Athena Care Homes (Bretton) Limited

Ashlynn Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ashlynn Grange provides accommodation, nursing, and personal care for up to 156 adults, some of whom may be living with dementia. It also registered to provide the regulated activity: treatment, disease, disorder and injury. At the time of our inspection there were 81 people living at the service. People lived in four areas of the service; Yeoman, Woolsack, Hayward and Harvester unit.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

This was the first inspection carried out at this service under this provider since it was registered with the CQC in November 2016.

Staff assisted people in a way that supported their safety and people were looked after by staff in a kind and caring manner. Staff encouraged people to make their own choices. However, people's privacy and dignity was not always promoted and maintained by staff.

Staff were knowledgeable of how to report incidents of harm and poor care. Accidents and incidents were identified and recorded. Actions were taken to, as far as possible; reduce the risk of recurrence where incidents had occurred. Staff were trained to provide effective and safe care. However, staff did not always move people in a safe way that would reduce the risk of injury and in accordance with their training.

People were supported to take their medicines as prescribed and medicines were managed by staff whose competency had been assessed. However, accurate records of people's medicine administration were not always kept by staff members. Where there had been any errors in the administration of people's medicines, these had been identified and were being dealt with appropriately. The provider's quality governance manager had been tasked with undertaking a thorough audit of medicines management as a result of concerns identified by their own quality monitoring systems. This showed us that the safety of people's medicines' administration was effectively audited.

People and their relatives / advocates were involved in the setting up and agreement of their/their family members care plans. People's care arrangements took account of people's wishes including their likes and dislikes and any assistance they required.

Risks to people who lived at the service such as poor skin integrity or dehydration were identified and plans were put into place by staff to minimise and monitor these risks. During the inspection additional information about people's specific health conditions and the management of these, including any equipment required, were added into people's care records.

People were looked after by enough, suitably qualified staff to support them safely with their individual needs. Staff enjoyed their work and were supported and managed to look after people. Staff understood their roles and responsibilities and were supported to maintain their skills by way of supervision. Pre-employment checks were completed on new staff members before they were deemed to be suitable to look after people living at the service.

The service was flexible and responsive to people's needs. People maintained contact with their relatives and friends and they were encouraged to visit the service and were made welcome by staff.

Activities took place at the service; however, some people felt that the number of activities taking place could be increased to improve social interactions.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to eat and drink sufficient amounts of food and fluids. Choices of meals were not always given to people, with some memory loss, in a visual manner to aid with their choices and as per the providers 'dining experience' audit action plan. This meant that people were not always given the support they needed to make a choice.

Staff monitored people's health and well-being needs and acted upon issues identified. They also assisted people to access a range of external health care services when needed and their individual health needs were met.

There was a process in place so that people's concerns and complaints could be listened to and acted upon and where possible resolved to the complainants' satisfaction. However, where actions had been taken to try to resolve people's concerns, not all people that raised complaints verbally were made formally aware of any actions taken as a result of their complaint.

Arrangements were in place to ensure the quality of the service provided for people was regularly monitored. Due to areas of improvement found by the management team, the provider's clinical governance manager was working within the service to make the necessary improvements. People who lived at the service, their relatives and staff were encouraged to share their views and feedback about the quality of the care and support provided and actions were taken as a result to drive forward any improvements required.

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.

People's medicines were not always managed safely due to poor record keeping.

People were not always supported by staff, when moving them in a way that promoted their safety.

Staff were aware of their responsibility to report any concerns about suspicions of harm and/or poor care.

People's care and support needs were met by a sufficient number of suitably trained staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the principles of the Mental Capacity Act 2005.

People's nutritional and hydration needs were met.

Staff were trained to support people effectively. Staff performance was reviewed via supervisions and competency checks.

People were enabled to access external healthcare provision when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always promoted and maintained by staff.

People and/or their relatives were involved in the setting up and review of their care records.

Arrangements were in place to support people with accessing advocacy services if needed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities for people living at the service were sometimes limited. This meant that people were put at risk of social isolation.

People's support and care needs were assessed, discussed, planned, agreed and appraised to make sure they met their current requirements.

There was a process in place to receive and manage people's suggestions, concerns and/or compliments. Complaints raised verbally did not always receive a formal response detailing actions taken.

Is the service well-led?

Good

The service was well-led.

Governance and audit arrangements were effective in identifying areas for improvement.

People were given opportunity to engage with the service and feedback on the quality of service provided.

A registered manager was in post and they supported an open and honest staff culture.

Ashlynn Grange

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 10 and 16 August 2017. The inspection was carried out by three inspectors and an expert-by-experience. An expert-by-experience is somebody who has had experience of a family member living in this type of service.

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 looked at this and other information we hold about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection we received information from a representative of the local authority quality improvement team; clinical commissioning group; and continuing healthcare team. We also received information from a representative of a local authority contracts monitoring team, practice manager of a local GP surgery and a fire safety officer to aid us with planning this inspection.

During the inspection we spoke with eight people who used the service, five relatives/visitors, the nominated individual (this is the person who has overall responsibility for supervising the management of the regulated activity, and ensuring the quality of the service provided); registered manager; clinical governance manager; and the clinical care manager. We also spoke with, three unit managers, one nurse; an activities co-ordinator; two care assistants and one housekeeper. We looked at seven people's care records and records in relation to the management of the service, management of staff, management of people's medicines and three staff recruitment files.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People and their visitors told us that they had no concerns with the way their/their family member's/friends prescribed medicines were managed. A visitor told us, "Her [relative/friend] medication is very well managed." The majority of people spoken with said that staff supervised them taking their medicines. Although, one person told us that they would have liked to have continued self-medicating. They said, "I say to them [staff] leave them with me and they say they are not allowed. So then I insist and tip them onto my table and they [staff] leave them with me. I have been doing my tablets for 10 years for goodness sake. I get frustrated." We fed this back to the management team during the inspection, who said that they will review this to make sure it was safe practise.

Staff told us they had attended training and refresher training in the management of people's medicines. We saw that medicines were stored at the correct temperature and disposed of securely. There was adequate information in place for people who required support with their 'as and when needed' (prn) medicines. Such as those for pain relief and/or increased agitation and the frequency people could have these medicines if required. Medicine administration records (MARs) showed that the majority of medicines had been administered as prescribed. However, we noted several record-keeping discrepancies within these records. Including incorrect medicines stock balances, gaps in the recording of people's medicine administration and the reason why a medicine had not been given.

We also found that due to a new pharmacy contract to supply people's medicines, there were some medicines that had not been available for short periods of time. Therefore, we found evidence that some people had not been given their medicines as prescribed. The clinical governance manager told us of the steps being taken to try to remedy this situation as soon as possible. This included the setting up of a meeting with the pharmacy management to discuss these concerns. Documented records we looked at confirmed these actions taken.

For people with limited mental capacity to make decisions about their own care or treatment, there were records, held separately to the care records, of decisions to administer their medicines given to them crushed in food or drink (covertly). These records showed staff had consulted with the people's GPs/pharmacist about this and there were documents showing that assessments of people's mental capacity were carried out. However, where people could be given their medicine covertly when required, we saw that there was a lack of details for staff on what actions staff to take before resorting to giving a medicine in this manner. The clinical governance manager told us that they were currently reviewing covert medicines within the service. This was to ensure that covert medicines being given in line with National Institute of Health and Care Excellence guidance.

Action was in the process of being taken by the provider as a result of concerns raised within the services internal audits findings, around the safe management of medicines. A unit manager told us, "The [clinical governance manager] has been bought into the service due to concerns around medication and is overhauling the system. The main concern currently is that we have changed supplier [pharmacy] and they are not delivering medication in a timely manner when requested." The provider's clinical governance

manager was, during this inspection, carrying out an additional on-site medicines audit due to concerns found by their quality monitoring. Where there had been any errors in the administration of people's medicines, the management team assured us that these had been identified and were in the process of being dealt with.

Care, support plans and risk assessments were in place and staff were aware of their roles and responsibilities in keeping people safe. This included following the guidance as set out in people's risk assessments. Risks included, but were not limited to, people being at risk in relation to their moving and handling; being at risk of falls and a person's nutritional and hydration risk. These assessments included actions to be taken by staff to minimise the risk of harm to people as far as possible.

Monitoring records were in place to review people's deemed risk. For example, how often a person needed to move position in bed to protect their skin integrity and for those people at risk of poor nutrition or poor fluid intake. These records were for staff to document at what time the person moved position in bed or what a person had eaten and drunk each day. The clinical governance manager told us that record keeping and the accuracy of records held was an area already identified as needing work. As a result of these concerns, they had developed a system which enabled unit managers to prioritise each person's risks to be fed back to the management team. However, despite this system, we found record-keeping discrepancies as they were often incomplete such as those for repositioning or fluid intake. This put people at increased risk of their wellbeing and health not being identified correctly.

Risk assessments included risks in the event of a foreseeable emergency such as a fire. We saw that there were contingency plans in place for these types of emergencies. Records showed that personal emergency evacuation plans were available for people living at the service and records documented that fire drills were practiced.

One person told us, "I can't walk so they [staff] use a hoist. It's been okay and I've not had an accident." However, another person said, "I'm in bed mostly or they [staff] hoist me into the armchair. It depends who hoists me. I can trust some [staff] more than others." A third person told us, "They [staff] could do with some more training in moving us." Accidents and incident records were held to document and investigate any incidents that occurred during the service. During July 2017, we saw two incidents forms which documented that two people had a minor injury. This was as a result of staff using inappropriate/unsafe moving and handling equipment to support them. During this inspection, we observed a person being moved by staff using equipment in an incorrect manner and not in line with their training. This incorrect use of equipment increased the risk of the person becoming anxious and possibly injured.

A detailed dependency tool was used to determine safe staffing numbers based on people's assessed care and support needs. There was a mixed response from people and their visitors who told us whether there were enough staff on duty. Although, they did tell us that people were safe. One person told us, "It's the place itself that makes you feel safe." A visitor told us, "If we had any concerns [family member/friend] wouldn't still be here – no qualms on her safety." Another person told us, "I feel safe here as nothing untoward happens. We're well safeguarded." A third person said, "They [staff] meet my needs alright really. The bell [call bell] reply is quite good mostly." However, some people gave us examples of how they had waited a long time for support from staff. A fourth person said, "There's nowhere near enough [staff]. It's the long waits." Examples of the impact on people of these long waits were fed back to the management team during the inspection. The registered manager advised us that one of the biggest challenges to the service was staff short notice absence. They told us the actions they were taking to improve this. During this inspection we saw that there was enough staff to meet people's needs. Staff were busy but did not hurry the people they were assisting.

Staff spoken with were able to demonstrate that they knew how to recognise and report any suspicions of harm or poor care. They gave examples of different types of harm and what action they would take in protecting and reporting such incidents internally or to external agencies. This showed us that staff knew the processes in place to reduce the risk of harm occurring.

Records showed that pre-employment checks were carried out to clarify that the proposed new staff member was of a good character. This demonstrated to us that there was a process of checks in place to make sure that staff were deemed suitable to work with the people they supported.

Good

Is the service effective?

Our findings

Staff told us, and records confirmed that they received training, including specialist training, to deliver effective care and support that met people's individual and complex health needs. Records showed that some staff's refresher training was overdue according to the provider's policy, but this had been identified already as an area for improvement by the management team. One staff member said, "We are doing a lot of e-learning [computer training courses]. We will get a memo reminding us that there is more training to do." Another staff member told us, "We are updating [our training] more training is good." Competency checks on staff's medicines administration were undertaken and supervisions were used by the registered manager to monitor staff members' progress. These meetings were also a forum to discuss any additional support needed, and any training and developmental needs. This demonstrated to us that staff were supported to maintain and develop their skills and knowledge.

New staff completed an induction programme Staff told us that their induction consisted of training and a probation review. This was until the registered manager deemed them confident and competent to carry out care and support.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes are called the Deprivation of Liberty safeguards (DoLS). People's capacity to make day-to-day decisions had been assessed by the registered manager. Staff we spoke with demonstrated to us an understanding of how they put their MCA and DoLS training into practice. One staff member said, "Let people make their own decisions and choices. If a person has dementia we sometimes have to do things in a person's best interest." Another staff member told us, "Assume capacity. Any decisions made are in [the persons] best interest." We found that people were supported with making their decisions and had no unlawful restrictions imposed on them.

People told us that staff asked them their preferred choice and respected these choices. One person said, "They [staff] do indeed ask me [my choice]. They're easy going with me." Another person confirmed to us, "I settle myself down when I am ready. Food and drink is up to me to choose what I fancy each day." A third person said, "They will do me something different to the menu if I ask." This showed us that people's choices were respected by the staff members supporting them.

Our observations showed that people could eat in the dining rooms or have their meal in their room if they preferred. Dining tables were laid with a tablecloth, placemat and napkin to enhance the dining experience for people and make it a social occasion. A recent 'dining experience' audit had an action for staff to show plated up meal choices. This visual prompt would help assist people with memory loss make a choice. However, our observations at lunchtime showed that this support for people was not happening on all of the units. This was a missed opportunity to help visually engage a person to make a choice.

People and their relatives/visitors had mainly positive views over the food on offer. One person said, "It's the same type of food as other places. They [staff] let me have an alternative. I asked for poached eggs as I don't

at pasta. It was most weird when [the eggs] came and hard on not very nice toast. I'd prefer plain English food like meat and vegetables, not with sauces on everything. I have to ask for a fork as they [staff] assume we all need a spoon to eat. And when the pudding comes, they [staff] always put the spoon in it for you. Are we not capable of picking up a spoon?" This meant that there was a risk of people being deskilled in the ability to eat independently.

The majority of people were given the option to have hot and cold drinks and snacks, between meals by staff on request. One visitor said, "On the day [family member] arrived, she'd had nothing to eat since the morning so the chef made her a meal especially as she was hungry. We thought that was lovely thing to do." One person told us, "We get gallons of drinks. I'm a tea queen." Another person said, "I need to drink more water so they [staff] keep me topped up." A third person told us, "I get very thirsty with my [health condition] so get through a lot of water. They [staff] keep my jug topped up." Observations showed that when people requested additional requests for food, that the majority of staff facilitated this.

People were supported to access a range of health care services to maintain their health and well-being. Records showed that external health care professionals such as, dieticians, and GP's were involved in people's care as and when required. A person told us, "I've had the chiropodist and optician here. I go to the hairdresser now and then. The girls [staff] do my nails." Another person said, "They [staff] are getting a specialist to see my [health condition] and the nurse bandages it every few days." A visitor confirmed to us, "She's [family member/friend] due for the optician soon. She gets the chiropodist regularly now and has a weekly hair wash."

Requires Improvement

Is the service caring?

Our findings

The lay-out of the service offered the potential to maximise people's dignity and respect; all bedrooms were en suite and were for single use only. The majority of people and their visitors told us that staff respected their/their family member's privacy and dignity. One person said, "They [staff] always knock first so I know who's there. My door gets closed at night." Another person told us, "My curtains and door will be closed if the girls [staff] are washing me." However, two other people told us of incidents of when they were left in an undignified manner that caused them anxiety. This, they said, was due to waiting for staff to assist them. We spoke with the management team about this during this inspection. They told us that they would look into these matters in line with their dignity protocol.

During this inspection, we observed a person being supported with their personal care by a member of staff who did not promote or maintain their dignity. This incident was fed back to the management team during this inspection, who confirmed to us of the actions they would be taking to address this.

People told us that they were asked their preference for either a male or female staff member to support them with their personal care. One person said, "They did ask me, but I'm so used to both, its fine." Another person told us, "They do ask me first if it is a male [staff member] on duty. One of them is the best carer here and does so much for me."

The majority of people and their visitors told us that staff were kind and friendly to them. One person told us, "They're lovely staff." A visitor said, "The permanent staff are fantastic, they all stop and speak to her [family member/friend]." However, another person told us, "90% [of staff] are very good." Our observations showed that staff were patient and caring, particularly when people were becoming anxious. We saw that staff kneeled beside people who were sitting, so that they were at eye level, took people's hands to reassure them and talked calmly to them about topics that would distract their anxiety. We saw that people recognised staff, interacted with them and responded to them often with smiles.

During the inspection we observed that staff were busy, but we saw that they supported people in an unrushed manner and at the persons preferred pace. Our observations showed that staff explained to people what they were doing when helping them. For example, when guiding them to sit down into a chair or assisting them with their meals. This was confirmed by people and their visitors we spoke with. A person told us, "They [staff] take on board what I say and will help me out." Another person said, "I am very happy with their [staff] help."

With the support from staff and the registered manager, people's rooms had been individually decorated with their own belongings. This meant that these individualised rooms enabled each person to make the service their own home.

People were supported to maintain contact with their relatives and friends. Visitors to the service told us that they were made to feel very welcome by staff. A visitor told us, "They [staff] made us feel very welcome from day one." Another person said, "My daughter can turn up at any time."

People's needs were planned for; this included a person's likes and dislikes. These plans gave information to staff to help them understand how to support people to meet their required needs. They also included people's end of life wishes, including, where appropriate, a wish to not be resuscitated.

Records confirmed that people and /or their relatives were involved in the setting up and reviews of their care plans. A letter had been sent to relatives of people living at the service inviting them to take part in the review of their family members care records. The majority of people and their relatives told us that they felt involved with their family members' plans of care as communication was satisfactory. One person told us, "My daughter does everything for me and sees my care plan. She came in for the relatives' meeting recently." A visitor told us, "My brother comes in for meetings with social services. He is very pleased with the place."

Advocacy services were available to people at the service should they wish. Advocates are people who are independent and support people to make and communicate their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

We looked at compliments and complaints received by the service. We saw that there was a formal process in place if people ever needed to complain, raise concerns, make suggestions and provide compliments. There was a complaints procedure available in the service that explained the process to new people to the service.

The majority of people spoken with said that they knew how to make a complaint but had not yet had the need to do so. One visitor said, "Honestly, nothing to complain about here." However, two people told us about concerns that they had raised with senior staff. Although dealt with, both people had not been made aware formally of the actions taken to resolve their concerns and this was not to their satisfaction. One person said, "They don't tell you what happens after." Another person told us, "One of the nurses came in a bit later and I complained to her but she said that the agency [staff member] had gone off duty so she couldn't speak to [them] tonight....I've heard nothing more from the nurse." This limited people's ability to be assured that any actions taken had been effective and to their satisfaction.

Records showed that people's requirements had been assessed before they moved into the service to make sure that the staff could meet the person's needs. Care plans contained adequate information about people's life history before they moved into the service. People, and their visitors told us and we observed that they/their family member had limited access to a range of activities and links with the community. One person said, "I get asked if I want to join in something, but I can't get there easily. My entertainment is my reading and puzzle books. Church people come in once a month to chat around the bedrooms for company. No-one [staff] else spends time, apart from my family." Another person told us, "I just watch TV or play my music. If family come, we might play cards. No-one on the staff [team] comes in to play." A third person said, "I hate bingo, but will go along for the quiz. They [staff] used to tell us mid-morning what's on that day but they haven't done that lately, so I don't know what's on. I can't come if I don't know. So I stay in my room all day and read otherwise." This put people at risk of not having their care needs met in a person centred way and of being socially isolated.

On the day of inspection we saw some activities taking place in the communal lounges. However, a visitor confirmed to us that, "She's [family member/friend] has done nothing today for an activity, so it varies day-to-day. Yesterday she went with people and staff in a taxi to [Peterborough. She is allowed to help in the garden as well." These concerns around the lack of activities taking place within the service were also raised by people during a recent meeting held during a dementia café event. Another visitor told us, "We went to the meeting last month and mentioned activities [staff] were doing the tea trolley now. It concerned me slightly as it means less time to do activities." We spoke to the management team about the lack of activities within the service. They told us that they had identified this as an area requiring some improvement.

Good

Is the service well-led?

Our findings

There was a registered manager in post. The registered manager was supported by a team of care and non-care staff. They demonstrated to us that they understood their roles and responsibilities and told us that they felt supported to carry out these roles.

Concerns had been identified by the quality monitoring systems already in place at the service. The provider's nominated individual and clinical governance manager formed part of the management team who were present at the service to drive through the improvements they had identified. During this inspection we found that they were working on improvements for the majority of areas we had identified as needing attention. A unit manager told us, "I feel supported by the management team, even the owner [of the service] is visible on the units…I feel the changes being put in place are positive and being made for the better of the home [service]." However, there were several missed opportunities by staff observed during this inspection. These included requests for additional meals not being facilitated, poor moving and handling techniques, record keeping discrepancies and not always promoting a person's privacy and dignity. This showed us that the improvements required identified by the service's governance arrangements were not yet embedded and were on-going.

The registered manager showed us that there were arrangements in place to regularly assess and monitor the quality and safety of the service provided. Examples of quality monitoring checks that took place included people's care records; people's dining experience; housekeeping; medicines; a night visit audit and a health and safety review. A provider's monitoring visit was also undertaken which looked at the service as a whole. Actions from the most recent visit in June 2017 highlighted the need for improvement around the safe management of people's prescribed medicines. This demonstrated to us that the provider had a range of systems in place that assessed and monitored the quality of the service, including shortfalls and actions taken to address them to drive forward improvements.

People and their visitors spoken with had mixed opinions about whether they were aware of who the registered manager was. One person said, "She sometimes comes round in the morning, walking around. A nice lady." Another person told us, "I have seen her once or twice for a chat and she'll ask me how I am. A third person said, "I have only met her once." A visitor told us, "We've seen her in passing but that's about it." However, people and their visitors were aware that they contact them via the unit manager and/or nurses.

Visitors were aware of meetings held where they could receive updates about the service and ask any question should they wish to do so. One visitor said, "We've seen a notice for one [meeting], but haven't been to one yet."

Records showed that a 'customer satisfaction' survey had been carried out in March 2017. Positive feedback was received, with areas of improvement highlighted. Areas suggested for improvement were about the laundry service and for staff to have, 'more time to sit and talk.' In addition, the management team had introduced different ways and events to capture feedback about the service from people and their visitors. In addition to regular meetings being held, forums, including the dementia café had also been set-up as an

event for people/their visitors to sit, chat, and ask questions about the service provided. The event that took place in June 2017, asked people for assistance with ideas about activities. This showed us that there were meetings held to engage people living at the service and their visitors, with the running of the service.

Staff attended meetings and said that they could raise any suggestions and/or concerns that they might have and be listened to. Records showed that at these meetings, information and ideas on how to improve the service were discussed. Staff meetings were informative about the expectations of the provider. Updates also included any organisational changes and reminded staff of their roles and responsibilities in providing people with safe care that met their individual needs.

Staff were aware of the whistleblowing policy and procedure and their responsibility to raise any concerns that they may have.

Notifications are for events that happen at the service that the registered manager is required to inform the CQC about such as a person experiencing a serious injury after a fall or safeguarding concern. Our findings showed that the registered manager informed the CQC of these events in a timely manner.