Isand Limited

Oxley Woodhouse

Inspection report

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Date of inspection visit:
27 January 2016

Date of publication:
29 March 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 28 January 2016 and was unannounced. The previous inspection was carried out in December 2013 and the service was compliant with the regulations at that time.

Oxley Woodhouse is registered to provide accommodation for up to 17 people. There were 17 people living at the home at the time of our inspection.

Accommodation at the home is provided over two floors, which can be accessed by stairs.

Prior to our inspection we reviewed information from notifications. We had received some anonymous information of concern that suggested people's care was not being carried out safely or properly. We found some, although limited, evidence to support the concerns raised to us, although could not find evidence of any impact upon people's care.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Risk assessments were thoroughly recorded and known by staff and the environment was well thought out to meet the particular needs of people living in the home.

Staff demonstrated safe practice and had a good understanding of how to keep people safe, with regard for the safeguarding and whistleblowing procedures.

Accidents and incidents were analysed in detail to ensure people's safety was being maintained

Staffing levels were seen to be supportive of people's needs, although staff sometimes worked long hours and combined their caring duties with ancillary tasks, such as cleaning, which had the potential to detract from the quality of care people received.

Staff had regular opportunities to update their skills and professional development and they demonstrated a very good understanding of the impact of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People experienced good quality interactions from kind and caring staff.

Staff worked well as a team, although some staff said morale was low and they did not feel fully supported by managers and the organisation.

Care records were highly person centred with clear information covering all aspects of people's

individualised care and support. Staff knew people well.

People felt supported to complain if they were unhappy about any aspect of their care and there was plenty of information in easy read format for people to understand.

Quality assurance systems were in place and there were clearly defined roles so that all staff knew who was in charge of the running of the home.

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.

Risk assessments were clearly documented and known by staff.

Staff were confident in their knowledge of how to ensure people were safeguarded against possible abuse.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were given choices in the way they lived their lives and their consent was sought in line with legislation and guidance. Staff had a very good understanding of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Staff had regular access to relevant training to enhance their role.

There were systems in place to support staff, although some staff said they worked long hours.

Is the service caring?

Good

The service was caring.

Staff promoted positive caring relationships with people and they were kind, patient and respectful in their approach.

Staff involved people well in their care and in meaningful ways in line with people's abilities.

People's independence was promoted well.

Is the service responsive?

Good

The service was responsive.

People's individual preferences were considered in the provision of their care and there was evidence of person centred planning.

People understood how to make a complaint and the complaints procedure was readily accessible.

Is the service well-led?

Good

The service was well led.

Systems were in place within the organisation to regularly monitor and review the quality of the service.

Communication to staff was clear, although some staff reported low morale.

Documentation to support the running of the home was in place.

Oxley Woodhouse

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 28 January 2016 and was unannounced.

The inspection team comprised one adult social care inspector and a specialist professional advisor in mental health. Prior to our inspection we reviewed information from notifications. We had received some anonymous information of concern that suggested people's care was not being carried out safely or properly. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We spoke with 4 people who used the service. We spoke with the deputy managers, four staff and the clinical services manager. We observed how people were cared for, inspected the premises and reviewed care records for 6 people. We also reviewed documentation to show how the service was run.

Good

Is the service safe?

Our findings

People told us or showed us they felt safe. One person said: "It's good here, I like it, I feel safe. I catch the bus to college and staff go with me so I know how to be safe doing that". We saw through some people's non-verbal communication they felt safe with staff. For example, one person reached for a member of staff's hand when going out for a walk and smiled when they held it. Staff spoke with people and gave reminders about safety in their routine. For example, staff reminded people not to put too much food in their mouth in case they might choke, and when cooking, staff reminded people the cooker was hot.

Staff we spoke with had a good understanding of the individual risks to people and they promoted people's independence according to their capabilities. We saw information in people's care records that matched with what staff told us about people's abilities, which showed staff knew how to manage people's care safely.

Safeguarding and whistleblowing procedures were in place and known by staff. Staff understood the signs that may suggest a person may be being abused and staff were confident to report any concerns to their line managers and to the local safeguarding authority where necessary. Where people's behaviours may challenge the service or others, staff were aware of techniques to use to de-escalate potentially harmful situations and to report any incidents, with referrals to safeguarding as required.

Accidents and incidents were recorded well with clear analysis to establish where trends or patterns occurred, for individuals and the organisation. This was completed on a monthly basis. We saw behaviour analysis records for each person and individual incident report files detailing the behaviour and the staff response. Staff said there was effective communication about accidents and incidents so all staff could learn from these. We saw the communications book and staff meeting minutes had reference to incidents that had occurred and highlighted positive strategies to avoid or minimise reoccurrence.

Staff understood emergency evacuation plans and discussed these where appropriate with people who lived at the home. One person told us if they heard the fire alarm they would "go to the safe place outside". People who wished to smoke understood there were designated smoking areas outdoors to ensure people's safety and the reasons for this were reinforced by staff in conversation with people.

We completed a tour of the premises as part of our inspection. We inspected 5 people's bedrooms, bath and shower rooms and various communal living spaces and laundry rooms and saw premises were suitable and safe.

We saw fire-fighting equipment was available, emergency lighting was in place and all fire escapes were kept clear of obstructions. We saw upstairs windows all had opening restrictors in place. We found many of the radiators in people's rooms, although they had thermostatic controls, were uncovered and not of cool panel design which may have posed a risk to the client group at the home. The deputy manager told us they would remedy the matter and in the meantime carry out immediate risk assessments.

We found all floor coverings were appropriate to the environment in which they were used and posed no trip hazards. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and with one exception found them to be compliant and within date. The exception was with how hot and cold water temperatures were taken and recorded as the form showed incorrect safe temperatures to be monitored against. It defined the upper cold water temperature threshold to be 30°C yet the safe upper limit is 20°C. We saw on three occasions in the past month cold water temperatures had exceeded 20°C and as such the effectiveness of the control regime for legionella at the home was in doubt. The deputy manager assured us they would seek professional help to reduce cold water temperatures.

We looked at people's medicine administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete and people had received the medication they had been prescribed.

We found people's medicines were available at the home to administer when they needed them. We asked a care worker about the safe handling of medicines to ensure people received the correct medication and they were knowledgeable about the procedures. We saw one person was prescribed a particular medicine and we asked a care worker what precautions must be taken for people taking this medicine. Without any hesitation they told us of the checks they would carry out to ensure people's safety was maintained. We observed a member of staff whilst they conducted part of a medication round. We saw medicines were given safely and people were sensitively helped to take their medicines. This demonstrated that medicines were given in a competent manner by well trained staff.

Some people living at the home had Autistic Spectrum Disorders (ASD) with coexisting mental and physical disorders. We looked specifically for the use of antipsychotic, anxiolytic or antidepressant medicines as interventions for challenging behaviours. We found functional analysis had taken place to identify what appeared to trigger untoward behaviours and trends in behaviour to enable staff to de-escalate situations, without the need for 'as necessary' (PRN) medicines.

We looked at information available for staff when people were prescribed medicines for PRN administration. We found when people were prescribed medicines for such matters as anxiety relief, a record was held of the times when a person declined or took the medication. We also found records showed the effectiveness of the medicine over time. Clear protocols existed to guide staff as to when PRN medicines should be given.

We asked about people's ability to self-medicate. We were told that no people independently self-medicated and scrutiny of care plans demonstrated specific mental capacity assessments had taken place. We saw one person with diabetes administered their own insulin under supervision and another person applied a topical preparation, again under supervision. Assessments in care plans supported this action. This demonstrated that staff were making all efforts to enable people to retain independence as far as possible.

We asked whether anyone had their medicines administered covertly. We were told not and our observations confirmed this. The home had a covert medicines policy in case of need.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained and medicines safely stored in line with current legislation. The giving of the medicine and the balance

remaining was checked by two trained care workers.

We noted that the date of opening was recorded on all liquids, creams and eye drops that were being used and found that the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. We inspected the medicines fridge and found it to contain appropriately stored medicines. The fridge temperature and the medicine store room temperatures were taken daily and found to be within a permitted range.

Staffing levels were appropriate for the needs of people and we saw people received high levels of support. Where people required one to one care and support we saw this was managed well overall, but on occasion we saw staff struggled with competing tasks. For example, staff who were preparing food for some people who needed one to one support struggled to prepare food and to meet the needs of the people at the same time.

The home was visibly clean and we saw staff engaged in cleaning tasks, sometimes alongside people they supported; staff we spoke with said this was to develop people's skills in independence. However, some staff said cleaning tasks at times detracted from people's care and support. For example, they told us people were unable to have spontaneous outings if there were cleaning duties to undertake. We discussed this with the deputy manager who said they would monitor the balance between promoting people's independence in daily living tasks and offering choice in people's lifestyles. Staff we spoke with were aware of the need to use personal protective equipment (PPE) and we saw there were adequate supplies. Staff knew the colour coded system for cleaning cloths to minimise the risk of infection.

Good

Is the service effective?

Our findings

People told us they thought staff knew how to do their jobs. One person said: "[Staff member] is good at everything and especially good at cooking." Staff we spoke with said they thought people received care from staff who had the skills to do so.

Staff said they felt supported to undertake their work and complete relevant training. The training matrix showed which staff had undertaken each aspect of training and identified where refresher training was due. Staff had completed training in mandatory areas, such as safeguarding and first aid as well as additional relevant topics, such as epilepsy and MAPA (Management of Actual or Potential Aggression).

We saw the staff supervision matrix showed staff had engaged with their line managers in supervision meetings each alternate month. Staff we spoke with confirmed these took place regularly, although there was mixed opinion amongst staff about the value of these; not all staff said they felt these were beneficial as a supportive mechanism for them to discuss their work. The management team said they monitored staff suitability through observation and had mechanisms in place for ensuring staff's ongoing suitability was managed.

Some staff we spoke with said they worked long shifts and this sometimes made them feel tired and work less effectively. Some staff said they were happy to work extra hours and had signed a waiver to the working time regulations so they could work extra shifts if the service needed staff. We found from staff rotas and through speaking with management that some staff were working shifts of 14 hours with little time between shifts. Although there had been some management analysis of this, the deputy manager agreed to review the balance of ensuring adequate staff numbers with maintaining staff effectiveness when working long shifts.

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff sought consent to help people with their needs. When people were not able to verbally communicate effectively we saw staff accurately interpreted body language to ensure people's best interests were being met. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The deputy manager told us 14 people were either subject to an authorised DoLS or an application had been submitted for a renewal of an expired authorisation. Of the remaining three people at the home, scrutiny of care plans showed two people had capacity and the third person had been formally assessed and found not to require DoLS.

We looked at four care plans and saw on two occasions the best interest's assessor had recommended conditions be attached to the authorisation. We saw care plans had been constructed to ensure the conditions would be acted upon and be subject to regular review. Annotations in the care plan showed conditions had been acted upon and the outcome had proved beneficial, as the best interest assessor had hoped for. We spoke with the deputy manager to gauge their understanding of current legislation regarding the Mental Capacity Act 2005. Their answers demonstrated a thorough understanding of the law and how it had to be applied in practice.

Some people had a learning disability with co-morbid mental disorders, including mood disorders, personality disorders and abnormally aggressive or seriously irresponsible behaviours. We saw these people were under constant close supervision by one or two staff. Scrutiny of care records showed on occasions physical restraint had to be used to protect the person, other service users or staff from harm. Each person who had a history of aggression had recorded in their care files how aggression manifested itself. For example one person had a history of slapping, kicking, punching, hair pulling and screaming. We also saw staff were encouraged to wear a hat when caring for this person during periods of disturbed behaviour to discourage hair pulling. This level of information ensured staff had the knowledge to best care for people's needs and protect themselves and others from harm. We spoke with the deputy manager about the use of restraint and the policy documents to underpin restraining methods. They told us physical restraint was an action of last resort and on every occasion it was used, a full and detailed report was compiled which was subject to managerial review. They told us all staff had undertaken MAPA training to provide staff with positive strategies for dealing with difficult situations. We were told staff had been trained in using emergency holding procedures in specific circumstances related to extreme risk or acute behavioural disturbance. Care plans identified which people may need to be physically restrained. Detailed guidance was contained in care plans to describe which holds may be used and whether one or two care staff should be involved. The restraint plan recorded signs the individual may show when becoming agitated and appropriate de-escalation techniques to be used. We saw on each occasion restraint was used staff recorded the incident in full.

People told us or showed us they enjoyed the food in Oxley Woodhouse. We observed breakfast time. We saw some people independently accessed the kitchen to prepare their own food and drinks, whilst others were supported by staff. Those people who were supported were offered choices. However, one person wanted porridge or an alternative cereal and none of these two items was available, so staff offered a third choice which was accepted. We asked staff whether it was usual for food items to be unavailable and staff said it was not usual, but the inspection day was close to the day for the grocery shopping. Staff said that if the people really wanted something that was not immediately available they would go to the shop to get it. Apart from the choice of cereal not being available we saw there was a well-stocked refrigerator and food cupboards with plenty of fresh fruit and vegetables.

Staff told us there was no set meal time as this was determined by each person and they worked round individual needs. We noted one person was having breakfast at 11.30am and we asked staff how this may affect the person's lunch. Staff said the person chose to get up late that day, but had a predictable preferred diet routine that meant it was important to them to have their meals in order, so breakfast would be the first meal of the day in order for them to maintain their secure routine. Staff said they were mindful the person may not want lunch for some time afterwards.

This showed staff responded to meet people's needs effectively.

The premises had been adapted to meet the needs of the people. Whilst one part of the service was in a separate building, the main house had clearly defined spaces. How a space feels, looks, smells and functions are of extreme importance to a person with ASD. People with ASD need rooms in buildings with clear functions and sensory qualities which define its use. The home had adapted a room into a multi-sensory environment, commonly referred to as a 'snoezelen' room. This room was of particular benefit for some people with ASD to promote pleasure and feelings of well-being. The main building had three defined areas which service users recognised. We saw some lounges appeared bare but were designed to provide low levels of stimulation. Our observations throughout the day showed some people were happy and content with the spaces they had chosen to spend time in. We saw no people wandering aimlessly about or people pacing up and down in a state of anxiety. We saw much effort had been put into creating an environment suitable for people with ASD and associated mental illnesses. The colour of walls and furnishings avoided the use of patterns and commonly used low-arousal colours such as cream. Lighting did not glare with little use of fluorescent lighting.

We saw all bedroom and en-suite doors opened inwards. We noted some people currently at the home had epilepsy and the care group who may in the future occupy the home had a higher than normal incidence of the condition. We asked about risk assessments for people with epilepsy to ensure staff could gain access to a bedroom if a person had a seizure and fell behind the door. We were told by the deputy manager the risk had not been identified but they would look at the risk and if necessary provide some rooms with outward opening doors.

Good

Is the service caring?

Our findings

People and staff told us the home was caring. One person said: "It's a happy place here". We heard one person tell a staff member: "You make me laugh, you're fun, it's good fun here". We saw people spontaneously hug staff and staff responded warmly and with smiles.

We observed staff supporting people in a positive way. Some people living at the home had Autistic Spectrum Disorders (ASD). We saw staff interacted with people with ASD with a structured and therapeutic approach. Staff helped people to develop social skills and manage stress. Staff communicated in a way which helped people to understand what others may be trying to communicate to them. We saw the service used schedules and timetables to give the necessary structure and visual cues to people with ASD.

Staff's consistent approach ensured people were all included equally in what took place within the home. Staff spoke with people in a respectful way and used friendly gestures to accompany words and reinforce communication. Where people had limited verbal communication staff were observant of their body language and facial expressions. Staff interpreted one person's sign language to understand they wanted more breakfast and a drink and they mirrored this to clarify with the person what they wanted. Where people were visually impaired staff supported their independence by ensuring they had what they needed within reach and offering reassurance.

When supporting people with their care, staff offered good explanations to enable people to do as much for themselves as possible. For example, staff were on hand when one person prepared their packed lunch for the day and engaged the person in discussion about how best to wrap their food and what foods would go together to make a healthy meal.

We observed interaction between a care worker delivering continuous one-to-one care to a person who had very recently suffered the loss of a close family member. We saw comfort and consideration being given to the person who displayed signs the interaction was of benefit to them. Discussion with the care worker demonstrated they had a good understanding of the person's needs and this level of knowledge had been used to relieve the person's current acute distress.

Each bedroom was a single room which gave people privacy. We saw rooms were personalised with people's own possessions, photographs and personal mementos. This helped to make each room personal and homely for the person concerned. We spoke with one person who was cleaning their room. They told us they liked living at Oxley Woodhouse and were free to decorate their room to their taste.

We saw care plans were constructed to maintain a collaborative approach between the person with autism and their families. Where people did not have family support or close friends we saw people were supported by either lay advocates or Independent mental capacity advocates (IMCAs).

Good

Is the service responsive?

Our findings

People we spoke with said the care provided was responsive to their individual needs. One person told us: "It's up to me what I do. I like to go out and they [staff] help me to do that".

All staff we spoke with had a good understanding of the individuals needs of people. We found staff who were delivering one-to-one care to a person for a protracted period had an excellent understanding of the persons care needs.

We saw there were details of people's preferred activities in their individual files. Some people had pictorial timetables of what they liked to do. We saw staff engaged with people in their chosen activity. For example, one person had a particular love of balloons and balls and staff supported the person by inflating these. Another person wanted to go for a walk with staff and we saw staff encouraged them to fasten their own coat with discussion about the cold weather. The person linked arms with staff and went happily for a walk in the local area.

Staff understood when matters were important to a person and made every effort to ensure their well-being. For example, one person had lost a favourite slipper and staff searched the home until a suitable pair could be found.

Care plans recorded what each person could do independently and identified areas where the person required support. When people moved into the home detailed assessments took place which ensured people's independence was maintained. We also saw evidence of pre-admission assessments by psychologists to ensure those people with Autistic Spectrum Disorders (ASD) were placed in a suitable therapeutic environment.

We looked at three care plans that had been individually developed for each person. Care plans followed a logical format and each care plan was individually tailored to reflect people's needs. We saw very little evidence of generic planning tools being used which reflected well on this type of service. Care plans were person-centred and were written in the first person to document people's wishes in relation to how their care was provided. The care plans evidenced how people liked to spend their time and how they liked to be supported. The plan also showed what people or health care professionals told staff about what provoked people's anxieties and inappropriate behaviours. Where appropriate easy-read documentation had been used.

There was detailed care planning where necessary surrounding the management of physical and verbal aggression. Needs were assessed based on people's past history of verbal and physical aggression, environmental damage and superficial self-harm. Care plans recorded all known antecedents to aggression, giving staff sufficient information to quickly de-escalate potential problems. Where assessed needs meant additional staff were required this was put in place.
Care plans illustrated to staff the optimal method of caring for people which would generate the best outcomes in terms of behaviour and at the same time protect staff from possible harm through aggression

directed at them. Care plans also sought to provide boundaries within which each person could function in a constructive way. The boundaries were designed not to constrain but to provide the necessary structure to daily living which people with autism combined with coexisting mental disorders need.

We looked at a care plan for one person whose daily living was dictated by long established rituals. The care plan listed almost every aspect of daily living and the importance of staff adherence to those rituals. Records of daily care compiled by staff demonstrated the significant adverse effects of extremely complex rituals not being followed or where new rituals had been experienced for the first time. We saw a written record of the ritual to be followed at bedtime. The time of going to bed was important and staff were instructed to follow this precisely in order to ensure the person's well-being.

The people at Oxley Woodhouse required structure and seamless care to be able to function without experiencing anxiety or an inability to cope with everyday life. Care plans made particular note of the need for care staff to ensure they handed over care at the end of a shift in a manner which delivered a seamless service. Staff we spoke with said they felt the handover of information between shifts was thorough and enabled them to be up to date with people's needs.
People we spoke with said they knew how to make a complaint if they were unhappy about the service. We saw there was easy read complaints procedure information available in the service to assist people. Staff we spoke with said they would ensure people's views were heard and should people have cause to complain, staff said they would support them to follow the procedure. Complaints and compliments were recorded, although the outcome of the last complaint in June 2015 was not documented. The deputy manager told us all complaints were resolved and it was likely the resolution to the last complaint had been done verbally, not documented.

Good

Is the service well-led?

Our findings

The service had a registered manager who was registered with the Care Quality Commission. The registered manager was absent during the inspection, although the running of the home was managed by one of the deputy managers with support from another deputy manager. We saw the deputy managers were involved and visible in the service and were supported by the clinical services manager on the day of the inspection. Feedback within service user questionnaires from January 2016 about the standard of care was positive.

The values and vision of the service was displayed and staff we spoke with told us they felt confident in their roles and responsibilities. Staff understood who was in charge in the absence of the manager and all staff said managers encouraged staff to raise any concerns with them should they need to. Some staff told us they felt supported in their work, although not all staff we spoke with said this and some staff reported poor staff morale throughout the home. We found there had been a recent turnover of staff with more experienced staff having left the service. Some staff said they did not feel valued by managers and their sometimes excessive working hours meant it was difficult for them to achieve an appropriate work-life balance. We discussed with the deputy managers that there were mixed feelings within the staff team and although not all staff reported feeling unsettled, there was still some unrest. The management team said they were keen to promote a culture of openness and communication and so would give consideration to how they could improve morale within the staff team.

We saw there were measures in place for assessing and monitoring the quality of the service provision. For example, a member of the management team carried out weekly audits of medicine administration, storage and disposal. The audits demonstrated medicine irregularities were of a minor nature with no evidence of recurrent themes. Written comments on the audit demonstrated issues were picked up early and used as a learning tool to ensure a climate of continuing quality improvement.

Policies and procedures were clearly documented and regularly reviewed. Where relevant, such as with the whistleblowing policy, staff were provided with relevant contact information.

Maintenance records for the premises, vehicles and equipment were organised appropriately and available for inspection. Where improvements were highlighted, such as through the infection prevention and control team audit, a clear action plan with timescales was in place. The deputy manager told us where people were transported in staff vehicles, checks were carried out to ensure people's safety and we saw a sample of documentation relating to the checks made. The clinical services manager showed us how analysis of information took place to ensure information gathered was meaningful, such as for training and untoward events.