Ellenbern Holdings Limited

Cherwood House Care Centre

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

We inspected Cherwood House Care Centre on 15 June 2015. It was an unannounced inspection. We previously inspected the service in January 2014, when we identified People did not always have records that were accurate or contain information about how they should be supported. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a plan outlining what actions they would take to bring the service up to the required standard. At this inspection we found these actions had been completed but identified some further improvements were still required. This was because people's changing needs were not always documented in people's records in a timely way.

The service provides nursing, residential and extra care housing for people over the age of 65. Some people at the service were living with dementia. The home offers a service for up to 116 people.

There were two registered managers at the service, one for the residential care and extra care housing services and one for the nursing wing. A registered manager is a

Summary of findings

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. People and staff felt the service was well led and the management team were open and approachable. There were a range of quality monitoring systems in place that were used to monitor and improve the quality of the service.

There were enough staff to meet people's needs. People felt safe and supported by competent staff. Staff felt motivated and supported to improve the quality of care provided to people and benefitted from regular supervision and appraisal. Staff were encouraged and supported to gain further skills and knowledge to be able to meet people's specific needs.

People described the service as a community and valued their relationships with staff and each other. People felt they mattered and spoke highly of the staff and of the quality of care they received. People were cared for in a caring and respectful way. Staff demonstrated an appreciation of people's individual needs around privacy and dignity.

People were provided with person-centred care which encouraged choice and independence. Staff knew people well, understood their individual preferences and unique ways of communicating. Risks to people's health were identified and plans were in place to minimise the risks. People were supported to maintain their health and were referred for specialist advice as required.

People were supported to have their nutritional needs met. People liked the food, regular snacks and drinks were offered and mealtimes were relaxed and sociable. People who had lost weight had a plan in place to manage their weight loss. People were supported with specialist diets and nutritional supplements as prescribed.

Where people were receiving end of life care they and their families were supported in a caring and compassionate way. Other professionals were involved and the service strived to ensure people experienced a comfortable and dignified death.

People knew how to make a complaint if required. People's views about the quality of the service were sought through residents' meetings and surveys. However, people told us their views were not always acted on because they had asked for an art board to be put back up on the wall but it had not been done.

Medicines were stored and administered safely.

The provider, registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions or who may be deprived of their liberty for their own safety.

Summary of findings

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 identified and managed the risks of people's care.

People received their medicines safely.

People felt safe. Staff understood their responsibilities around safeguarding and knew how to raise concerns.

There was enough staff to meet people needs.

Is the service effective?

Good

The service was effective. Staff received the training and support they needed to care for people.

People were supported to maintain their independence, stay healthy and eat and drink enough. Other health and social care professionals were involved in supporting people to ensure their needs were met.

People were supported by staff who acted within the requirements of the Mental Capacity Act.

Is the service caring?

Good

The service was caring. People valued their relationships with staff and spoke highly of the staff and the level of care they received. People were supported in a caring, patient and respectful way.

People described the service as a community and valued the support they had been given to make friendships.

People were supported to maintain their independence and were given the information, support and equipment they needed.

People were cared for in a personalised way. Staff were aware of each person's unique ways of communicating and supported them to make choices and decisions about their care using these methods.

People received end of life care in a dignified and compassionate way.

Is the service responsive?

Requires improvement

Some improvements were required in this area. People were involved in the planning of their care which was individualised and person centred. However, some care records had not been updated promptly to show people's changing needs.

People knew how to make a complaint if required. People's views about the quality of the service were sought. However, their views were not always acted on.

Summary of findings

People enjoyed the activities on offer.

People knew how to make a complaint if required.

Is the service well-led?

Good

People benefited from a service that was well led. There was a positive and open culture where people, relatives and staff felt able to raise any concerns they had.

The quality of the service was regularly reviewed. The manager took action to improve the service where shortfalls had been identified.

Staff felt supported and motivated to improve the service they delivered to people.

Cherwood House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 15 June 2015. This was an unannounced inspection. The inspection team consisted of five inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke with local authority contracts team. We received feedback from two healthcare professionals.

We spoke with 31 people who were living at the service. We also spoke with 11 people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 20 staff which included nursing, care, activity, housekeeping, maintenance and catering staff. We also spoke with the registered managers and the provider. We looked around the home and observed the way staff interacted with people.

We looked at 18 people's care records, the medicine administration records for 30 people and seven staff files. We looked at a range of records about how the home was managed. We reviewed feedback from people who had used the service and their relatives.

Good

Is the service safe?

Our findings

People told us they felt safe and supported by staff. Comments included, "I feel very safe here", "I'm safe and comfortable here" and "They know what I need to keep me safe and how to look after me". Comments from relatives included, "Without a shadow of a doubt, I know she is safe and well cared for" and "Always people [staff] check on him to ensure that he is safe. I can go away from here and know that he is safe and that he is well cared for".

People told us there were enough staff to meet their needs. The provider calculated staffing levels according to people's dependency. Call bells were answered promptly. People told us they felt safe because they knew staff would come quickly when they needed them. One person who was living in the extra care housing told us, "I feel really safe living here. If I need help the girls come over quickly to see what I need. I'm never very far from help. It is a safe site so no worries". People living in the nursing and residential areas of the service said, "Staff are always available. They answer my bell quite quickly" and "I've got this call bell and when I press it help comes pretty swiftly". Some people were unable to use a call bell. Staff had identified the risks associated with not having a call bell, for each person, and there was a plan in place for managing those risks.

People were supported by staff who were knowledgeable about the procedures in place to keep them safe from abuse. For example, staff had attended training in safeguarding people and had good knowledge of the provider's whistleblowing and safeguarding procedures. They knew how to report any safeguarding concerns to the manager or provider. Staff also knew how to protect people in the event of a suspicion or allegation of abuse, which included notifying the local authority and Care Quality Commission (CQC). Both people and staff told us there was a culture of openness within the Home and they would have no hesitation in raising concerns if they saw any examples of poor care.

People had risk assessments in a range of areas such as falls, pressure area care and moving and handling. Ways of reducing the risks to people had been documented. Where advice and guidance from other professionals had been sought this was incorporated in people's care plans. Staff were aware of the risks to people and used the risk assessments to inform care delivery. People were supported to take risks in a safe way to maintain their independence. For example, one person told us "Because of my condition I am restricted because I have difficulty in walking but all I have to do is call the girls and they will help me get around with their support. There are never any restrictions placed on us" and "I tend to fall easily so staff have spoken to me and have suggested that I let them know if I want to move so that they can be nearby if I am struggling".

Some people had risk assessments and equipment in relation to moving and handling. Where people used the hoist on a daily basis they had their own sling and the details of the type and size of the sling was recorded in their risk assessment. However, where people used the hoist occasionally, for example, one person whose care record documented "Needs full body hoist if tired" the type and size of sling was not recorded. Staff told us people who were occasional users of the hoist did not have their own slings. This could present a risk around infection control or the incorrect size of sling being used.

People told us they were given their medicines when they needed them. Medicines were stored and administered safely. We observed staff administering medicines; staff supported people to take their medicines in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why.

Where people refused their medicines but were assessed as lacking mental capacity to make decisions around their health needs, staff took appropriate action. Best interest decisions were made with staff, people's representatives or advocates and the person's GP. Where it was found to be in the person's best interest, people received their medicines covertly. Guidance had been sought from the local pharmacist around administering covert medicines safely.

Equipment used to support people's care was clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, checks were conducted by maintenance staff and night staff. Any concerns were escalated and dealt with promptly. For example, an incident form had been completed when one member of staff had seen that a screw had become loose. Action had been taken immediately by maintenance staff to ensure the bedrail was safe to use. Not all day staff we spoke with were aware

Good

Is the service safe?

of the checks required to ensure bedrails were in safe positions. Other health and safety checks were carried out on equipment and premises to ensure people were kept safe.

People's rooms, bathrooms, equipment and communal areas were clean. Some chairs in the communal areas were stained and had cushions missing. There was a plan in place to replace these as part of the services current program of refurbishment and redecoration. The service had adequate stocks of personal protective equipment and staff used them as appropriate to prevent the spread of infection.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role.

Good

Is the service effective?

Our findings

Staff were supported to improve the quality of care they delivered to people through the supervision and annual appraisal process. One staff member said they were, "Very supported". Regular supervision gave staff the opportunity to discuss areas of practice. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process. One staff member told us, "I love working here; they have supported me to develop, from a care worker to a senior care worker."

Staff were up to date with attending the services mandatory courses such as annual basic life support and safeguarding. Staff were motivated to develop their skills further to ensure they were able to effectively care for people. For example, one member of staff told us how training for caring with people who had Parkinson's disease had helped them to provide better care for the person because of their greater understanding of the disease and its related symptoms. One staff member said, "Training is really good. I can request any training". Where staff were new to the service they received an induction. A member of staff told me, "I'd never worked in care before I started here. I had a lengthy induction, a mixture of formal training and shadowing other staff. It was overwhelming at first, but I felt well inducted and well supported".

People told us they enjoyed the food. Comments included, "The meals are very nice", "They [meals] are very good – lots of taste and the sort of food that I enjoy" and "We never stop eating here. The food is very good". Relatives said, "He loves his food, always a clean plate which is good because he needs his calories because of his medical condition" and "He used to be a chef so if he says the food is good then it is". Meals were attractively presented.

People choose where they wanted to eat their meal. People who ate in the communal dining rooms described the mealtime as a sociable event. One person said, "I need to see people so they have arranged for me to eat over in the residential unit. I enjoy the food and the company". In one of the dining rooms on the nursing unit several people required assistance to eat their meal. Although people were supported in a dignified way and were brought to the table when a staff member was free to assist them, the manner in which this was done made it feel as though people were in a queue. These people did not benefit from the same social mealtime experience as other people who did not require assistance to eat.

When people were being assisted to eat, support was given in a patient and sensitive manner. For example, When a person had fallen asleep during their meal, a member of staff touched their arm gently and spoke to the person to remind them of their drink and meal. The person then continued to eat their meal.

People were given a choice of what to eat. Although People had chosen from the menu the night before they were shown the food at the mealtime and were still offered a choice. One staff member told us, "There's no problem if someone changes their mind at the last minute, or doesn't like the meal when it is served, we just ask the kitchen and they will provide something else". People were also able to request food that was not on the menu. For example, One person had a cheese salad twice a week instead of a choice from the main lunch menu.

People's specific dietary needs were met. For example, people having softened foods or thickened fluids where choking was a risk. Where some people had lost weight there was a plan in place to manage weight loss, people had been reviewed by the GP and referred for specialist advice if required. Staff ensured people took their dietary supplements as prescribed.

People had regular access to other healthcare professionals such as, chiropodists, opticians and dentists. People were referred for other specialist advice for example, from the speech and language therapist (SALT) if they were thought to be at risk of choking or the falls team for issues with mobility. We saw evidence specialist advice was followed. Professionals told us they were notified of people's changing needs.

People could move around freely in the communal areas of the building and gardens. There were several sitting rooms and themed garden areas, which gave people a choice of where to spend their time. Some areas of the nursing wing where people were living with dementia were not decorated in a way that followed good practice guidance for helping people to be stimulated and orientated. This part of the service was currently in the process of being redecorated and the provider told us they would seek some specialist advice around this.

Good

Is the service effective?

Staff understood their responsibilities under the Mental Capacity Act 2005. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity, there was evidence of decisions being on their behalf by those that were legally authorised to do so and were in a person's best interests.

The provider understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be restricted of their liberty for their own safety. The provider was aware of the outline of the supreme court judgement and was reviewing people to identify those whose situations might now be brought into the widened definition of deprivation of liberty.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. Comments from people included, “Staff are very kind here and they are very caring and loving”, “Everyone is so caring here” and “Very kind girls here and they are very caring because they know how you liked to be cared for”. Many caring interactions were observed between staff and the people they were supporting.

People and their relatives were very complimentary about the level of care people received. One person said, “It's Home from Home here”; I must say I couldn't be looked after any better”. Another person said, “I'm looked after very well, It's lovely here”. A person’s relative said, “This is our sixth home and I absolutely love it here. This is the best care and I will keep him here until his last breath.”

Visiting professionals were very complimentary about the service. They said, “If other care homes were as good as this we would be extremely fortunate” and “I would have no hesitation in allowing them to care for my elderly relatives”.

The atmosphere in the home was calm and pleasant. There was chatting and appropriate use of humour throughout the day. People felt they mattered and were treated with patience, respect, warmth and obvious affection. People valued their relationships with staff and told us, “The staff are very friendly”, “I have established a relationship with them [staff]” and “It's more like a friendship; all the staff are friendly”.

The service provided accommodation for people with varying levels of independence, some people lived independently in bungalows and others were provided with more enhanced support within the main house. People described the service as a 'community'. People told us about the friendships they had formed since coming to live at the service and how much these meant to them. One person who lived in a bungalow told us, “I have met lots of others from the house”. They described how staff had been caring in their approach to help them settle in when they first came to live at the service. They had been invited into the house and introduced to people to help them make friends. They said, “They sat me with three [people] for lunch the first day and then on a different table with three more the next day.” This person told us they had been unhappy about coming to live at the service but said, “When I met the people I changed my mind”.

People were supported to be independent and were encouraged to do as much for themselves as possible. For example, one person said, "I clean my top half and she [staff] does my bottom half”. A relative told us, “She is still quite independent but very deaf. The staff are very patient and will write down notes for her if she can't hear”. Some people used equipment to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it. For example, walking frames and specialist cups and plates at mealtimes.

Staff supported people in rebuilding their self-care skills. For example, one person who lived in a bungalow told us “Staff noticed that I was rather going ‘downhill’ I was getting depressed and I wasn’t really looking after myself properly so they took me in to the residential wing and got me up and running again and now I have moved back in [to the bungalow]. They are keeping an eye on me and have arranged for me to go over to the main building to use the facilities and have my meals over there”.

People were supported to make decisions around their care. One person who was staying in the main house following a hospital stay was planning to move back to their bungalow. They told us they had the support and information they needed to make choices around their care. It was evident that their support was person centred and provided practical help combined with emotional support and reassurance. Another person with a medical condition that affected their daily life had made choices around their care, their meals and how they ate their meals. Staff had made sure this person had all of the information they needed to be aware of any risks and to make informed choices. Staff knew how this person wanted to be supported and respected their choices.

People were supported with their personal care discretely. Staff had an appreciation of people’s individual needs around privacy and dignity. For example, a person told us that staff would explain and “ask first” before giving personal care. Another person told us when being assisted with personal care staff were “kind and careful”. One person told us how staff took care to make sure his wife’s privacy was respected. He told us, “They always put a screen up

Good

Is the service caring?

when they assist her. I now leave the room in the evening, and go for a walk. Dignity is important". Staff knocked on people's doors, waited to be invited in before entering and addressed people with their preferred name. People were clean, well kempt and dressed appropriately for the weather. One person told us staff helped them "Choose what to wear from the wardrobe and help me get dressed". A relative said, "The staff make sure she has her hearing aids in and also put some jewellery on and help her to dress".

Staff talked about people in a respectful way and knew the preferences and needs of the people they cared for. For example, one person was supported with a cup of tea, staff clearly knew how the person wanted their tea, what biscuits they liked and the support they needed to drink and eat. Another person could be resistive of personal care. Staff were able to describe the strategies in place for meeting this persons personal care needs in a sensitive way. Another person had behaviour that could be described as challenging. Their relative told us staff managed this in a positive way. They said, "His behaviour can be very challenging. His carer recognises straight away that he is becoming agitated and sings him a particular song that calms him down".

Staff were respectful in their approach to ensuring people were not distressed or worried by having a team of inspectors in their home. The inspection team was introduced to people throughout the day. Staff took time to explain the purpose of our visit to people and sought people's consent for us to speak with them. Staff told us how each person preferred to communicate and shared any special methods of communication such as by body language and hand signals to ensure we were able to obtain views from all people including those who could not communicate verbally. Understanding people's specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care.

People were able to have visitors when they wanted. Visitors told us they were warmly welcomed into the service. One person told us "My family live nearby and visit regularly with the grandchildren. The home is very happy to see children come in and my other son brings his dog in and we go into the garden with a ball". People were supported to keep in touch with friends or family when they couldn't visit. For example, two computer stations had been set up for video calling so residents could keep in touch with families. People were supported to gain any knowledge and skills required to enable them to do this.

Relatives told us the communication at the service was good and where people had given permission, or it was in a person's best interest, they had been fully informed about their relative's care. For example, one relative said, "If there is a concern then I am phoned straight away. They always let me know if anything has changed and that is very reassuring for me".

People were involved in decisions about their end of life care. We saw conversations with people had been recorded which showed people had been involved in planning their care. For example, their preferred place of death and preferences for undertakers. Where 'do not attempt cardio pulmonary resuscitation' (DNACPR) documentation was in place we saw this had been discussed with the person and their representatives. A summary of the conversation was recorded and people had been given time to think about all of their decisions and discuss them with their family. This meant that people were given information and time in order to make any decisions.

When people were nearing the end of their life they and their relatives received compassionate and supportive care in the way they preferred from knowledgeable staff. One relative told us their parent's end of life care was "very well organised". Appropriate professionals were involved at an early stage of the persons illness and continually contributed to the person's plan of care as their condition changed. Levels of pain were monitored and extra help and advice was sought swiftly if needed to ensure people were pain free. An extra member of staff was added to the usual staffing numbers to provide one to one monitoring, care and support. This ensured people were as comfortable as possible and had their dignity respected at the end of their life.

Requires improvement

Is the service responsive?

Our findings

At our inspection in January 2014, we identified people who lived on the nursing wing did not always have records that were accurate or contain information about how they should be supported. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a plan outlining what actions they would take to bring the service up to the required standard. At this inspection we found these actions had been completed but identified where further improvements were required. For example, two people's needs had recently changed but their care record had not been updated to reflect these changes. In some care plans, the daily records were not detailed and did not provide an account of the care provided. For example, some daily entries only recorded 'full care given'. Staff knew people well and detailed information about each person was provided to staff at handover and recorded in a handover book.

Before people came to live at the home their needs had been assessed to ensure that they could be met. Peoples care records contained personalised information about their health, social care and spiritual needs. They reflected how each person wished to receive their care and support. People and their families confirmed they were involved in the planning and review of their care. One relative told us "I am consulted about my Husband's care planning and I am consulted if anything changes".

People benefitted from care that was planned and delivered in a person centred way. One person told us, "People [staff] are meticulous about getting to know the residents and what their specific needs are and how to cope with them". Where people had specific medical conditions, training, advice and support had been sought from specialist nurses and advisors to ensure care was personalised and met their needs. One relative told us this had helped ensure their relative was, "Able to lead the best possible life".

On the day of the inspection there were limited organised activities available for people because the activities organiser was on holiday. However, staff spent time with people and people told us there was usually plenty to do such as activities in the home and trips to the local town or villages where people had lived. Outings to a local garden centre took place regularly and people were encouraged to take an interest in maintaining some of the garden areas. There were designated activity staff as well as the 'friends of Cherwood House' who also organised some outings and activities such as a multi faith remembrance day in honour of people who had lived at the service and passed away. One relative praised the activity provision and told us "She [relative] joins in with lots of activities, knitting, crafts, Vicar, sing-alongs, the farm visit and also bingo sessions".

Feedback was sought from people through regular relatives and residents meetings, quality assurance surveys and suggestion boxes. When some people and their relatives had provided feedback about the condition of the furniture on the nursing wing a plan had been developed to deep clean or replace it. However, we also saw where people's views were not always acted on. For example, a notice board for displaying peoples work had been taken down in February. One person told us "People enjoy seeing their artwork" and "We asked for it to be put back up but it hasn't been". We saw minutes of a residents meeting where people had asked for the board to be replaced but it had not yet been done.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. People spoke about an open culture and felt that the Home was responsive to any concerns raised. People who had raised minor complaints said that these had been resolved quickly. Comments included, "I've raised a few minor things and carers sorted them out straight away" and "The staff and the boss are all right If anything is wrong I can chat to staff and it is soon sorted out they are all very approachable". Any concerns received about the quality of care were investigated thoroughly and recorded. The registered manager discussed concerns with staff individually in supervisions and more widely at team meetings to ensure there was learning and to prevent similar incidences occurring.

Good

Is the service well-led?

Our findings

The service was well led by the provider and two registered managers. 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 registered managers had both been in post for a number of years. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

Feedback received from health and social care professionals praised the level of service offered to people; their relationship with the registered managers and how well the management and staff team communicated with them.

Relatives and residents told us there was an open culture within the home and described the management team as being open and approachable. People said they all knew the registered managers and they were always visible around the Home. People told us, "We get on well with manager, she is very good" and "I get on well with the managers but I don't need to see them much. I have no complaints".

Staff also described a culture that was open with good communication systems in place. Staff felt valued, motivated to improve the service for people and were confident that the management team would support them if they used the whistleblowing policy or needed to raise concerns. A staff member told us that the manager's "door is always open".

Staff understood the vision and values of the service. The registered managers ensured that staff were aware of their responsibilities and accountability through regular supervision and meetings with staff. Where other staff supervised care staff they told us they had received training and support to supervise staff. One said, "I was supported by the manager. We talked about supervision and they shadowed me on my first supervision."

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. There were a wide range of quality monitoring systems in place to review the care and treatment offered at the home. These included a range of clinical and health and safety audits. Where any shortfalls had been identified there was an action plan in place to address them.

There was a clear procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented and actions were recorded. Incident forms were checked and audited to identify any trends and risks or what changes might be required to make improvements for people who used the service.