Autism Anglia

Whitstone House

Inspection report

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Date of inspection visit:
14 March 2023
16 March 2023

Date of publication:
16 May 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Whitstone House is a residential care home providing personal and nursing care to up to 10 people with a learning disability, and autistic people, with mental and/or physical healthcare support needs. At the time of our inspection there were 8 people using the service. The service provider is Autism Anglia, and the building is owned by a housing association.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

People's experience of using this service and what we found

Right Support:
We identified continued breaches of regulation as part of this inspection. This meant the provider did not assure us that people's safety could be upheld, as not all risks associated with people's care and their environment had been assessed and rectified. For example, risks from poor infection control, risks from falls from height and risks from broken or poorly maintained equipment placed people at increased risks of avoidable harm.

People were mostly supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always document this practice.

We were still not confident that people were appropriately supported to make more complex decisions in regards to their health care needs in line with the principles of The Mental Capacity Act 2015.

Best interest decisions did not clearly demonstrate how and why decisions had been made.

Relatives spoken with were not confident that people who staff supported were receiving good outcomes of care. They told us communication could be poor and staff did not always inform them how people spent their day. Relatives said they were advised of anything of an urgent nature but would like to know how people were supported with their needs. They described activities as mundane and not in line with people's needs and experiences of what they used to enjoy.

We identified a positive culture in the service with people going out often, but less so at the weekend due to staffing fluctuations. Continuity of care and support was important to both people and their relatives, and

we still had concerns about staff vacancy rates and the regular use of agency staff which potentially limited people's opportunities.

Staff were supported in their role by the registered manager, through a recognised national induction and were assessed to ensure they had the right competencies and skills. Some staff training had lapsed, and role specific training had not been fully rolled out which meant potential gaps in staff's knowledge, some who were new to their roles.

People's care plans had improved and the ones we looked at were up to date. We reminded the provider to ensure records were cross referenced and to make sure all staff were aware of the records they must adhere to when providing people with care and support. We also recommended that care plans and risk assessments were updated by staff following an incident to ensure risks and actions were clearly documented.

We found medicines were administered to people in line with their needs and monitored to ensure they were necessary and correctly given in line with prescriber's instruction. We have made 3 recommendations about medicines management in the service. They are around ensuring people understand why they are taking medicines and what the side effects are. Monitoring medicines and where possible reducing them and thinking about a more person-centred approach to medicine administration.

Right Care: Some progress had been made since the last inspection and a new organisational structure and management team meant further improvements had been identified and planned. Relatives were aware of some of the changes but were not aware of how their feedback was acted upon or how they could influence the service. People using the service were encouraged to make choices by staff supporting them, but information should be readily available to them to help them understand more complex aspects of their support such as medicine administration.

At the last inspection we noted notifications were not being submitted in a correct, timely way to CQC in line with the provider's regulatory responsibilities to provide safe care and support. We were confident the provider now understood their regulatory responsibilities and were submitting notifications in a timely way.

Right Culture:
The provider had learnt lessons and was developing the service to consider people's immediate needs and how their needs might change in the future. Staff had not received training in end-of-life care. The provider advised us forward planning documents were going to be put in place.

Effective auditing was still not in place and risks identified as part of our inspection had not been identified by the provider. Whilst we were assured that people were going out and received good outcomes of care, we were less assured by the progressiveness of the service and how they ensured people were living their best lives with measurable outcomes of care.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 29 November 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of 4 regulations. The provider had not ensured the premises were safe and fit for purpose. We had concerns about how staff sought consent from people for more complex decisions and the governance and oversight

was improving but had failed to identify some of the areas we did as part of our inspection.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has not changed and remains requires improvement.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whitestone House on our website at www.cqc.org.uk.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

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Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Whitstone House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors, 1 of whom was a medicines inspector.

Service and service type
Whitstone house is a 'care home.' People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Whitstone House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed all the information we had received about the service since the last inspection. We sought feedback from the local authority who had inspected recently to monitor the service progress against their action plan. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During our inspection we observed the care and support provided to people and spoke briefly to people as they prepared for the day, most were going out. We looked at 3 care plans and associated care records and looked at other records in relation to the safe running of the service including recruitment, training, and fire safety. We spoke with 9 staff including a senior member of staff, the care coordinator, care staff, the registered manager, the operational manager, the finance director, and a trustee. Following the inspection, we continued to seek validation from the provider and spoke with 4 relatives.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires improvement. At this inspection, the rating has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At the last inspection we identified a breach of regulation 12: Safe care and treatment and identified concerns with safety, the premises and infection control. The provider has not done enough and is still in breach of this regulation.

● Risks associated with people's care and support and risks associated with the environment had not been fully addressed since the last inspection. This placed people at increased risk of avoidable harm and meant staff were unclear how to effectively reduce risk and work consistently.
● We noted several incidents had occurred in or around the kitchen including a person becoming upset when unable to access the kitchen due to others being supported in the kitchen. Risks associated with this had not been fully considered and the kitchen was not well maintained. We also noted a person either pulling up or injuring themselves on exposed floor edging.
●One person's room was almost bare due to their behaviours and further consideration had not been given to the purchasing of heavy-duty furniture which might be more appropriate to their needs.
●Risks associated with paraffin based emollient creams had been documented but staff spoken with were not aware of these. The individual fire risk assessments in the hallway had not been updated in the 6-month timescale and did not refer to the individual fire risk assessments.
●Risks associated with people's care was documented but we still had concerns about safety associated with epilepsy. Documentation was not always cross referenced and did not always show who was consulted in drawing up the documentation to keep people safe from harm.

Preventing and controlling infection
●We were not fully assured the provider was promoting safety through the layout and hygiene practices of the premises. At the last inspection we identified that although regular cleaning took place, a reduction in staffing at the weekend meant less cleaning took place. We also found the layout and the condition of the building made it more difficult for staff to keep the service clean. At this inspection, some improvement was noted but the condition of the building, the floors and general decoration was still poor.
● Cleaning was taking place and there were checklists for frequently used areas such as shared toilets. Despite best efforts, several areas of the home had an unpleasant odour from the flooring which required replacing.
● Environmental issues either had not been identified or addressed in a timely way, some of these issues increased the risk of infection such as bins which were not foot operated and were overflowing. Replacement floors were necessary to reduce the risk of cross infection and smell within the service.

Learning lessons when things go wrong
● The provider had an oversight of incidents, and the records provided a brief overview of the incidents and actions taken but it was not clear if risk assessments and care plans were updated to consider any additional actions needed.
● We reviewed incident records and body maps were completed when an injury had been sustained. Debriefs took place as confirmed by the incident form and by staff spoken with. Information provided on these forms did not provide a more detailed analysis: antecedent, behaviour and consequences (ABC) charts were not always completed. This extra information would help for a more detailed analysis.

The environment and standards of cleanliness did not promote people's safety and inaction from the provider meant risks were not always identified and acted upon in a timely way. There was also insufficient analysis and learning from incidents to help reduce the likelihood of these. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Reasonable precautions were being taken to control the spread of infection and staff were observed washing their hands and encouraging people to wash their hands between tasks, particularly before eating. The provider kept up to date with current government guidelines regarding infection control. Staff currently did not wear masks but had appropriate personal protective clothing and shared areas had a ready supply of gloves, hand gel and paper towels.
● A recent infection was rapidly contained by the staff and did not spread which showed measures taken by staff were effective.

Visiting in care home.
This was permitted in line with any guidance issued by the government and the needs and wishes of people using the service.

Using medicines safely
● During our inspection, we identified several issues relating to medicines. The registered manager was aware of Stopping over medication of people with a learning disability (STOMP) guidance, but some staff spoken with were not. They also identified limited information being shared with people about their medicines, what they were taking and why. Information about medicines was not broken down in a way people could understand and medicine administration practices did not demonstrate a sufficiently person-centred approach.

We recommend the provider has clear evidence of regular medicine reviews and the review and reduction of medicines whenever possible considering both the benefits and risks of certain medicines.

We also recommend that information about people's medicines is made available to them in an easy read format or other appropriate means to ensure people could understand why medicines were necessary.

We also recommend that the storage and administration of medicines from a central medicines room is reviewed and consider if people might be able to administer some medicines themselves. For example, creams which could be safely stored in their rooms.

●Staff when administering creams must go to the medicines room each time which is time consuming and not in line with a person-centred approach.
● People received their medicines as prescribed, and staff were trained and assessed as competent before

being permitted to administer medicines. Staff spoken with confirmed they were observed at least 3 times or until they felt confident to administer medicines. Guidance about when to administer medicines was in place and reviewed.

Staffing and recruitment

● Staff recruitment was ongoing and there were 6 full time vacancies as additional hours had been created within the service. Additional night staffing had been put in place since the last inspection and a person had additional staffing hours agreed. The service were covering core hours but were reliant on agency staff and overtime. Staff told us weekends could be a bit slim staff wise and this impacted on activities for people.

● Continuity of care and support was a concern at the last inspection due to people's complex needs. Core staff supported people but reliance on agency was still an issue and not a good long-term strategy.

● Recruitment processes were satisfactory to ensure only staff suitable to work in care were employed.

Systems and processes to safeguard people from the risk of abuse

● At the last inspection we identified minimal notifications had been received from this service and we had received no safeguarding concerns. The manager's understanding was that they needed to wait for the outcome of a safeguarding investigation by the local authority before notifying us. This was not correct, and the registered manager has since been notifying us of any incidents, and or safeguarding concerns.

● Staff understood what constituted a safeguarding concern, what they should report and what actions they might take if the provider failed to act upon their concerns. Staff received regular updated training and safeguarding was a regular agenda item. Staff met regularly with people where they would be able to discuss any concerns, but staff recognised they would need considerable support to raise concerns.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment, and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires improvement. At this inspection, the rating has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Adapting service, design, decoration to meet people's needs
At the last inspection we identified this was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 15.

- The property had been poorly maintained over an extended period and there was a lack of clarity about what parts of the building were listed. This resulted in people living in a building that was potentially unsafe. Some repairs had been completed since the last inspection, but numerous actions remained.
- Pipes and radiators had been covered, but we identified some radiator covers already broken exposing people to unnecessary risk of scalds. This had not been identified by the provider.
- A broken handrail and risk from stairs had not been mitigated by the provider. One person had been identified as being unable to safely access stairs but risks to others had not been taken into consideration, and we noted stairs to the garden. Stairs were not visually contrasted.
- The design of the property did not consider people's needs both in terms of their independence and in terms of their needs as they got older. There had been no forward planning and certain areas of the service, for example, the kitchen and laundry were locked, and people could only access these areas with staff support. Other areas of the service such as the disused swimming pool had no defined purpose.

The continued condition of the building had meant people lived in an environment that was not suited to their needs or properly maintained. This was a continued breach of regulation 15 premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
At the last inspection we identified a breach of regulation 11 (consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were not assured staff upheld people's human rights by ensuring they followed the principles of the Mental Capacity Act 2015. At this inspection we found some improvement, but the service had not done enough and were still in breach of regulation.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorizations were being met.

● Mental capacity assessments had not been completed at the time of the last inspection for all aspects of people's support where they might not be able to make their own decisions. The registered manager has since introduced a consent to care form. This explores with people their understanding of various aspects of their care and whether they were able to consent. The form was completed by a staff member, but their role was not determined, and it was not clear who else they consulted before determining if the person lacked capacity to make a specific decision.
● Information given to people did not support them effectively to help them decide or understand aspects of their care. For example, an information leaflet telling people why they take medicines, the risks, and the benefits. This would help people understand why their medicines were necessary.
● Where decisions had been taken in people's best interest the rationale, the risks and benefits had not been carefully weighed up or demonstrating who had been involved in the decision, to have or deny access to health care.

The lack of adequate assessment and planning in line with people's consent is a continued breach of regulation11 consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider had made DoLS referrals, but we found at the last inspection no evidence to show these were regularly followed up. Since the last inspection applications had been chased up and 1 application approved.

Staff support: induction, training, skills, and experience
● Staff we spoke with had varying levels of experience and some were new to care and, or new to their role. Staff new to their role were supported through induction by more experienced staff and completed the care certificate which covered an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care.
● Some staff in management roles had not yet had specific training in line with their job roles and this was planned.
● Some staff training was not up to date which could impact on their knowledge of certain aspects of their role.

Assessing people's needs and choices, delivering care in line with standards, guidance, and the law
● The service had contacted other health and social care agencies to review and support staff in meeting people's needs. The local authority had agreed additional funding for 1 person which enabled them to support the person to go out more and reduce their distress behaviours.
● Some support plans including positive behavioural support plans and risk assessments still did not demonstrate a collaborative approach or show who was consulted when drawing up guidelines and ensuring best practice.
● Agency staff had access to summarised information to help them understand and meet the needs of

people using the service. People's relatives expressed concerns at the last inspection and stated they wanted regular staff who were able to provide consistent support to their family members, several people were not able to verbalise their needs.

Supporting people to eat and drink enough to maintain a balanced diet

● Staff supported people at mealtimes to ensure their safety. Staff supported people to access the kitchen and be involved in meal preparation, when accompanied by staff. We observed one person who went food shopping with staff and purchased what they wanted to eat for lunch and then prepared their meal with staff. People took in turns deciding what should be on the menu and the menu expressed their preferences.

● Staff documented risks associated with people's diets. Senior staff had oversight of what people were eating and drinking and staff recorded this. Staff were supporting a person to lose weight and encouraging them to be more active. Their records did not demonstrate this had been discussed with a dietician to ensure rapid weight loss was carefully monitored.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support

● Staff worked with other agencies to improve the service, review people's needs and ensure support offered was appropriate to their needs.

● People's health care records and care plans were kept in multiple places and it was difficult to find the relevant information as they were not always cross referenced or updated as required.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. At this inspection, the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements: Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people.

At the last inspection we identified a breach of regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 17.

●People continued to live in a poor environment which did not fully consider their needs and the provider had failed to identify and rectify some of these issues in a timely way. We identified multiple breaches of regulation at the last inspection. At this inspection some, but not all actions, had been taken by the provider and they were still in breach of regulations. This did not assure us that all aspects of the regulated activity were carried out in line with best practice and regulation Governance and oversight at all levels of management had been weak.

●We discussed this with the operational manager and the registered manager and pointed out environmental issues we had identified on the day of inspection which included: broken recently fitted radiator covers, broken kitchen cupboards, a broken dishwasher, unsuitable waste bins, doors banging, floors that had not been replaced by the provider and a person had a sparse, unhygienic bedroom. The provider had not considered the risks associated with the large staircase.

●Infection control processes had improved and there was evidence that staff had managed to contain the spread of infection and were doing more regular cleaning. However, the condition of the building made it more difficult for staff to keep clean. We discussed this with the operational manager who told us weekly deep cleans were going to commence.

● Governance and management oversight was not yet effective. Of the senior management team, the registered manager was in their first registered manager post and had not completed all the training necessary for their role.

●The senior team was newly formed, and it was not clear from discussions with staff who had oversight for what. For example, the deputy manager completed daily walkarounds but neither the registered manager or other members of staff knew where the forms were kept, and the forms did not identify the concerns we had. The registered manager had completed risk assessments for emollient creams, but staff spoken with were not aware of this.

●Staffing remained a concern and relatives commented on the changes of staff and lack of effective communication. Agency staff were used to backfill vacancies across the service, and this impacted on the

quality of the service with relatives telling us that continuity of care and support was difficult to achieve without regular, core staff. Agency staff completed training through their agencies but did not have access to the same value base training that core staff were required to take.
●Whilst family members acknowledged they had been asked for feedback they were not aware how their feedback was used to identify improvements. Not all families felt well informed about their relatives care and whether it was of a sufficiently good standard. One relative was not aware if reviews had taken place or how their family member's health care needs were being met. Relatives mentioned a key worker system but said staff changed so they did not always get routine feedback about what their family member was doing but did agree anything urgent was fed-back.

The provider did not have effective governance and oversight to ensure people received care in line with their assessed needs. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider's service action plan had been implemented and actions carried out. The provider had discussed and shared this with us and the local authority. Concerns identified by us on the day were mostly rectified within 24 hours of the inspection giving us some confidence of the responsiveness of the newly formed management team.
●The registered manager told us champion roles were being discussed which would mean certain staff having key areas of responsibility based on their knowledge and interests, but this was not yet fully developed across the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had been open and accountable with families and taken responsibility for the lack of investment and breaches of regulation. Where incidents had occurred, the provider told the families and other relevant agencies.

Continuous learning and improving care: Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Care plans reflected people's needs and took into account their characteristics and how they wanted to be supported.
● Joint partnership working had increased, and we saw some good examples of where other health and social care agencies had been involved to discuss people's needs and support staff. People were encouraged to access the services they needed.
● The manager was supporting the staffing team to ensure they had the necessary skills to develop and improve the service. Staff spoken with were positive about their roles and time spent with people using the service. They demonstrated good interpersonal skills and enthusiasm for their role.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● A family member said staff supported their relative to visit regularly and we noted people had started to do activities they had done before the pandemic which included holidays and swimming.
●The registered manager promoted good staff practice and awarded staff for working well or going the 'extra mile.' Staff recognised the improvements in the service and why these were necessary.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Best Interest decisions were not clearly recorded showing how and why decisions had been made in line with The Mental Capacity Act 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's care and their environment had not been properly assessed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not appropriately maintained or in line with people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance and oversight was not sufficiently robust and did not ensure timely actions to ensure people's needs could be met safely.