Community Integrated Care

Fir Tree Road

Inspection report

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Date of inspection visit:
08 June 2016

Date of publication:
28 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 8 June 2016 and was unannounced. This was a comprehensive inspection.

Fir Tree Road is registered to provide accommodation with personal care for up to eight people who have learning disabilities and some associated physical or mental health conditions. On the day of our inspection there were six people living at the home. People were aged between 73 and 91 years old. Many of the people living at the home had lived together for 30 years.

The home had 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.

Staff understood their role in safeguarding people and we saw that incidents were being reported where appropriate.

We found that policies and procedures were in place to guide staff in how to keep people safe in the event of emergencies. Fire drills and fire alarm tests were carried out along with regular audits of emergency and contingency planning.

People were administered their prescribed medicines by staff who had received medicines training. Medicines were stored safely and systems were in place to ensure medicine stock could be monitored and audited.

Staff routinely carried out risk assessments and created plans to minimise known hazards whilst encouraging people's independence.

Staff training was tailored to the individual needs of people who live at the home.

Staff provided care in line with the Mental Capacity Act (2005). Correct procedures were followed when depriving people of their liberty in their best interests.

Staff followed the guidance of healthcare professionals where appropriate and we saw evidence of staff working alongside healthcare professionals to achieve outcomes for people.

People told us that they enjoyed the food people were being provided with choice and also being involved in writing menus.

Information in care plans reflected the needs and personalities of people. People had choice about activities they wished to do and staff encouraged people to pursue new interests.

People were given the opportunity to provide feedback on the care they received through residents meetings and keyworker sessions. We saw evidence that issues raised by people were responded to by management.

Staff told us that they were well supported by management and had regular supervision.

People and relatives told us that they had a positive relationship with the registered manager.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of their responsibilities in safeguarding people and understood how to follow procedures to keep people safe.

Risk assessments promoted independence whilst also ensuring people were kept safe from known hazards.

Accidents and incidents were recorded and systems were in place to monitor patterns and respond appropriately.

Contingency systems and emergency procedures were in place in case of emergencies and staff understood how to respond.

Medicines were administered safely by staff who were trained to do so.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and knowledgeable about their individual needs.

People were happy with the food served at the home and were supported to develop skills in cooking and daily living activities.

Staff understood the Mental Capacity Act (2005) and people were supported in line with its guidance. Where applicable, applications had been made to deprive people of their liberty.

Healthcare professionals visited regularly and had input into assessments and reviews.

Is the service caring?

Good

The service was caring.

People were supported by staff that knew them well.

People were included in decision making and the running of the

home.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Assessments and care plans were person centred and reflected people's needs, interests and preferences.

People were supported to engage in activities that were meaningful to them.

A complaints policy and procedure was in place that gave people opportunities to raise any concerns that they might have.

Is the service well-led?

Good

The service was well led.

Staff told us that they had support from management and staff feedback was acted upon to improve people's lives.

There was an open culture. Staff knew how to whistle blow and the home's management had an open approach to whistleblowing.

Systems were in place to monitor the quality of care and to ensure that people received good care.

Fir Tree Road

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 08 June 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not request that the provider completed or returned a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. Instead we sought evidence of the quality of the service during the inspection.

As part of our inspection we spoke to five people who used the service, one relative, three members of staff and the registered manager. We observed how staff cared for people and worked together. We read care plans for three people, medicines records and the records of accidents and incidents. We looked at three people's mental capacity assessments and reviewed applications to the local authority to deprive people of their liberty.

We looked at three staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits.

We looked at a selection of policies and procedures and health and safety audits. We also looked at minutes of meetings of staff and residents

Good

Is the service safe?

Our findings

People told us that they felt safe at the home. A relative told us, "There's always plenty of staff around to look after everyone." One person said, "Yes" when we asked if they felt safe living at the home.

People were protected against the risks of potential abuse. Staff demonstrated a good understanding of safeguarding procedures and knew their role in protecting people. Staff were able to recognise signs of abuse and told us that they would respond by informing their manager or contacting the local authority safeguarding team. Staff had attended safeguarding training and all staff had read the safeguarding policy, which complied with national legislation. Where potential abuse had occurred, the Local Authority had been notified. People had access to information in an easy read format on how to contact outside agencies if they were concerned about their safety, staff told us that they discussed this with people. The keyworker system meant staff knew people well and would be able to spot potential signs of abuse in people who were not able to express themselves verbally.

People were protected from financial abuse. There was a robust system in place where money was checked by two members of staff every time it was needed and there was a daily audit at each shift change. We observed this taking place during our inspection. We noted that there had been no allegations or complaints relating to financial mis-management at the time of our inspection.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. For example, one person was being supported to go out to a day service during our inspection. This person's care records contained risk assessments with techniques on how best to support this person in the community to minimise risks of falling. We observed staff following this guidance when supporting this person to leave the home. Risk assessments in people's records were clearly written and included a variety of risks with guidance to staff on how to manage them. The registered manager told us that she often meets with people and staff to discuss any new risks that people may be exposed to as their needs or circumstances changed. Records showed that risk assessments were reviewed regularly.

Accidents and incidents were documented and staff learnt from these to support people to remain as safe as possible. The accidents and incidents logged in people's records included a record of all incidents, including the outcome and what had been done as a result to prevent the same accident happening again. For example, one person had suffered three falls in a short period of time. The registered manager had informed the appropriate healthcare professionals who provided equipment that helped to reduce the risk of further falls. Staff worked alongside healthcare professionals which enabled this person to develop a better range of movement that improved their mobility and reduced the risk of further falls.

People could be assured that in the event of a fire staff had been trained and knew how to respond. Staff were able to explain what action they would take. There were individual personal evacuation plans in place that described the support each person required and these had been reviewed to make sure they reflected people's needs. Information in these plans reflected people's individual needs. For example, an evacuation chair had been purchased because one person would need this during an evacuation and staff had been

shown how to use it. There was a business contingency plan in place which informed staff how to respond to other emergencies that could prevent the service from operating safely. The contingency plan included emergency contact numbers the staff needed and staff knew where to locate this document.

There were sufficient staff to meet people's assessed needs. We observed there were enough staff present to respond to people swiftly. The registered manager had a tool to calculate the staff hours available each week and deployed staff appropriately, taking into account the needs of people. For example, on a Wednesday nobody goes out so they use this day to have one less staff member and they make use of their activity rooms within the home. Senior staff were also on call if staff needed them out of hours.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable for their role. The staff files contained evidence that the provider had obtained a Disclosure Barring Service (DBS) check for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also included proof of staff's identity and references to demonstrate that prospective staff were suitable for employment.

Staff administered people's medicines safely. Staff had been trained to manage medicines and they were required to pass a competency test before being able to support people with medicines, these were documented in all staff records. For example, at the time of our inspection one member of staff was new and had not yet completed the medicines training. This staff member did not administer medicines. Spot checks and audits were completed regularly and documented to ensure staff maintained good practice in administering people's medicines. We observed an audit taking place during our inspection and this highlighted no issues. Medicines to be returned were stored safely with a clear record of which medicines were being returned to the pharmacy. This meant that medicines no longer in use were kept to a minimum and therefore reduced the risk of medicine errors occurring.

People's medicines were stored, administered and disposed of appropriately and securely. Medicine Administration Records (MARs) were up to date and showed who had administered medicines or the reasons for medicines not being administered if applicable. People's medicine records and people's individual medicine cabinets had photographs of them on, this further ensured that staff knew who they were administering medicines to. There had been no recent medicines errors.

People's care records contained information on how they liked to take their medicines. For example, one person's care records stated that they may decline medicines. Staff were advised to come back later and ask the person again as they often changed their mind.

Good

Is the service effective?

Our findings

People told us that staff were well equipped and competent to do their job. One person said, "They're good." One relative told us, "The staff know what they're doing and they're really good with the people."

People's needs were met by staff who had access to the training they needed. One staff member told us, "The induction training is thorough and useful." Staff training included safeguarding, health and safety and the Mental Capacity Act (2005). The registered manager took steps to ensure training needs were identified and met effectively. For example, at the time of our inspection they were preparing to undertake fire safety refresher training. The registered manager had circulated a form with a short test on it to identify areas of learning for staff and was in the process of receiving these back. Training records documented all training completed by staff and confirmed that staff had passed competency tests to ensure that they had learnt from training.

Staff also received training specific to the needs of the people that they were supporting. For example, staff cared for people ranging in age from 73 to 91. In one instance, staff had been trained by a palliative care nurse on how to provide end of life care for a person before they had passed away. Staff had an understanding of end of life care that meant they would be able to provide support to people who were receiving palliative care. Staff said they always tried to stay with people and they would recognise if they were in pain and call for a doctor or the district nurses.

The registered manager used supervision to identify learning needs and to develop staff skills and knowledge. Supervision records were documented and showed staff had regular supervision meetings and were able to speak about their development. For example, the registered manager had found through supervision that one member of staff was less confident using the computer so they supported them and set small tasks for them and checked how they progressed. This meant that the staff member was now more confident in using and contributing to electronic records which ensured they maintained up to date records of the care they provided.

Decisions were made in people's best interest and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager ensured that mental capacity assessments were carried out to determine if a person had capacity to make a specific decision. If they did not have that capacity then best interests

meetings took place. If people were being restricted in their best interests for example, by being unable to leave the home unaccompanied then DoLS authorisation applications had been submitted and received by the local authority. The provider had delivered training in this area and staff understood how the principles of the legislation applied in their work.

There were numerous instances of people's best interests being considered when decisions that affected them were made. For example, one person had been keen to buy a new television but a mental capacity assessment had identified that they lacked the capacity to make this financial decision. The care records clearly showed the steps taken to reach the best interests decision, with the involvement of the person, their relatives and healthcare professionals. This ensured that decisions were reached that took into account the person's wishes whilst also ensuring that the decision was made in their best interests. The person told us that they were very happy with their new television.

People told us that they liked the food on offer and they were offered a choice. One person said, "I like sausages." And we saw this person being supported to have sausages as they were on the menu that day. Their care records clearly reflected this as one of their favourite foods. A relative told us, "The food seems to be very nice. The smell made me feel hungry when I visited." People who were not able to verbally express their opinion of the food were observed eating their meals and finishing them, indicating that they enjoyed the food.

People were supported to have a meal of their choice by organised and attentive staff. Staff pointed at pictures to offer people choices of drinks during the day. There was a pictorial menu that included alternative options for people. The registered manager told us that she involved people in writing the menus and people would sit with her and help with internet shopping, as people could make choices by using the pictures on the website. For example, one person really enjoyed Caribbean food. Staff supported this person to buy ingredients and to prepare meals from the region.

Dietary requirements and food preferences were a part of admission assessments and were reviewed regularly as a part of people's care plans. For example, staff had noticed one person was coughing when they were eating. They contacted a Speech and Language Therapist (SALT) who identified a slight swallowing difficulty and the person was given thickener and advised to avoid certain snack foods. Care records were updated following this and on the day of our inspection we observed this person being given drinks that were thickened. The person was now offered alternative snack foods that would not cause them to cough, this was clearly stated in their care records

People's care records showed relevant health and social care professionals were involved with people's care. Care records included information about people's healthcare needs and these had been reviewed on a regular basis. For example, one person's care records contained information from a behavioural specialist on how to approach them and to provide positive reinforcement. Staff were instructed to use a high and happy tone of voice and to be clear with them, allowing time for them to answer. During our inspection, we observed staff approaching the person in this way. Care records showed that there had been no recent occurrence of behaviours that could challenge.

Staff attended healthcare reviews and information following these was clearly recorded in people's records. Reviews were with a range of professionals such as nurses from the community learning disability team, care managers in social services and Speech and Language Therapists. The registered manager told us that they have good links with local community health services which was clearly demonstrated by the input they had in people's care.

People's care records contained 'Hospital Passports' which reflected people's needs including important information about people's medicines and allergies. These records would be taken to hospital with people if they were admitted. This demonstrated that the home shared important information with healthcare professionals.

Good

Is the service caring?

Our findings

People told us that the staff were caring. One person told us staff were, "Kind and you could have a laugh with them." A relative told us, "(Person) is always happy. The carer is very nice."

Interactions between people and staff showed kindness and compassion. People were supported by staff who sat with them and encouraged them kindly when assisting them to eat, drink or take part in activities. No one was rushed and staff made sure they took time to listen to people and engaged them in conversation they knew would interest them. For example, one person really liked one particular piece of sensory equipment. We observed staff engaging with this person using the equipment that they responded well to. People appeared to be relaxed with the staff, holding their hands, smiling and chatting. One person said they liked the staff as they danced with them and enjoyed the same music.

Staff knew the people that they were supporting. Staff were knowledgeable about people's preferences and life histories and the information they told us clearly matched with the information recorded in people's care records. For example, one particular topic of conversation could cause one person distress. When this topic came up staff were able to discreetly inform us of the reasons for this and steer the conversation away from that topic. This demonstrated a good understanding of this person's needs and personality.

People's bedrooms were personalised and decorated to their tastes. One person's care records stated that they had a strong interest in football. Their bedroom was decorated in colours selected by them with various football memorabilia on the wall. They had their own furniture that staff had supported them to choose and buy. The person told us that they were very proud of their room.

Peoples dignity was respected by staff. One person said the staff always helped them when they needed help. We observed staff being attentive. For example, staff were quick when one person needed help with their personal care and helped them straight away. Staff were discreet and spoke quietly before taking the person to another room to attend to their needs. At other times the staff checked people were alright by asking them or by sitting with them.

People were involved in the running of the home which created an inclusive atmosphere. For example, the registered manager told us one person often sits in the office and will answer the phone, which they enjoyed doing. This person had also assisted in producing an easy read fire evacuation poster which they told us that they were pleased with.

The home operated a keyworker system, where a named member of staff takes special responsibility for working with individuals and coordinating their care. Each person had a member of staff who acted as their keyworker. A relative told us, "(Person) and their carer seem to get along well." Care records contained information from meetings between people and their key worker with action points or outcomes. We could see from the content of these that people could bring up things that they were concerned about. For example, one person had been regularly declining personal care. This had been a concern to staff and healthcare professionals. The person's keyworker had worked with the person to identify particular staff

they were comfortable with and times of day when this person would be happy to have personal care. Staff adapted their approach accordingly and this person is now happier to be assisted with personal care tasks and they happen more frequently. This showed that staff took time to include people as well as creating environments where people could speak up and have their voices heard.

People's privacy was respected by staff and people were given control over their own personal space. For example, where people had keys to their rooms, staff waited whilst people unlocked their doors before going in. Two people had chosen to have their own keys whilst others wanted staff to look after theirs. We observed staff always knocking before entering people's rooms or asking permission to come in if the door was already open. The people who had their own keys moved freely between their rooms and downstairs and staff supported other people to go to their rooms whenever they wished. People were treated with respect to their privacy and staff explained how they helped people with their personal care in their rooms with the doors shut.

People were supported to be as independent as possible. For example, one person had asked to look after their own care records. The registered manager had risk assessed this and the person now kept their care records in their room. This demonstrated that people were empowered by being able to take ownership of their own personal information. Other people's care records were stored securely by staff.

One two occasions we heard staff speaking about people in front of others. We informed the registered manager who spoke to them immediately. Staff told us they do not normally do this and that it had occurred as a result of them explaining to inspectors how they care for people. On other occasions people's privacy was respected by staff. For example, staff shut the door when they spoke to us about people and made sure to include people in conversations about them when they were present.

We recommend that all staff be reminded of the importance of confidentiality, particularly when speaking in front of people and visitors.

Good

Is the service responsive?

Our findings

People told us that the service was responsive to people's needs. One person told us, "I like music." A relative told us, "They do lots of activities with them."

People's needs had been assessed before they moved into the home to make sure their needs could be met. One person told us, "They came to see me and then I came here and stayed for a meal to meet everyone, I liked it so much I moved in and I have settled in really well". People's assessments were detailed and they included information staff would need to understand to meet people's assessed needs. The registered manager said that even if there were other assessments completed by a care manager they would always go and meet the person and assess them themselves. Most people had lived together for 30 years. The registered manager told us that they were aware that they needed to meet people first to ensure that they would fit in well with the other people at the home.

Care plans were personalised and information on what was important to people was clear. One person told us that they really liked trams. This person's care plan contained pictures of trams and they were listed as one of this person's key interests on a "Getting to Know Me" document. The document had been completed by people with the support of staff. This person was supported to access a local tram service regularly and enjoyed going to Blackpool to see the trams there. A trip was planned for this person to visit in the near future and photos of previous trips were in this person's room. Staff told us about this interest, along with others, which demonstrated that they knew this person because they had read their care plan. Care plans had been signed by all staff to confirm that they had read them.

The home environment and equipment was suited to people's needs in a way that enabled them to remain as independent as possible. The downstairs area was open plan, which meant people could move around easily using walking frames and specially adapted wheelchairs. There was a lift that people were able to use independently. People's rooms were decorated and furnished to their own tastes and interests. The garden was quite overgrown which would prevent people freely using the lawn but the registered manager had already organised a gardener for the following week. This was important to one person who liked football and enjoyed going outside with staff in the summer to kick a ball.

People were encouraged to take part in activities that suited their interests and hobbies. Activity timetables were on display in an easy read format throughout the home. Activities covered a range of interests such as games, aromatherapy and sensory activities. These catered to the different needs of people who lived at the home. There were also activities that people could request on a one to one basis. These were on a card with pictures that people could point at in order to make a choice. One person had a keen interest in World War Two and their care plan included one to one time to read books and watch films on this subject with staff. During our inspection people were supported to choose additional activities that they wished to do as well as being supported to join the main group activities that day. There was a separate sensory and activity room where people could spend quiet time or use crafts materials. In the afternoon staff supported people to spend time engaging in sensory activities. As well as organised activities people were supported to visit a local shop as often as they wished.

Activities on offer were reviewed in line with the needs of people living at the home. Most people had been living at the home for a long time and as they were becoming older the activities they enjoyed had changed and the registered manager recognised this. For example, some people used to enjoy going to the theatre. As they had become older they found the journey and late nights more difficult. In response to this, staff now supported them to attend matinee performances.

People told us that they knew how to make a complaint. The complaints policy was clearly visible on a wall in an easy read format and staff told us they could tell if someone wasn't happy by their facial expression and behaviour. Staff told us that they would report complaints to the registered manager or senior staff. The complaints records showed that complaints had been dealt with. At the time of our inspection records showed that there had been very few complaints from people and relatives. There were lots of compliments and one family had written messages of thanks to each member of staff for the care they had shown towards the end of their relative's life.

Good

Is the service well-led?

Our findings

People spoke highly of the registered manager. One person told us, "She's kind." A relative told us, "The manager is a settling presence and she certainly seems nice."

Staff told us the support they received from the management team was good and they were involved in the running of the home. For example, each member of staff was responsible for a different aspect of the home each day. Assignment sheets were completed to document that duties had been done.

Staff said team meetings took place regularly and they were encouraged to have their say about any concerns they had or how the home could be improved. Minutes of meetings demonstrated that issues raised were followed up on. Minutes from the last team meeting had resulted in the risk assessments for people being updated. Staff felt able to make suggestions to the manager and these were acted upon. For example, one member of staff said they had discussed how one person seemed to respond especially well to music. As a result of this discussion the registered manager had organised a regular music session in the home and the person enjoyed this.

The registered manager encouraged openness and valued the whistle blowing policy as an important document in achieving this. A whistleblowing policy was in place and posters were visible within the home. Staff told us that they knew how to raise concerns if they needed to. A member of staff had raised a whistle blowing concern within the last year regarding the care one person had received. The registered manager had used it as an opportunity to involve and consult a number of healthcare professionals about a specific health need. This information was clearly recorded in the person's records and healthcare professionals were satisfied that the person's needs were met. The registered manager told us, "It takes a lot of courage to whistle blow and we encourage it."

The registered manager had another role with the provider and was present at the home three times per week. When the registered manager was not at the home shift leaders took on responsibility and made decisions, but they could call the registered manager for any support. Despite not being there every day the registered manager had set up organised systems and processes and trained the staff so that they could manage in her absence. For example, shift leaders would complete a task sheet to ensure they had completed or delegated all tasks for that shift. Shift leaders were also mostly staff who knew the service well. The registered manager told us that staff development was important and she supported her staff to progress. For example, the registered manager had supported two members of staff to progress into senior roles since coming into post last year. At the time of our inspection the registered manager was in the process of completing annual appraisals. These contained goals for staff and were an opportunity for them to discuss career development.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. The registered manager carried out regular spot checks and documented their findings and any actions taken. For example, the last spot check identified that there were gaps in night shift records. The registered manager met with staff and reminded them that they needed to maintain these records. The

registered manager told us that these had since improved. The provider also carried out annual unannounced inspections where they would look at the running of the home and people's experiences. These inspections involved a manager and a person who lived at another home coming to visit to speak to people. They gathered people's feedback which was documented and actions taken where needed. For example, one person had expressed that they wanted simpler care plans. In response to this, the registered manager had updated everyone's 'One Page Profiles' in line with people's wishes. The person who visited from another home left feedback stating "The staff are very friendly." The outcome of these audits were recorded in a way that was accessible to people in the form of a 'You Said, We Did' sheet. The registered manager also carried out inspections of other locations and told us that she valued these as a learning experience and an opportunity to pick up or share areas of good practice.

Residents meetings happened weekly and people also used these as an opportunity to bring up any issues they had. Minutes of residents meetings were documented and we could see actions being taken. For example, one person had requested an outing. We could see that this was being discussed with people to establish where they wished to go and people were involved in making this decision.

The registered manager sent out a yearly feedback questionnaire to relatives and healthcare professionals. Feedback was collated in order to identify areas for improvement. The registered manager kept a log of all complaints and compliments and recorded outcomes. The provider's regional manager oversaw all feedback.

The registered manager expressed a vision for the future of the service and was looking for ways to improve. A relative told us, "Since she's been there the place has changed." For example, the registered manager told us that she'd identified that people's records had not been kept up to date and were not very person-centred. She has since updated everybody's care plan and ensured that everybody's needs were re-assessed. Reviews and re-assessments were happening regularly and we saw evidence of this in all care records that we looked at. The registered manager had been working to improve the activities that were on offer, and the choice of activities that we found during our inspection were the result of work carried out to improve these for people