Niram Investments Limited

Widecombe Nursing Home

Inspection report

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Date of inspection visit:
26 April 2016
28 April 2016

Date of publication:
17 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 26 and 28 April 2016 and was unannounced. When we last inspected the service in March 2015 we rated the service as 'good' in each of the areas we looked at.

Widecombe Nursing Home provides accommodation, personal and nursing care for up to 38 older people, some of whom may be living with dementia or physical disabilities. The service also supports people who require palliative and end of life care. At the time of our inspection there were 31 people 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.

There were robust recruitment policies in place and staff were recruited safely to work in the service. However there was no on-going system in place for assessing staffing dependency. Because there was a high turnover of people using the service, this meant that people might have been at risk of not having their needs met due to insufficient numbers of staff. People did not always receive prompt responses to call bells and sometimes had to wait to receive care.

People were safeguarded from avoidable risk of harm and staff understood the process to follow to report concerns regarding people's safety. There were risk assessments in place which detailed how people could be supported safely, however there were not always clear protocols for the management of behaviour which might have impacted negatively on others. Accidents and incidents were recorded but there was not always evidence of what learning had been taken from these or how the risk of recurrence was being minimised. People's medicines were stored and managed appropriately and administered by trained staff. The environment was regularly audited and checked for safety and there were robust emergency plans in place. Staff received training in moving and handling which allowed them to move people safely using the correct equipment.

Staff received a variety of training and this was refreshed and updated as required. However staff did not always demonstrate a full understanding of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DoLS). Staff were supported by management through a programme of supervision and performance reviews.

There was evidence that people consented to their care and treatment but we observed a lack of consent being sought during the inspection when staff were providing care. People's healthcare needs were identified and met by the service and a dedicated team of nurses with a variety of specialisms. External healthcare support was sought if required from community-based professionals. People had enough to eat and drink and were offered drinks and snacks throughout the day.

The design and decoration of the service was inconsistent. A recent program of refurbishment and redecoration had taken place but some elements of the environment were not always in good condition or following the latest guidance for good practice in dementia care.

People were treated with dignity and respect and had a named nurse support system in place so they had a point of contact for expressing their concerns or issues. Staff were kind and caring and demonstrated a patient and compassionate attitude.

People received a thorough assessment of their needs and care plans were detailed enough to enable staff to deliver responsive care and support. However there was not always evidence of involvement from people or their families and there was limited information regarding people's social histories and backgrounds. Care plans were reviewed and adapted according to people's changing needs. There was a programme of activities on offer so people could pursue their interests in and out of the home. People and their relatives knew who to complain to and there was a system in place for handling and resolving complaints effectively.

There was a quality monitoring system in place for identifying improvements that needed to be made across the service. Staff attended regular team meetings and told us they felt well supported by management.

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.

There was no formal system for assessing staffing dependency in response to the changing needs of the service.

There were risk assessments in place to support people safely; however these did not always include protocols for the management of behaviour which may have impacted negatively on others.

People's medicines were stored and managed appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always demonstrate sufficient understanding of the Mental Capacity Act 2005.

The design and decoration of the service was not consistent with guidance on dementia care environments.

People had enough to eat and drink and had their healthcare needs met.

Staff received a programme of induction, training, supervision and appraisal to support them in their roles.

Is the service caring?

Good

The service was caring.

Staff showed kindness, compassion and patience in their interactions with people.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans contained enough information to support people but lacked personalisation or background information.

Complaints were handled and resolved effectively.

Is the service well-led?

Good

The service was well-led.

People and staff were positive about the management and culture of the service and felt the registered manager was approachable.

There was a quality monitoring system in place for identifying improvements that needed to be made in the service.

Staff attended regular team meetings to provide an opportunity to contribute to the development of the service.

Widecombe Nursing Home

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 over two days on 26 and 28 April 2016 and was unannounced. The inspection was carried out by one inspector and an expert 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. The expert had experience of nursing and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed local authority inspection records and asked for feedback from nine professionals involved with the service.

During the inspection we spoke with 11 people who used the service and four of their relatives to gain their feedback. We spoke with the registered manager, the deputy manager, the quality assurance officer, three members of the care staff, one nurse, the domestic supervisor, the maintenance officer, the gardener and the kitchen assistant.

We observed the interactions between members of staff and people who used the service and reviewed the care records and risk assessments for five people who used the service. We checked medicines administration records and looked at staff recruitment and training records. We looked at complaints and compliments received by the service. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

There was no formal method in place for assessing the staffing dependency of the service based on the needs of the people that lived there. At the time of our inspection there were 31 people using the service and the home had an occupancy level of 38. There had been 40 notifications of deaths since our previous inspection in March 2015, which meant that the service had a high turnover of people with a variety of needs, including palliative and end of life care that may have been subject to frequent change. Despite this the staffing level had remained the same. One member of staff told us, "No, it doesn't change. There is always six of us here in the morning and four in the evening." Another member of staff said, "Sometimes we do need more staff." People's needs in relation to personal care and moving were documented but not used to routinely assess whether staffing levels were appropriate.

During the inspection we observed one person asking if they could be taken to bed as they were tired. A member of staff acknowledged this request and told the person they would take them but then did not return until half an hour later, when they had to be prompted by the person's relative again. On another occasion a person told us they felt unwell and we used their bell to call for assistance from staff. However no staff attended and this resulted in us having to fetch the manager to ask for somebody to support the person concerned. One person we spoke with told us, "I have to wait if I ring the bell." A relative felt that response times were too slow and commented; "Buzzers take too long to be answered. On one occasion I was stood outside for 15 minutes because nobody was available to answer the door."

The registered manager provided us with rotas from the beginning of the year which showed that the staffing levels were consistent. There were two nurses available during the day at all times and one at night alongside two members of the care staff. While people and their relatives felt that they were kept safe, the delays in response and lack of a formal system for assessing fluctuating dependency meant that there was a risk that staff deployment was not always safe and that there was an impact on people when waiting to receive care.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

Each person had individualised risk assessments in place which detailed how to safely manage any avoidable risk of harm. For people who required support with moving safely around the service, there were risk assessments in place for each item of mobility equipment they used. For people who were unable to use their call bells to request assistance there had been alternative measures put into place to keep them safe. For example we saw that those people had more regular checks recorded. However there were not always specific protocols in place for people who might have displayed behaviour which impacted negatively on others. One person had been described as being at risk of 'abusing' staff physically, but there were no specific control measures or protocols in place to support staff to know how best to manage this. This meant people who might have been anxious and displayed behaviour that was abusive; there were not always specific guidance in which staff were supported to manage such behaviour safely.

Accidents and incidents were recorded in detail but there was not always a clear indication of how the service was taking action in response to these incidents to minimise the risk of recurrence. This meant the provider could not always demonstrate learning or changes made as the result of accidents around the home.

People using the service told us they felt safe. One person said, "It's safe. They come and see me often to check I'm alright and it's safer here than at home now." Before the inspection we received information regarding an incident which had progressed to safeguarding in which people had been put at risk of harm. We noted that the appropriate notifications had been made and that decisive action was taken to reduce the risk of such an event recurring.

Staff were able to describe some of the ways in which they kept people safe and protected people from avoidable risk of harm. One member of staff said, "We keep people safe here. We get training in safeguarding but then there's the little things- checking on them regularly, asking them if they're okay and knowing the person so you can tell if there's anything wrong." Staff received regular training to understand the different kinds of abuse and the process to follow to safeguard people where necessary. There was a whistleblowing policy in place so that people could report concerns anonymously without fear of the consequences of doing so.

There were individual risk assessments in place in case of emergencies and a personal emergency evacuation plan (PEEP) had been created for each person. The environment was regularly audited for safety and employed a dedicated maintenance staff to carry out the appropriate checks. We saw that fire safety checks, gas safety certificates and PAT (portable appliance safety) checks were completed regularly. There was a business contingency plan in place in case of any emergency or significant event that might affect the running of the service.

Staff were recruited safely to work in the service. We looked at the staff records for seven members of staff and found that two references had been sought from previous employers before anybody commenced employment. Staff were asked to fill out healthcare questionnaires and complete a DBS (Disclosure and Barring Service) check. DBS is a way for employers to make safer recruitment decisions and monitor whether staff have any prior convictions on their record.

People's medicines were stored and administered safely. Medicines were only administered by registered nurses who were subject to regular observations of their competency. The medicines that people had been prescribed were listed in their care plans along with protocols for any PRN (as and when) medicines they took. Each person had a medicine file which included their picture and details of how they had their medicines given to them by staff. If people were at risk of missing or refusing their medicines then this was stated in their care plan. We saw that one person had begun to routinely refuse to take their medicines. They had been referred for further assessment with community-based professionals to ensure that measures were being taken to minimise the risk and consider alternatives. Medicines were stored in a locked, secure room in lockable cabinets and were subject to regular temperature checks and audits of stock levels. There was a system in place for recording deliveries and returning refused or spoiled medicines to the pharmacy as required.

Requires Improvement

Is the service effective?

Our findings

The home had recently undergone a programme of redecoration and many areas of the home had been redecorated and rejuvenated. However we observed that there were several scuffs and scratches on walls. In the conservatory there was a loose grill plate hanging from the wall. One communal area had recently been redecorated with wallpaper that might not have proved suitable for people living with dementia. Current best practice in dementia care is to use plain and simple patterns as complicated patterned walls or floors might prove confusing or disorientating.

We recommend that the provider acts on latest guidance in creating dementia-friendly environments.

Staff we spoke with did not always demonstrate an understanding of the Mental Capacity Act 2005 (MCA) or deprivation of liberty safeguards (DoLS). 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 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 (DoLS).

While one member of staff with a background in mental health was able to describe the principles behind the MCA, the other staff we spoke with showed limited or no awareness of how this might have impacted upon people using the service. One member of staff said, "I've had the training but I don't really know how that works here." We spoke with the registered manager who explained that staff did receive regular reminders in meetings and supervisions regarding this framework and had undertaken the correct training. Records we saw confirmed that the training had been completed by staff, but the lack of knowledge demonstrated that they might not have always been confident in applying the MCA or recognising when people might have been deprived of their liberty.

We saw that DoLS authorisations were in place and that further applications had been made as necessary to the local authority. The service had asked for regular updates on the progress of these applications to ensure that there was a clear audit trail of how these were being managed.

Staff understood the principles behind consent and were able to describe the ways in which they made sure that people were happy to receive the care and support provided. One member of staff told us, "We always ask them before we do anything, they have to give us their consent or we have to be sure that what we're doing is right if they can't." However we noted that staff were not always asking for consent before providing care to people. On two occasions we observed staff moving people without saying anything to them or asking for their consent. On another occasion we witnessed a person being assisted to eat and having their mouth wiped but with no verbal communication from staff to tell them what they were doing. In one care plan we noted that a friend had signed to consent to the use of bedrails even though the person was assessed to have had capacity with their care plan stating 'has full mental capacity and makes [their] own

decisions.' Care plans included an assessment of people's capacity to make decisions in different areas and there were consent forms in care plans for people to indicate that they had provided their consent to receive care and treatment from the service.

People using the service felt that they were looked after by staff who understood their needs. One person told us, "They're good staff, they know what they're doing and they've worked with me for a long time."

Staff received a variety of training and were refreshed regularly in courses that the provider considered essential. These included food hygiene, health and safety and safeguarding. In addition to these courses there was more specialised training available to staff which helped them to better understand people's needs. Most staff were positive about the quality of the training they had received. One member of staff said, "The training is good, I did a few different courses when I first started but then I've done e-learning every year since." However other staff felt the quality had declined recently, saying "It's okay now, it used to be more face to face but it's all e-learning now, it's not always as good for learning."

Staff received a full induction when they first joined the service which included opportunities to work alongside experienced members of staff and read through people's care plans. One member of staff told us, "We have an induction, some of it is online and then we read files and work alongside the other staff. It's good for getting you used to the people and the service and how they work here."

Staff told us they received regular supervision and appraisal of their performance. One member of staff said, "I've had three in the last six months, we talk about policies, safeguarding and we share any concerns with our manager." The management staff had recently completed a round of supervisions with all staff at the time of our inspection and told us she hoped to increase the frequency of this. Prior to our inspection they had been more infrequent but there was a clear action plan in place to address this. Annual performance reviews took place each year to provide an appraisal of staff's competencies and to set developmental goals and objectives. Staff told us they felt well supported and that they were able to request additional supervision if they felt it was necessary.

People had enough to eat and drink although the feedback on the quality of food was mixed. One person told us, "The food leaves a lot to be desired," while another person said, "The food is excellent." We observed two mealtimes in the home and felt that the food was of sufficient quality and was healthy and nutritious. People were supported to eat where necessary and staff were patient and considerate when helping them with this. There was a standard menu in place and we noticed that most people were eating the same food. However people told us they could request an alternative option if they liked and were asked if they liked the meals that were available. We noted that some people were given their dessert alongside their meal which meant that they might not have always been able to enjoy their meal in the correct order if they were not being supported to eat. During the inspection we noticed the food and drink trolley coming around and offering people drinks and snacks throughout the day. The staff felt that the standard of food was good, with one member of staff saying, "The quality is good, they have meals and tea throughout the day and it's all home cooked, fresh food. They have a choice over what they eat, too."

Each person had a risk assessment in relation to eating and drinking. People's care plans detailed any dietary needs, preferences and support was required around mealtimes. Before the inspection we had received concerns that people were not always being given the correct dietary supplements or that some people had been offered prescribed supplements that were not appropriate for them. We looked at people's care plans, spoke with the kitchen staff and checked to see what action had been taken in response to this. The manager had discussed the issue with staff and checked across each plan to ensure that the information was relevant and reflective of the most recent information provided by GPs and dietitians.

Dietary supplements were stored appropriately and only being given to those who were prescribed them. Care plans included details of how people should be encouraged to take these if they were at increased risk of malnutrition or dehydration. Details of people's needs in this area were shared with the kitchen staff. One of the kitchen staff told us, "We always meet the people and ask them for what they want and like each day."

People's healthcare needs were routinely assessed and people were supported to receive appropriate care from nursing staff and community-based healthcare professionals. The nurses employed by the service had a range of backgrounds and specialisms and were supported to revalidate through the NMC (nursing and midwifery council) as required. People were supported to attend healthcare appointments or seek the advice of professionals as necessary. The frequency and nature of these appointments was included within their care plan. If people were at risk of developing pressure ulcers then tissue viability had been assessed and control measures put into place. For example we saw that several people were using pressure relieving mattresses where this had been assessed as being necessary. The input of tissue viability nurses was sought if additional guidance was required.

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind, compassionate and understood their needs. One person said, "Everyone's kind, couldn't be better." A relative told us, "They really couldn't do any more for [relative]. They have good care."

During the inspection we noted that people were spoken to respectfully and kindly. We observed one member of staff talking to a person who used the service about where they were from and asking questions about their family life and background. We saw another member of staff laughing and joking with another person and talking to them about things they enjoyed. One member of staff told us, "Coming in and seeing the people is the best thing about this job. You never know if you might end up needing help when you're older and you just hope you end up somewhere as caring as this. I love it here." We saw in one person's care plan that they had a stuffed cat that was important to them and needed to be kept within reach to comfort the person. We visited this person's room and were pleased to note that the cat was placed in the bed with them.

People's privacy and dignity was being observed. One person told us, "Everyone here treats me with respect and kindness." One member of staff said, "We always make sure we cover them, make everything as they like it and as we'd want to be treated." We observed staff knocking on doors before entering and covering people during personal care. We saw in one person's care plan that they preferred to have their door closed throughout the day and noted that this was being observed when we visited. The staff used signs which read 'do not enter- personal care' to help staff and visitors to observe people's privacy.

For people who were receiving end of life care, monthly checklists had been introduced which used the PEPSICOLA aide memoire to assess needs, wishes and choices towards the end of their life. PEPSICOLA is part of the gold standards framework and provides a way of holistically assessing each area of a person's care to enable the service to support them effectively during this time. We received feedback from a palliative care nurse who told us, "they have a good understanding of the care patients need at the end of their life and adhere to their organisations policies and processes around patient care. The care that they give families, carers also demonstrates a good understanding of the needs that they may require at that point in the patients disease trajectory."

The service had received a number of compliments praising the care that their relative had received while with the service. One such compliment read "you all worked so hard to make [person]'s time at Widcombe as comfortable as possible. [They] enjoyed many conversations and cups of tea with you, and from what we saw you all went over and beyond your job as carers. You really got to know [them]."

The service had recently introduced a 'named nurse' support system which meant that each person had a specific point of contact within the staff team. The named nurse was responsible for updating their care plan, checking the person's needs were being met and listening to their views and feedback.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people and their families when we asked how they were involved in the planning of their care. One person told us, "Everything was explained to me and my family; we've all seen the care plans." However a relative we spoke with said, "No I haven't been involved with the care plan, I don't feel I'm always up to speed regarding [person]'s care."

An initial assessment was completed with people when they first came to the service which outlined their needs across different areas and the kind of support they required. If a person was living with dementia then were was a specific assessment in place to state how this condition affected them and how this could impact upon the kind of care and support they received.

There was some limited information in place in some plans regarding the person's social history and background which included their adult life, family, hobbies and interests and personal preferences. However we found that this was only present in two of the plans we looked at and that the information was limited to one word answers. This meant that plans were not always truly person-centred and that staff may not have had much insight into important details about the person's life. The manager told us they were hoping to introduce profiles across each of the care plans to address this issue which would provide more detail in this part of the plan.

Care plans were changed according to people's changing needs. We saw an example of a care plan where the person's mobility had deteriorated recently and noted that the care plan had been updated to reflect this. This included newer equipment that had been introduced and what this meant across different areas of their plan. We received feedback from a healthcare professional who told us that the service were quick when acting upon advice and guidance. They said, "they always listen to my advice and act on the information given. I have checked the care plans and advice given to staff. The care plan was adjusted immediately whilst I was still present."

Daily activity forms were in place to record occasions upon which each type of care had been offered including washing, bathing and personal hygiene. This allowed staff to undertake a comprehensive handover and relay to staff coming onto shift what care and support the person had received. We did find that there were some gaps in recording however. For example for one person who's care plan stated 'staff to assist with dental hygiene daily', there were several gaps in their oral hygiene record with no explanation given as to why. Daily nursing reports recorded people's food and fluid intake to help with monitoring the person's health and well-being and meeting the requirements laid out in their care plans. The service had recently introduced a monthly care evaluation checklist which reviewed all of the information recorded over the course of the month.

People told us the home provided activities to keep them stimulated throughout the day. However one relative told us, "[Relative] is more able than most and there's not many activities for [them] to do." There was an activity schedule in the front hallway which detailed the activities that people were going to be undertaking during the week. During the inspection a volunteer was providing activities for people in

communal areas which included games, quizzes and music. There was a full-time activity co-ordinator employed who was on annual leave at the time of our inspection. We saw that there was a regular program of activities available for people and that this included time spent with people in their rooms when they were not able to go into communal areas. We saw that people had enjoyed various opportunities for trips and days out in the past and this had included pantomime trips and meals out. There was a mobility vehicle in place but this was not available for use at the time of our inspection.

There was an effective system in place for handling and resolving complaints. We saw that 12 complaints had been received by the service since our last inspection. Each one had been investigated thoroughly by the registered manager and a response had been provided to the complainant within a few days. We saw evidence that there was learning from each complaint and that appropriate action was taken in response to each. For example where a community-based professional had raised concerns regarding the management of one aspect of people's healthcare, a response had been issued and the measures taken to address the issue were evidenced in the records we saw during the inspection.

Good

Is the service well-led?

Our findings

People and their relatives were positive about the management of the service and felt that the registered manager was supportive and approachable. One person said, "[Registered manager] is in charge here, she's so nice." The manager was a registered nurse who had worked in the service for a significant period of time and was knowledgeable and enthusiastic about the service and the people living there. Without exception the staff we spoke with were positive about the manager and the leadership in the service. One member of staff said, "The manager has a real eye for everything, the home has improved so much since she's been in charge. She's approachable and knows her stuff."

Staff were positive about the culture of the service and understood the visions and values of the provider. One member of staff told us, "Things have improved here over the years and we all get on so well, the atmosphere and culture of the home is lovely." Another member of staff said, "It's just such a happy place to work. I've been here a long time, it's challenging at times but I love working here and I'm happy with how things are."

Regular meetings were held with the staff team to discuss issues and to allow them to contribute towards the development of the service. Staff were positive about the meetings and told us they were useful for communicating updates and information with each other. One member of staff said, "We have general meetings and then meetings for specific members of staff, for example I know the nurses meet often to discuss more clinical issues." Another member of staff told us, "We use meetings to talk about staff, residents, training needs and just to have a general catch up on things. We have handovers every day too so communication is good in my opinion."

Questionnaires were sent out to people using the service and their relatives to ask for feedback, concerns and to give them an opportunity to contribute towards the improvement of the service. We saw that these had been returned with largely positive comments but that any issues raised had been addressed. For example we saw that one person had raised a concern that their relative's care plan did not contain enough information about the food they enjoyed. We saw that the staff had met with the relative in question to create a list of meals and snacked they liked and disliked. In addition to standard surveys there were questionnaires sent out to families following any deaths to ask for feedback on the end of the life care that was provided.

Following a local authority monitoring visit which had highlighted some issues with quality monitoring, the manager was able to show us the changes that had been made to address this. There were now a series of audits in place to identify improvements that needed to be made across the service. There had been quality monitoring systems introduced to audit care plans, medicines and health and safety. There was evidence that the improvements that had been identified were being made. For example we saw that a lack of cross-referencing between documentation had been highlighted as an area for improvement. The care plans we saw included more cross-referencing in response to this, for example where a DoLS was in place or where a risk assessment might have been relevant to another piece of information in the plan. The service had formulated an action plan for business development going forward with each of the actions that needed to

be taken. This meant that the service had a clear plan to continue to develop the quality and compliance of the home in the future.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was no formal method in place for assessing the staffing dependency of the service based on the needs of the people that lived there.