Life Path Trust Limited

# Life Path Trust Limited

## Inspection report

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Date of inspection visit:
16 June 2016
17 June 2016

Date of publication:
29 July 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

We undertook an announced inspection of Life Path Trust Limited on 16 and 17 June 2016.

Life Path Trust limited provides personal care for people with learning disabilities. The service supports people in three supported living complexes in the Oxfordshire area. In addition they also provide support for some people in their own homes. At the time of our inspection 12 people were using the service.

There was a registered manager in post. 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 supported living complex atmosphere was open and friendly. The registered manager, area manager and staff were keen to show us their work and how they fostered a positive, open and honest culture.

Relatives told us people were safe. Staff understood their responsibilities in relation to safeguarding adults. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People benefitted from caring relationships with the staff. We saw many positive interactions where staff respected people's privacy and promoted their dignity. People and their relatives were involved in their care and people's independence was actively promoted.

People received their medicine as prescribed. Where risks to people had been identified risk assessments were in place and action had been taken to manage these risks. However, some staff had not always followed guidance to keep people safe from risks. We saw the registered manager had taken action to address these concerns.

There were sufficient staff to meet people's needs. Staff rotas confirmed planned staffing levels were consistently maintained. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act 2005 (MCA) and applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The operations manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected.

People had enough to eat and drink. People could choose what to eat and drink and their preferences were respected. Where people had specific nutritional needs, staff were aware of, and ensured these needs were

met.

Relatives told us they were confident they would be listened to and action would be taken if they raised a concern. The service had systems to assess the quality of the service provided. Learning needs were identified and action taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager. Staff supervision and other meetings were scheduled as were annual appraisals. Staff told us the registered manager and area manager were approachable and there was a good level of communication within the service.

People told us the service was friendly, responsive and well managed. People knew the registered manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Staff had not always followed guidance relating to management of risks.

Relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns. Sufficient staff were deployed to meet people's needs and keep them safe.

People had their medicine as prescribed.

### Is the service effective?

**Good**

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act 2005 (MCA) and understood and applied its principles.

People had access to healthcare services and people's nutrition was well maintained.

### Is the service caring?

**Good**

The service was caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The provider and staff promoted people's independence.

### Is the service responsive?

**Good**

The service was responsive.

Care plans were personalised and gave clear guidance for staff on how to support people. People were supported to engage in hobbies and interests.

Relatives knew how to raise concerns and were confident action would be taken. People's opinions were sought and they were involved in the running of the service.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

## Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service.

There was a positive culture and the registered manager shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff in the service. Staff knew how to raise concerns.

# Life Path Trust Limited

**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 was 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 16 and 17 June 2016. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be available. This inspection was carried out by one inspector.

We spoke with two people, five relatives and three care staff. We also spoke with the registered manager and the area manager. In addition we spoke with a healthcare professional, Oxfordshire County Council (OCC) safeguarding team and the commissioner of services.

We looked at four people's care records, staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's care route through the service and obtaining their views about their care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Requires Improvement

# Is the service safe?

## Our findings

People's relatives told us people were safe. Relatives comments included; "Oh yes very safe. They make sure [person] is ok and they really are aware of her needs", "Yes, I have no worries about [person's] safety" and "Yes I do think [person] is safe there". One relative we spoke with gave a conflicting view of the service. We therefore looked at the concerns this relative had raised and found that whilst this relatives concerns had been justified, the service had taken appropriate action to resolve these concerns. On the day of our inspection we found no evidence to support any further concerns.

People were supported by staff who could explain how they would recognise and report potential abuse. Staff told us they would report concerns immediately to their manager or senior person on duty. Staff were also aware they could report externally if needed. Staff comments included; "I would report any concerns to the manager or the client's social worker" and "I'd raise the alarm, these are vulnerable people. I'd contact the manager, whistle blow or call the local authorities". The service had systems in place to investigate concerns and report them to the appropriate authorities.

Risks to people were managed and reviewed for most people. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. A traffic light system was used to highlight the level of risk to the person. For example, one person was at risk of choking. The risk assessment highlighted the level of risk as 'red'. This was because the person could choke 'due to eating large pieces of food'. The person had been referred to a speech and language therapist (SALT) who had provided guidance for staff to follow to keep the person safe. This included 'cutting food into small pieces' and using 'a plate guard'. Staff were also advised not to leave the person alone when they were eating. Staff were aware of how to keep the person safe and followed this guidance. Other risks managed for people included mobility, medicine and fire.

However, we were alerted to two incidents where care staff had not always followed people's risk assessments. In both instances, the provider had taken immediate and appropriate action and followed their procedures to ensure people were safe. Although actions were taken we have asked the manager to provide us with details of how these improvements will be sustained as further updates are required to people's risk assessments.

Staff were effectively deployed to meet people's needs. On the day of our visit we saw two staff supporting one person. This was in line with the person's support plan. Other people in the service received one to one support and the staff rota evidenced planned staffing levels were consistently maintained. A high proportion of staff were provided by an agency. However, we saw these were regular agency staff who knew the people they supported well. One relative said, "There is always at least four staff during the day. I've no concerns. There is a lot of agency staff but they are good". Another relative said, "Whenever I visit there always seems to be an army of staff around so yes, I think there is enough staff".

Staff told us there were sufficient staff to support people. Staff comments included; "There are enough staff. Very occasionally we get last minute sickness but even then we cover it" and "Enough staff? Yes, a lot are

agency but regular agency, they are very good". The registered manager had recognised the high use of agency staff and were in the process of recruiting permanent staff.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised with people. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions. The registered manager told us, "We conduct value based interviews where the emphasis is away from candidate's qualifications and more about their values. I can train someone to give medicine, I can't train them to care". This meant the manager recognised the need to ensure suitable care staff were employed who had the right attributes to care for people.

People received their medicine as prescribed. Where people needed support we saw that medicine records were accurately maintained and up to date and stored securely. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. We spoke with staff about medicines. Staff comments included; "I help with medication. I have been trained and my competency is often checked" and "They trained me in medicine administration and I am checked regularly".

One relative commented about medicine management. They said "I've no issues with medicines at all. I am a nurse and I see the MAR (medicine administration records) charts". Another relative said, "No issues currently with medication, they are well looked after".

Good

# Is the service effective?

## Our findings

People's relatives told us staff were well trained and supported people effectively. Relatives comments included; "They have very good knowledge, especially regarding [person's] diet. They know exactly what she needs, they are good", "I've not come across any problems, they seem very good and they know his little quirky ways" and "Yes they do know what to do and seem to have the right skills".

People were supported by staff who were knowledgeable about their needs and interests. We saw one person using an electronic tablet to choose what mobile phone they wished to purchase. A staff member was sat with them helping them to make their choice. The staff member was clearly aware of the person's interest in electronic technology and helped the person by reminding them of their favourite colours. The person responded by excitedly looking for particular coloured phone. Another person was unsure what to have for their breakfast. Staff were able to remind the person of their favourite foods as they knew the person well, and supported them to make a choice.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction programme linked to the Care Certificate and completed training when they started working at the service. The Care Certificate is a set of standards that social care workers adhere to in their daily working life. It is the new nationally recognised set of minimum standards that should be covered as part of induction training of new care workers. The training included safeguarding, moving and handling, management of medication and infection control. Staff also received training relevant to people's specific needs. For example, oxygen administration training was provided by Oxford Health NHS foundation trust respiratory and home oxygen assessment service. One staff member said, "Even as an experienced agency carer I still received training which was good. I've had specific training to people's needs before I could work with them. All very thorough".

Staff told us, and records confirmed, they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one member of staff had requested further training in dementia awareness and we saw this training had been completed. We spoke with staff about the support they received. One staff member said, "I can say I feel very well supported. I get supervision which I find useful. It helps me develop professionally". Another staff member said, "I do get supervisions. It is nice for managers to check we are ok and well. I once asked for intensive interaction training to help me communicate better with a client and I got it".

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to make these decisions when needed. When people lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager was knowledgeable about how to ensure the rights of people who lacked capacity were protected. The registered manager told us they continually assessed people in relation to their rights.

Where people were thought to lack capacity, mental capacity assessments were completed. For example, one person's capacity to make a decision about a risk had been assessed by healthcare professionals and an application to the Court of Protection had been made for a Deprivation of Liberty Safeguard. The Court of protection had approved the conditions of the person's support. The person's best interests had been considered throughout the process.

Staff demonstrated an understanding of the MCA and how to apply its principles in their work. We saw staff offered people choices and gave them time to make decisions. These decisions were respected. Staff checked people could understand information and if unsure staff found different methods of explaining the information to the person. For example, one person had difficulty understanding a particular phrase. A staff member then showed the person a picture and they quickly understood, laughed and clapped their hands. We asked staff about their understanding of the MCA. One member of staff said, "Some people may not have the capacity to make certain decisions. I'm here to help them with this, all in their best interests". Another staff member said, "It's looking at people as individuals and I assume they have capacity. I give them choices".

We asked staff about consent and how they ensured people had agreed to support being provided. One staff member said, "Once you get to know them (people) they can tell you what they want and don't want in many different ways. Body language for example. I just always ask to be sure". People signed consent to care documents held in their care plans. The document stated 'I am an adult and have the mental capacity to consent'. Where people were unable to sign, documents had been signed by an advocate, healthcare professional and the person's family to confirm they agreed this was in the person's best interests.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, dentists, opticians and district nurses. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans. On the day of our visit a care worker accompanied one person to their GP appointment. The person later returned and showed us the medicine they had been prescribed. One healthcare professional we spoke with said, "I've never had anything I could complain about with this service. I regularly visit them when they contact me and I provide some training for staff. I have no issues at all and the staff are doing amazing work with the clients, they have all developed at the service". A relative spoke with us about access to healthcare professionals. They said, "They are very on the ball with this. [Person] gets his appointments with no trouble. They took him to the hospital because they thought they could improve his mobility if he had specialist shoes, all without prompting. It worked".

People had enough to eat and drink. Care plans contained information about people's dietary preferences and details of how people wanted to be supported. Any allergies or special nutritional information was highlighted in people's care plans. People's preferences were also displayed in the kitchen. For example, one person's favourite foods were listed and attached to the fridge door. Another list displayed certain foods a person should not have. We observed people enjoying their breakfast meal. This was a lively event and we saw people were able to eat independently without support. However, staff were sat with people encouraging them to eat and joining in the discussions. One person ate in their room and they needed support. We saw this was provided appropriately. One person was able to tell us about eating and drinking. They said, "I like the food here. I eat loads of food". This person grinned and they laughed when they told us this. Staff who supported this person confirmed, "Yes [person] does like his food". One relative said, "I have no problems with [person] eating and drinking".

Good

# Is the service caring?

## Our findings

People benefitted from caring relationships with the staff. During our visit we saw many positive and caring interactions between people and staff. People appeared comfortable and were open and familiar with staff. Staff clearly knew the people they were supporting well. For example, we saw staff engaging with one person about football. It was a lively discussion and at one point the person asked for our opinion on the subject. When we replied they smiled and said, "I like football". Another person was sat in the lounge watching television. Staff respected this person's privacy but regularly asked them if there was anything they wanted. One person spoke to us and said, "I like it here. I'm going out today". We saw people had the confidence to speak to staff on equal terms and staff responded with warmth and respect.

Relatives told us people benefitted from caring relationships with staff. Their comments included; "They (staff) are really good. The staff are really caring, most certainly", "The staff enjoy being with [person]. They make sure he gets all he needs, they are really caring" and "I've seen an impressive bond develop between [person] and their carer. I see very caring relationships here".

Staff spoke with us about positive relationships with people. Staff comments included; "Yes there is a lot of caring shared between us. We get time to spend with service users and we all have a passion and mine is working with this clientele" and "We are 100% very caring. We all get along very well. I do like this work, I fell in love with this place and these guys (people)."

People's dignity and privacy were respected. When staff spoke about people with us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. We saw that where staff were providing personal care in people's rooms, doors were closed and curtains had been drawn promoting their dignity. A relative we spoke with said, "[Person's] dignity and privacy is respected, absolutely".

We asked staff how they promoted, dignity and respect. One staff member said, "I make sure I give them respect. I keep them (people) clothed as much as possible and I shut curtains and doors". Another staff member said, "I don't keep people undressed for longer than necessary and I close doors. I just treat them like I'd treat myself".

Staff actively encouraged and supported people to be independent. For example, one person was supported to attend college. One staff member said, "I support them and prompt them. I don't do it for them if they can do it". Another staff member told us how a person's independence had grown at the service. They said, "When [person] first came to us we were told they couldn't eat or drink independently and required almost constant supervision. We were able to slowly encourage them to be independent and now they move around the house safely on their own and they eat and drink independently. Their family was amazed at the progress". We saw this person exercising their independence during our visit. We spoke with this person's relative who said, "Yes, her mobility has really improved. She doesn't use the walking frame anymore which is brilliant". Another relative said, "They have got [person] feeding the fish in the fish tank. It's brilliant".

People were involved in their care. We saw people were involved in reviews of their care and all documents were written in an easy read, picture format enabling people to understand and be involved in decisions. For example, one person had stipulated what times they wanted support so they could plan their day. Another person had listed specific details of how they wanted their personal care to be provided. This included showers, dressing and personal care. We spoke with staff about involving people. One staff member said, "I talk to them (people). Once you involve them, they respond and talk about things". One relative commented, "I am involved and they keep us informed. We know all about the reviews (of care) and they send us updates and letters constantly". Another relative said, "I'm very much involved, they call me frequently to keep me involved and they are fully supportive".

The provider ensured people's care plans and other personal information was kept confidential. People's information was stored securely at the office and we saw people's care plans were held in their rooms at Life Path trust. Where staff left their desks when in the office, computer screens were turned off securing people's information. Staff were provided with guidance in relation to confidentiality and were aware of the provider's policy on confidentiality.

Good

# Is the service responsive?

## Our findings

People's needs were assessed prior to receiving a service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's care plan stated the importance of the person's 'books, college and family'. Another person had stated they liked football. Staff we spoke with were aware of people's preferences.

Care plans also contained details of significant people and events in the person's life. For example, family members birthdays. The plan gave contact details and dates with prompts to remind the person of these dates and allow them to maintain meaningful contact with their family and friends. One relative told us about a birthday and how staff had supported the person to celebrate it. They said, "[Person] really enjoyed giving out the present and card".

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person's plan contained guidance on how the person wished to be supported with personal hygiene. The care plan stated 'I have a bath after my evening meal'. The care plan went on to state that two staff were needed to support the person with a bath and that they must never be left in the bath alone. We spoke with staff and they confirmed they were aware of these important requirements.

Care plans were personalised and reflected people's needs and preferences. One person had difficulty verbalising and used signs and body language to communicate. Their care plan detailed what signs and gestures meant to allow staff to respond appropriately. For example, when the person was hungry or thirsty, they put something in their mouth. Staff recognised this sign and supported the person to get a snack or a drink. Another care plan stated; 'when I put my hand on my bottom or side' this means I want to go to the toilet and staff were prompted to support this person. In communal area's notices were displayed on the walls at Life Path trust complex depicting pictures of signs used by people and their meaning. For example, in the kitchen the notice displayed signs for breakfast, drinks, more food and 'I've finished'.

People were supported by staff who understood, and were committed to delivering, personalised care. Staff explained to us how they assisted people with their personal care to suit their individual preferences. Staff comments included; "I treat people individually, person centred care every time" and "Personalised care means care given to an individual to meet their needs and requirements. It fits with them".

People's changing needs were responded to by the staff. For example, one person's weight could fluctuate and they had been referred to the community nutrition and dietetic team. Guidance had been provided to manage the person's condition and included diet options and a regular weight monitoring regime. We saw this guidance was followed and the person's weight was monitored and recorded regularly. The person was also reviewed by the GP and on the day of our visit the person's weight was within the GPs recommended range.

People were encouraged and supported to engage in activities and maintain community links. A weekly planner of people's activities was displayed and we saw people went out on trips to places of their choice. For example, visits to day centres, shopping trips and attending college. This demonstrated people were supported by staff to enjoy their hobbies and interests. We saw one person watching the television. At one point a staff member sat next to the person and engaged them in conversation about the programme they were watching. A relative spoke with us about activities. They said, "I popped round one day just to call in and saw they were all going out to a wildlife park. How wonderful, all going out together". Another relative said, "We can see since he (person) has been with the service he has blossomed and he is so much happier".

People's opinions were sought and acted upon. Individual needs were recognised as easy read 'citizens' surveys were sent to people. Also regular surveys were sent to people's families to obtain their views on the service. The results of the surveys were analysed and actions identified to make improvements. For example, in one survey it was identified some people did not know if they had a 'tenancy agreement which gave them the same rights as everybody else'. The provider took action to address this and the latest survey showed the number of people who were now aware of their tenancy agreements had increased. This meant the provider had identified the importance of ensuring people's rights were protected. People and their families were informed of the survey results through a detailed newsletter summary.

People and their families were provided with details of how to raise a complaint. Details on complaints were held in the 'service user guide' which was given to people and their families when they joined the service. The guide was written in an easy read picture format that people would be able to understand and how to raise a concern. Complaints were recorded and those we saw had been investigated and resolved in line with the provider's complaints policy. For example, one person had complained about being supported by a male staff member. The registered manager took action and a female member of staff was allocated. Relative's told us they knew how to complain and they were confident action would be taken to resolve any issues.

People were involved in the management of the service and their opinions were sought and acted upon. The provider had a 'citizen's board' and people were encouraged to join the board, attend meetings and take an active role in how the service was run. People were included, consulted and involved in the decision making process. For example, following a financial meeting, the 'citizen's board' decided a particular planned conference was too expensive and recommended the conference did not go ahead. The provider had considered this recommendation and ultimately decided to cancel the conference. The 'citizen's board' also had input into staff recruitment. The registered manager said, "This is not just a token gesture. These people really do have a voice and we listen".

Good

# Is the service well-led?

## Our findings

People knew the registered manager and the area manager. People approached both with open familiarity and called them by name. We saw people were well at ease in their company and laughed and joked with them.

People's relatives knew the registered manager and spoke with us about how the service was managed. Relatives comments included; "I think it is a well led service. All the managers seem fine. I do believe they give good quality care", "They are on the ball. I don't have a problem at all with management" and "I don't know the managers that well but they seem to do a good job, communication is fine and I believe they are honest".

Staff told us they had confidence in the service and felt it was well managed. Staff comments included; "The manager is very supportive, in fact the whole service is supportive and well run", "I think she (registered manager) is really good, supportive and serious about improving things" and "I think it is a good service. People grow here both in confidence and ability. We get lots of positive feedback from families".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. The registered manager, area manager and staff spoke openly and honestly about the service and the challenges they faced. The area manager said, "In life everyone takes risks and positive risk taking, when managed well, really helps these people achieve their potential and beyond. It is not easy but very worthwhile". A relative said, "Yes they are open and honest".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the registered manager to look for patterns and trends. This information was also overseen by senior management. For example, where a pattern of falls was identified information was fed back to the registered manager and area manager who created an action plan to manage the risk of reoccurrence. Actions were taken and the incidence of falls reduced.

Staff told us that learning from accidents and incidents was shared through staff meetings and briefings. One member of staff said, "We have meetings where we get updates and share learning. Any incidents are discussed and we sign minutes to show we are aware". Another staff member said, "We have a communications book, a diary and handover meetings. That's how we share learning. We sign the memo folder as well to show we have read it".

Staff meetings were held and recorded and we saw staff discussed people's needs, received updates and shared learning through these meetings. For example, following a care review staff were reminded they were required to sign the review to evidence they were aware of the changes. We saw staff had signed this review. At another staff meeting it was raised a person had requested their electronic device was placed on charge every night. Records confirmed staff had respected this person's request.

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care including risk assessments, care plans, training and medicine records. Audit results were analysed and resulted in identified actions to improve the service. For example, following one incident an audit was conducted and identified areas that needed to be addressed. This included briefing staff and reviewing the person's care in relation to the incident. These actions were completed. The registered manager shared this information with the provider to allow other services to be made aware of the risks identified. We saw a follow up audit by the provider was scheduled to ensure the measures taken were being sustained.

The service was subject to a full internal review by Life Path Trust senior managers every three months. The results were analysed by the provider's auditors and the results were overseen by the senior management board.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.