervisions I am asked how I am getting on, we talk about the team and we talk about anything we feel could be improved." Staff also told us about situations where the registered manager used additional supervisions to discuss how their work could be improved. This meant that staff were supported to enable them to provide care to a good standard.

Records showed that staff had an annual appraisal. Staff told us they could request additional training to develop their skills and careers. One member of staff had recently been promoted within the team. They told they had been on specific management training, for example how to carry out formal staff supervision.

The Mental Capacity Act 2005 (MCA 2005) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Best interest meetings about important decisions were recorded. People with changing capacity to make day-to-day decisions about their care were still offered choice and provided with information to help them decide what they wanted to do.

We checked whether the service was working within the principles of the MCA 2005 and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. For example the decision making process had been followed for a person who needed dental treatment at a specialist hospital. A health care professional said, "I'm asked to take part in any decision making processes and fully involved when considering best interest meetings and MCA 2005."

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 2005. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The resisted manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This reduced the risk of people being unlawfully restricted.

Good

Is the service caring?

Our findings

We observed good communication between staff and people living at Moordean, and found staff to be friendly and caring. Two people showed us their bedrooms and they both told us they liked their staff and were happy with their bedrooms.

Relatives said they were fully involved in peoples care. One relative said, "They [staff] ask for your input and say that you know him more than us." Another relative commented, "The staff at Moordean are amazing people. They work extremely hard with my brother. They support and encourage him, I can only praise all the staff that care for him."

Another relative said, "Relationships can be a problem, he's built up lots of relationships within the house now." And, "Staff ask for my views about the care plan. I can go to his key worker, or anyone if I want something added, it's a good one and its working."

A relative also told us they thought staff were caring. They said, "He was in hospital and staff were with him all the time on 2 to 1, and they stayed there at night and staff were coming to visit him when they weren't on duty."

A health and social care professional commented, "When communicating with people, staff give the individual time and space which allows them the freedom to make their choices and wishes known to the best of their ability. Whilst at the same time ensuring that both they (the individual) and any others involved with their support or indeed share their service are respected and as safe as possible in sometimes complex situations."

Staff assisted and encouraged people's independence. Staff told us that they see their roles as enablers for people. When they spoke to us they displayed the right caring attitude, they told us they gave people time to do things, they tried not to rush people. When appropriate staff calmly carried out the task for people to make sure they were calm and comfortable. For example, if people started to make a drink for themselves, but could not complete the task, staff made sure the person still got their drink.

Staff were able to describe ways in which people's dignity was preserved, such as making sure people's doors were closed when they provided care. Staff enabled people to have the personal space they required. Positive relationships had developed between people who used the service and the staff. Staff knew people well and there was laughter and conversation, which engaged people during the inspection. Staff were calm, reassuring and individually responsive to people at all times. Staff communicated with people using eye contact and appropriate language. Staff understood how to maintain a calm and relaxed atmosphere for people.

Staff were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information on these from the 'Person centred care plans', which had been developed through talking with people and their relatives. This information enabled

staff to provide care in a way that was appropriate to the person.

Staff told us how the transition plan was carried out before people moved from their last service to this one. Their needs were taken into account, enabling people to build familiarity to their new environment and reducing stress and anxieties. People had made numerous visits prior to the move, bringing a personal item every time and leaving it in their new room. Visual support including story books were used, and staff used easily understood countdowns such as how many roast dinners there were left until people moved.

The rooms within the service were personalised to a high degree to people's choice and lifestyle. This was a positive aspect of the service for people during the inspection. For example, people had sensitively been consulted about things that were important to them such as floor coverings and décor.

Staff explained that all information held about the people who lived at the service was confidential and would not be discussed to protect people's privacy. Information about people was kept securely in the office and the access was restricted to staff. Staff understood their responsibility to maintain people's confidentiality. We observed they were careful when discussing personal information.

Outstanding ☆

Is the service responsive?

Our findings

A relative said, "He's happy. His Epilepsy causes seizures and the service are good at informing me and getting bloods done. They include me as part of the circle [of support]. We work together. If I am worried I am able to approach anyone here."

A health and social care professional told us, "The service provides a very holistic approach to individual needs, often in the face of, at times, very difficult circumstances. Many of the individuals at Moordean, have mentors who work with them to enhance their quality of life. The individual [People] have access to a wide range of activities and participation in community life. With staff support, the individuals have built-up relationships in the community."

The providers had consistently acted to make sure people were safe and prioritised people's safety in the least restrictive way. The providers had a high degree of understanding of how to avoid creating triggers for people's behaviours that may cause harm to themselves or others either through the way care was delivered or by the environment people lived in. People experienced an environment and care that minimised the potential for harm and gave more opportunity for them to live fulfilled lives. At Moordean there had been 959 fewer instances of restrictive physical interventions used over a 12 month period prior to the this inspection. For one person there had been a significant decline in the monthly frequency of their challenging behaviour between June 2016 and May 2017. In June 2016, there had been 40 instances of physical aggression, self-harm, damage to property or verbal aggression. By May 2017, these behaviours had only occurred on 16 occasions. The correct implementation of positive behavioural support had a major impact to people's safety as it reduced the number of physical interventions being used by staff to control behaviours and a higher proportion of early verbal interventions had led to a reduction in physical interventions.

The actions that staff should take to reduce the risk of harm to people was detailed behavioural care plans. The provider employed specialised 1-1 mentors to assist with activities and positive behaviour therapist worked closely with people and their support staff to minimise risk in the service and in the community. There were personalised risk assessments and behaviour intervention plans in place for each person who used the service. The positive behaviour care plans were consistently used by staff to identify people's triggers for behaviours that had a negative impact on themselves or others or put others at risk. The steps and early interventions staff should take to defuse these situations and keep people safe was fully recorded. Staff successfully redirected people's behaviours at least eight times during the inspection. This stopped eight potential situations of escalation of behaviours that may cause harm.

The provider used a range of tools including clinical meetings, staff training and specialist behaviour support to manage risk and keep people safe, whilst ensuring they had a full and meaningful life. People's health and safety had been discussed at weekly clinical team meetings to inform and reinforce staff knowledge of the steps that were to be taken to minimise the risk after incidents.

People's care and support was planned proactively in partnership with them so that they received person

centred care. Person centred care is a way of thinking and doing things that sees the people living at as equal partners in planning, developing and monitoring care to make sure their needs and preferences were met. The provider employed their own positive behavioural support (PBS) staff and person centred care planning (PCP) co-ordinators. (PBS) or positive behavioural support is a nationally recognised model of care and is seen as the best way of supporting people who display, or are at risk of displaying behaviour which may cause harm to themselves or others. The employment of a specialist PCP planner made sure that people were put at the centre of service provision.

Staff worked continuously to support people to access the medical treatment they required. If people needed more invasive medical treatment this was facilitated over time as part of the positive behaviours planning process. Using positive behaviour responses reduced the need for medicines to be used to control behaviours. One person had successfully received a mouth X-ray as part of on-going dental treatment without the use of behaviour control medicines. Their relative said, "He's been taken to London to Guys for his wisdom tooth and they managed to X-ray him. He had three staff with him." This meant that the positive behavioural methods in use enabled people's health and wellbeing to be met.

People benefitted from a staff team who were very responsive and flexible in adapting their support to enabling positive intervention responses from people. For example, a relative had been unable to visit Moordean to see their loved one as this triggered negative behaviours when the relative left. Staff and the relative came together to discuss what could be done to re-establish this valued relationship. The outcome was to establish a process of gradual routine change, which resulted in the person making visits to the family home and the family visiting the person. This creative plan was facilitated by the service and the relative said, "They've put new rules in and it's worked, we come over now." This resulted in a resumption of positive contact between the person and their close relatives and reduced their isolation.

PBS care plans were comprehensive, with every area of the person's life broken down into sections, for example, activities, independence participation, personal care etc. Within each section each area was broken down further with realistic personalised targets. For example, making their own drink, which would include what they can do for themselves and how much support they need. Very small steps of progression were used to encourage development. The person's progress was monitored daily and weekly and the personalised targets were adjusted to promote successful outcomes. For example, one person was living more independently and taking small steps towards moving out of the care service to their own home. This approach had led to people learning new skills and doing more for themselves leading to more independence.

Staff were extremely responsive and flexible to people's choices and needs. The positive behaviour (PBS) worker visited the service weekly to spend time with people so that they got to know them all really well. The PBS worker regularly advised and worked with the staff to develop and update people's individual positive behaviour plans based on information collected by staff. This benefitted people as their changing needs could be responded to without the need to wait for external interventions.

There was a general policy about dealing with complaints that the staff and registered manager followed. A relative said, "No complaints, small bits and pieces, I talk to them about it and the staff responded to this". And, "If problems occur they are open about it, It's nice to get some positive phone calls as well." The complaints procedure was made available in the service. The information gained from PBS data and care records was collated and used to gauge people's contentment. For example, how were their independence and participation targets affecting instances and regularity of challenging behaviour. If challenging behaviours were increasing, staff then met at a weekly clinical group meeting and reviewed people's needs and environment and made adjustments accordingly. This was enabling for people who communicated

using behaviours and body language as staff understood the decisions and choices people preferred to make.

Person centred reviews took place with health action plans and communication passports in place. (Health action plans are recommended for people with learning disabilities by the department of health to promote people's health and their access to health services.) (Communication passports are easy to follow person-centred booklets for those who cannot easily speak for themselves when they need to use other services. For example, if they were admitted to a hospital.)

The activities people were involved in were tailored to their choice and lifestyle, encouraged participation and reduced social isolation. People could access the community in one of two mini buses available and three people living at Moordean had their own cars. Staffing was provided based on the assessment of risks the activity to be undertaken may have. Activities were introduced to people slowly so that staff learn by the person behaviours if they were comfortable with the activity.

People's behaviours that may challenge themselves or others were not seen as a barrier and people were consistently supported to participate in community life. A pictorial activity book was used by people to show them the places they had been and liked to go. Each page had a different place shown, there was a large photograph of the place at the top to help people choose. Underneath were descriptions of how people liked/responded to the experience and if they enjoyed it. Each activity was linked to a list of potential risks. Each page had a colour coded circle to show the risk assessment required. Green was basic risk assessment, red was a higher risk and authorisation was required and familiar staff needed. This demonstrated a person centred risk based approach was followed.

The service responded to people's individual choices and requests in a way which made sure they lead as full a life as possible. When one person asked to go for a drive their key worker chatted to the person using eye contact and simple phrases with actions/signing. The conversation concluded with an agreement for a drive and shopping trip. Staff continually repeated the plans for the few minutes before they left as this was essential to help the person remain calm. If the person became anxious while they waited to go this may have resulted in the person displaying behaviours that challenged and the trip out being cancelled. The person returned to the service later in the day with some new jeans that they had chosen.

People's feedback was valued and there were systems in place to make sure these views were used to drive forward improvements. The staff used analysis of behaviours and reactions within the PBS model to gain information about people to gauge what had made them unhappy and why. Any concerns were recorded in people's care plans and discussed within the weekly clinical meetings. For example, one person's routines and behaviour towards staff were unusual which could have been due to the person not feeling safe. The staff had responded by working with the person to make sure they felt safe. This included the person visually checking with staff that the external doors were locked and the alarm was set at night.

Outstanding ☆

Is the service well-led?

Our findings

The values of the organisation were clearly noted and identified within organisational policies and provider statement of purpose. Staff told us that they learnt about the values of the organisation from day one of their employment. Staff were committed and passionate about delivering high quality, person centred care to people living with learning disabilities and autism. A health and social care professional said, "I find the Insight company extremely person focused, with good communication, great implementation of PBS model and their work ethic is following good practice.

Team members and indeed management have instilled an ethos of respect and dignity for all concerned at all times." The registered manager had extensive experience of delivering person centred care to people with complex needs. They had been promoted to lead the service from within the organisation and understood the culture and values needed. It was clear from our discussions with them that they had the skills and motivation to lead the staff team in the delivery of positive outcomes for people.

A relative said, "They [staff] do a tremendous job and I'm always saying, thank you very much."

The provider's and staff demonstrated their commitment to a lifestyle approach model of care that fostered a proactive, positive values led approach to the management of challenging behaviours. The providers visited the people in the service on a weekly basis. They attended the weekly clinical meetings where discussions took place about people's progress.

Learning and practice development were supported by the providers. The providers maintained their nursing accreditation in Learning Disabilities which included maintaining their own professional knowledge and understanding of best practice in learning disability services. One of the providers was also an accredited Best Interest Assessor in Kent and took the lead in the correct implementation of the Mental Capacity Act 2005 (MCA 2005) and associated DoLS within the service.

The registered manager attended networking events such as the learning disability practice forums. A member of the team currently holds a certificate in person centred support and a diploma in positive behavioural support awarded by the Tizard and is currently working towards a BSc (hons) in Intellectual and developmental disabilities. Their learning was disseminated down to staff and staff approaches adapted for people when staff provided support. (The Tizard Centre is the leading UK academic group working in learning disability and community care, is widely known world-wide and has an international reputation and works to advance knowledge about the relationship between care services and their outcomes for people with learning disabilities.)

The providers contributed to finding solutions to the challenges or barriers people faced in living a fulfilled lives. For example, they had invested in the service to make it a place people felt comfortable in. The service had been adapted to suit people's needs. For example, the ceilings had been raised to make the service more airy. The service was fitted with Wi-Fi for people to use with their personal smart TVs and tablets.

The providers were strong role models and lead by example. They were actively involved in the delivery of care and were continually striving to improve the service. Staff said, "The providers attend weekly clinical reviews and our joint forums, they most definitely listen to staff ideas for improvements." And, "The providers support a very strong imbedding of the companies care values in staff, we belief that smaller things can make a big difference to the people's lives." Another member of staff said, "I feel massively supported by the providers, I've had a lot of learning and development and they are always available to me, we have their work and personal contact details and meet them face to face every week at the clinical meeting."

The provider was mindful of the emotional challenges staff experienced and understood that a resilient and valued team was essential to people receiving a high quality service from consistent staff. The providers and the registered manager sought to protect the health and emotional wellbeing of staff who often worked intensely in stressful situations. Key staff received training about stress management to enable them to understand and support the management of stress within the team. Staff meetings and staff surveys were carried out and we saw that the providers responded to any issues by offering additional support to staff. For example, by staff attended reflective discussion groups.

The provider's quality assurance systems were based on a person centred culture, putting people who lived in the service at the centre of everything they did. People's wider circles of support were included such as staff, relatives and health and social care professionals. Feedback from annual quality lifestyles and personal outcomes questionnaires was analysed and the data and actions were fed back to people. People were given additional support to participate in the completion of the questionnaires. From the most recent feedback there were high satisfaction rates, however the provider had highlighted six key areas for improvement prompted by the data collected.

People were protected by consistent and comprehensive quality audits. The audits included specialised analysis of positive behavioural strategies, person centred lifestyles and restrictive practice audits. The auditable data collected about each individual person significantly contributed to the decision making processes for health care professionals such as GP's making health related judgements and external behavioural specialist such as mental health teams. For example, epileptic seizure monitoring was enabling the specialist epilepsy nurse to change a person's medicines to manage and control the impact and frequency of the person's epileptic seizures.

The registered manager had carried out audits of the service on a monthly basis. Audits enabled them to identify areas of the service that needed improvement, which they recorded and took the actions required. They completed audits of all aspects of the service, such as medicines, kitchen hygiene, infection control, care plans, staff training and staff health and wellbeing. Over time there had been continuous improvement in the quality of the service which included moving people from their old service to a new, more suitable environment. With the continued improvement we found, people's experiences and safety had improved.

The provider had created cleaning and safety audit schedules for daily, weekly and monthly checks with designated responsible staff. The registered manager's role included checking that staff monitored and reported their findings to make sure appropriate action was taken when necessary and to minimise the risk of a re-occurrence. Records showed, for example, accidents and incidents were fed into the organisation risk management process, analysed for causes and effect and the required actions taken.

Actions taken as a result of analysis included changing behavioural management guidance for staff referring individuals to mental health professionals, refresher or additional training for staff and sharing information with relatives, the local safeguarding team and CQC. For example, the providers had organised additional

training for staff around caring for a person at Moordean with a bi-polar disorder.

People benefited from being supported by a staff team that felt valued and well supported. Staff told us they enjoyed their jobs. One member of staff said, "I am happy with the leadership in the service, we all get on really well." Another said, "The management team are very approachable, I find we work as a team and my colleagues are very supportive." Other staff said, "At supervisions we talk about the team and I am asked how I am getting on too". And, "At team meetings we discuss what we can improve, for example we have just introduced picture cards for one person." Good communication and support within the staff team led to the promotion of excellent working practices.

There were a range of policies and procedures governing how the service needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the service. Staff had signed to say they understood the policies. Staff understanding of the policy's they should follow was checked by the manager at supervisions and during team meetings.

The registered manager was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the service. This meant that people could raise issues about their safety and the right actions would be taken.