Aldanat Care Limited

Aldanat Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place between the 26 January and 1 February 2017. Aldernat Care supports people in supported living settings At the time of our inspection they were supporting 25 people between the ages of 21 and 70 years. Some people lived alone but others lived together in the same building and shared some communal space. The inspection was announced as this service supports people in their own home and we wanted to make sure that someone would be available when we visited.

The managing director of Aldernat Care was the registered manager and was based at the central offices along with other administrative personnel. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe and had a good relationship with the staff who supported them. The service had been commissioned to provide staff support with a care package of allocated hours to meet individual's needs. While we saw evidence that some people were receiving their full allocation of commissioned hours it was not always possible to ascertain what individual staff support was being provided and if the deployment of staff reflected all of the people's needs.

The systems to manage risk did not always work effectively and while actions were taken when things went wrong, the service needs to improve their assessment of risk to mitigate the risks to people's health, welfare and safety.

Medication was appropriately stored. However it was not consistently well managed and we have asked the manager to seek advice from the supplying pharmacy on supporting people who need to take their medicines with them when they go into the community.

Staff were knowledgeable about the signs of abuse, and the actions that they would take should they have a concern. We saw that staff received training on a range of areas including first aid, health and safety and autism. Staff also received training on how to defuse situations to reduce the need for restraint. However, there were gaps in training, in areas such as mental health but the provider assured us that they had identified this and had a plan to address this.

The provider had policies in place with regard to the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals. Care staff had a good understanding of the importance of obtaining consent and protecting people's rights.

We observed staff to be kind and caring and people who lived in the service looked at ease with staff. They

were not all able to talk to us about the support they received so we spoke with their relatives who were largely positive about the service and the commitment of staff. They told us that staff kept them updated and communicated with them.

People's independence was not always consistently promoted. We found examples of good practice in some projects but not in others. People would benefit from a greater emphasis on goal setting and ascertaining peoples aspirations. People's access to the community varied and this could be developed further in some of the projects.

There were procedures in place to manage and respond to complaints.

There was a lack of consistency across the service. There were elements of good practice but also areas where improvements were needed.

The provider had some oversight and had already identified some of the issues we found. There was some evidence of reflective practice and we saw that some changes were planned to improve the quality of the service.

During the inspection we identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and you can see what action we told the provider to take at the back of the full version of the report

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 consistently safe.

Staffing deployment was not clear and did not always meet the needs of people using the service.

Risks were identified but not consistently well managed.

Medicines were appropriately stored but staff were not consistently following best practice.

Staff knew how to respond to concerns and raise matters relating to avoidable harm and safeguarding.

Is the service effective?

Requires Improvement

The service was not consistently effective.

A training programme was in place for staff but did not always reflect the complexities of some of the needs of people that the service was supporting.

Consent and the Mental Capacity Act 2005 was well understood by staff, peoples choices were promoted and best interest decisions were in place.

People were supported to maintain a balanced diet.

People were supported to maintain their health

Is the service caring?

Good

The service was caring

People were happy with their care and staff had good relationships with the people they supported.

People were given information in way that they understood. Staff knew people well and supported them to maintain relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were detailed and informative in some projects but this was not consistent.

We saw some good examples where individuals were supported to lead a full and independent life however this was not consistent throughout the service.

Procedures were in place to address complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was some inconsistency across the service. There were elements of good practice but also areas where improvements were needed.

There were systems in place to audit the care provided but these would benefit from further development.

Aldanat Care

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 the 26, 31 January and 1 February 2017 and was announced.
The provider was given 48 hours' notice because the location provides a domiciliary care service for younger adults who are often out during the day; we needed to be sure that someone would be in. This inspection was carried out by two inspectors and we visited four separate sites where people were supported to live in the community.

The provider had 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 sent questionnaires to people who used the service, relatives and visiting professionals. We reviewed the previous inspection report and the PIR to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

We spoke with seven people who were able to verbally express their views about the quality of the service they received and four people's relatives. We spoke with three health care professionals. We observed the care and support provided to people and the interactions between staff and people throughout our inspection.

We looked at records in relation to ten people's care. We spoke with the registered manager, the operational director and fifteen members of staff.

We looked at records relating to the management of medicines, staff recruitment, staff training and systems for monitoring the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe and were complimentary about the staff. One person told us, "They are all mixes of ages and all very friendly and helpful." Observations of interactions demonstrated that people looked comfortable with staff, when they spoke and interacted.

One person told us, "I get quite a lot of support….Most of the time I have got my guys." Another person said, "I was two to one (staffing) for a while until they got to know me."

There were sufficient numbers of staff but we were not confident that they were always deployed in a way that met people's needs or for which their care had been commissioned. The service provides support to people in a number of different projects, some of which were dependent on agency staff. The provider acknowledged that there had been issues with some of the teams supporting individuals but they had begun to build teams around these people and this had begun to make a real difference. The provider told us that where possible that they tried to roster agency staff where it would least impact on the people using the service and that they were recruiting new staff. Staff told us that improvements had been made but that the service still had some issues retaining staff. We looked at peoples assessed hours and the staffing rotas and were not always able to see clearly how people received the staff support which had been commissioned. For example, in one project, an individual was wakeful in the early hours and required reassurance; this was at a time when limited staff were available. Similarly in the evening there was one member of staff on duty and it was not clear how people could be supported to access community activities. People told us they could only go out when staff were available and this meant evening activities rarely took place. The rotas just showed staff first names but not who they were allocated to, for what time and what care they were expected to support them with. The provider told us that rotas for all the other projects identified the hours and how staff were used.

This is a Breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff recruitment and found that the agency appointed a number of people with no previous experience in care. The interview process did not always fully explore staffs understanding of the needs of people they might be supporting. The management of the service told us that they provided staff with training and took peoples previous experience into account in the deployment of staff. We saw prior to staff appointment the necessary checks were undertaken to ensure the staff member's appointment was appropriate. This included previous employer and character references, the person's previous employment history, and proof of identification. It also included a disclosure and barring check to make sure the person did not have a criminal record which might make them unsuitable to work in the care sector. We noted that staff started work at the service before the results of their criminal records were known. The manager assured us that Disclosure and Barring first checks were in place. These are an initial check to identify if people are barred from working with adults. The records regarding these checks were not on people's records although the manager assured us that until the full check was returned staff only worked on a supernumerary basis.

Where offences were identified as part of the Criminal record check, there was no risk assessment process undertaken to identify and manage any potential risks. The manager told us that they considered risk but did not document this and it agreed to take this forward and address this.

We saw that the service used agency staff and we asked about how they assured themselves that the staff provided by the agency were competent and safe to work in the service. We were told that the agency provided a personnel profile, and this was supplemented by an onsite induction which identified areas such as fire procedures and risk assessments processes. The profile was however missing for one of the agency member of staff we identified and the provider told us that this would be followed up.

Medicines were not consistently well managed. We found an example of staff decanting medicines into a container for an individual to take with them when they were away from the service. This practice is called secondary dispensing and places people at risk of receiving the wrong medicines. We have asked the manager to seek advice from the pharmacy and update their medication policy.

Most people had staff assistance with their medication to ensure they received their medicines as prescribed. We looked at a sample of medication administration records and saw that these were clear and up to date corresponding with peoples medicines. Staff had signed following administration. Medication records included a medication profile list of medicines and what each drug was for with any potential side effects to help staff. This also included any allergies. Where individuals were prescribed medication for specific circumstances such as pain management, guidance was in place. There was a policy in place for homely remedies and we saw that peoples medicines were stored securely

Staff received adequate training to ensure people got their medicines as required and told us that they were not able to administer until this was completed. Staff received on line training, face to face training and their competency to administer medicines was observed. Medication audits were completed weekly and monthly to ensure medicines were administered correctly.

The systems in place to manage risk did not always work effectively. We reviewed some of the incidents that had taken place, the provider's response and outcome of their investigation We found examples where there had been a number of near misses, for example one individual had obtained the keys of the medicine cupboard and taken an overdose. Another individual was being supported to access the community when they became unwell. The member of staff supporting them had not been trained to administer the rescue medicine that they needed for their epilepsy.

Our review of incidents found that the service had acted promptly to safeguard individuals once incidents had occurred but they had not pre-empted or anticipated some of the issues. A number of incidents seemed to have occurred because there was insufficient forward planning and consideration as to the appropriateness of the activity in terms of the person's needs and known anxieties and sensory issues. A relative spoke about some of the errors that had occurred and told us that the staff were learning as they went along, "They have made a few mistakes, but always correct it."

We found that there were risk assessments in place which identified the steps needed to reduce the likelihood of harm, for example covering areas such assessing the community and self-injurious behaviours. These assessments sat along the behavioural support plan and provided staff with guidance such as how many staff should accompany the individual on specific activities. The assessments varied in detail and quality. For example, we noted one individual was vulnerable when in the community and could make allegations about others. There was not clear guidance in place to assess and mitigate risk to people when out accessing the community. One person was described as 'attention seeking' which did not give a good

insight into their behaviour or reasons for it.

The provider told us that the service users they support have very complex needs and some have lived in secure hospital. All the risks cannot be known with any given individual and they can only put into place what is known historically and what may happen based on this. When incidents have happened follow up meetings have been held with professional teams and care planning reviewed. In some case intense training and review of practice have taken place.

We saw that the service consulted with other health professionals such as social workers and the community mental health team on the causes of distressed behaviours and how risks posed should be managed. Assessments had not been signed by those involved in the discussion and documents were not always dated. We saw that on occasion restraint was undertaken by staff trained to do so and incidents were reviewed by the services behavioural advisor.

Staff told us that they had undertaken training on safeguarding and knew what actions to take if they observed poor practice. They told us that they would not hesitate to raise concerns if they were worried about people's wellbeing and expressed confidence that matters would be taken seriously. One person said, "We have a whistleblowing policy and we have to sign a form to say that we have read it."

We saw that safeguarding referrals had been made to the local authority which demonstrated that the management of the service had a good understanding of what was a safeguarding concern and the process to follow. Where investigations into safeguarding concerns had taken place, action plans were developed which identified learning from what had happened.

There were financial policies in place and systems in place to safeguard people's money. People had access to their money but this was managed by staff. Receipts were kept for bigger items and cash transaction sheets showed money in and out. Guardians had been appointed to manage people's financial affairs when there was not a relative.

Requires Improvement

Is the service effective?

Our findings

People told us that they liked the staff who supported them. Relatives said that the staff were "good" and when the staff team was stable they worked well together.

We interviewed a number of staff as part of our inspection, some had previous experience of supporting people with a learning disability but others had limited or no previous experience in providing social care. The organisation provided new staff with an induction which included a period of shadowing a more experienced colleague before working independently. Staff told us that they attended training and this was in line with the Care certificate, a nationally recognised induction programme.

The mandatory training included areas such as first aid, fire safety medication, moving and handling, autism, health and safety. Staff were provide with a combination of face to face and on line training. We expressed some concerns that the on line training may not adequately prepare staff for their role, given the complexity of the needs of some of the people that this service supports. The provider told us that they were in the process of reviewing their training and had increased the amount of face to face training. The provider told us that they work with the complex social team to give the staff face to face training around individual service users although certificates are not issued for these courses. In addition to the mandatory training we saw that some staff were in the process of undertaking the qualification in credit framework (QCF)

The feedback we received from staff about training was contradictory, some staff were positive about the training but others were less so. Some staff told us that the training was not specific enough or based around the needs/issues they faced. Others told us that they had received training from health professional specific to the individuals they were supporting .We identified that not all the staff had completed training on mental health needs and the provider assured us that they had identified this and had a plan to address this.

The provider told us that all staff had undertaken training on using physical restraint. One of the health professionals we spoke with told us that they had observed staff using restraint and this had been undertaken safely and for the least amount of time necessary. Following the incident they staff said, staff had showed concern for the individual wellbeing and provided comfort and reassurance.

The provider showed us a spreadsheet which listed the dates that staff had completed the training and flagged up when staff were due to have their training updated. Leadership training was planned for senior staff

Staff told us that they received support through one to one supervision support, meetings. Records were also maintained of these meetings. Records showed us staff had supervisions, observations of practice and annual appraisals but the frequency of these varied.

People's capacity to make everyday decisions was taken into account when supporting them. We checked staff understanding of the Mental Capacity Act 2005 (MCA). The MCA sets out what action providers must

take to protect people's human rights where they may lack capacity to make decision about their everyday lives. Staff told us they had received training on the mental capacity act and deprivation of liberty safeguards and had understanding of their responsibilities. One member of staff told us that to place unnecessary restrictions on people's activities would be unlawful. There were very few restrictions for people and we saw example of where people made their own decisions however unwise.

There was documentation in place demonstrating what actions staff took to try and promote people's safety without impinging on people's choices and chosen life style. We saw a number of best interest decisions on areas such as finance and medication. These recorded how decisions had been made and who were involved in these decisions and how to support the individual in the least restrictive way. These were reviewed on a regular basis. The manager told us they were liaising with the Local Authority regarding applications for deprivation of Liberty.

We reviewed the recording around a number of incidents of restraint which had taken place. The reasons and the background to the event were documented. Staff recorded how long each incident of restraint was and the type of hold used. Recordings were also made of the efforts made by staff to deescalate and use other strategies to defuse the situation. The records were all sent to head office for review and collation. We saw that practice was being changed as a result of these reviews. For example we saw that for one individual there were lessons learnt and the care plan had been amended

People were supported to eat and drink according to their needs, wishes and preferences.
We saw staff supported people with meal preparation and encouraged healthy eating. A number of people had health care issues such as diabetes and pre diabetes. Staff were aware of this and tried to monitor and reduce people's sugar intake. Records were maintained of people's weight and where people's weight fluctuated, staff had taken steps to support people such as encouraging the use of full fat milk. It was agreed that a referral would be made to the dietician for one individual.

We saw that people had regular access to health professionals such as GPs, speech and language therapists, dentists, opticians and podiatry. Referrals had been made for specialist input such as sensory assessments. We saw a number of examples of good practice where staff were alert to changes in people's wellbeing but staff had not all had training or specific guidance about how to respond. For example the day of inspection we noted that one person's blood sugars were quite erratic. The person had been out with a member of staff but returned as they were unwell and their blood sugar low. They did not have their rescue gel with them but were given a mars bar. We could not find specific guidance for care staff although noted that the specialist nurse had set up some training.

Hospital passports and grab sheets were in place if people required treatment in hospital in an emergency. Some of these were more detailed than others.

Good

Is the service caring?

Our findings

People spoken with were complimentary about the staff. About the senior carer, one person said "They are always here." A relative said, "They go beyond the call of duty." People said staff were very friendly and everyone said they liked the staff. We were told that the staff were, "like family." Some staff were clearly very committed and loved their role, one person said to us, "This is my life…I have a lot of job satisfaction." We saw a letter which a visiting professional had written; they stated "It was an absolute privilege to witness the compassionate caring approach of your team. They advocated for the resident with skill tact and care ……it was a privilege to watch the team at work."

We spent time observing interactions between staff and people who used the service within the communal areas. We saw that staff spoke to people in a kind manner and had a good rapport with them. We observed people to be at ease and comfortable when staff were present. Staff clearly knew people well and had shared interests with them. They were able to tell us about people and how they communicated. For example, we saw staff taking time to speak with people and making sure that they understood.

We observed staff using different methods to communicate with people and ascertain their views, including the use of photo books. One of the staff we spoke with about communication was aware of its importance to the person and told us, "It just takes time"

Care plans provided information to guide staff in supporting people and how they communicated. This was particularly important for those individuals who did not communicate in a verbal way. Efforts were made to support people to make choices for themselves in how they wished to spend their time and who with. For example, an individual was due to go swimming but then changed his mind, this choice was respected by staff supporting him and they agreed to go to another activity instead.

People's privacy was respected by staff, for example we saw that one person had asked to be alone and observed that the member of staff withdrew but later went back to check if they were ok

We noted that people were able to see visitors privately and maintain relationships with friends and family. The arrangements in place were all different and reflected individuals' wishes. Relatives told us that the staff supported them to maintain regular contact and a number of people living in the service had advocates.

Requires Improvement

Is the service responsive?

Our findings

People's independence was not always consistently promoted. We found examples of good practice where there was an emphasis on what the person had achieved and there had been a reduction in staff support as a result of the person becoming more independent. However we also found examples where people's independence was not always fully encouraged or facilitated. For example shopping for some people was completed on line by staff and the shopping bill split three ways .Cooking of the main meal on the day of our inspection was done by staff without any involvement of people using the service.

We also noted that people when asked did not have front door keys but instead accessed their home through the back door. In addition at least one person we saw had no credit on their phone. The reasons for this were explained but meant they had to use the phone in the communal area which might limit their privacy. They had no credit for emergencies.

People's access to the community varied. In some of the projects people had good access to the community and some people had their own transport. We saw for example that they regularly accessed activities such as swimming, the local town and college. Some people had been on holiday which they had enjoyed. However in other projects there was less evidence that people were leading fulfilling lives. Some people had no structured activities and the time spent with staff was limited. Trips out were restricted to when staff had time to support people. One person had a full life before their mental health declined and the activities they were now doing did not reflect their interests and hobbies.

Not everyone was supported in doing activities which had a therapeutic value or in line which things they use to do and enjoyed. One person had regularly refused 'therapy type interventions' but it was not clear how staff were supporting them around their behaviours. This was the case for another person whose needs were unmet because they refused to engage with some professionals.

Care plans were in place and contained information about people's needs and preferences. However they varied in quality with some being very informative and detailed but others were less so. For example the care plans did not always correspond with staff description of people's needs and therefore we could not be confident that staff supported individuals in a consistent way. Some of the statements were not very meaningful such as, 'I continue to look for opportunities to gain work experience.' But there was no evidence of how this was being facilitated. We saw that one person had a small amount of money a day and could have more at the staff's discretion however it was not clear when this might be appropriate. We could not always see how people had been involved in putting together their support plans. We saw some support plans did not include short/medium or long term goals and we could not see how some people were being supported with key areas of their daily living. People had contracts in place which stated the level of support people required and included setting goals in key areas. Staff when asked said they did not really set goals for people.

Alongside care plans individuals had behavioural support plans and behavioural management protocols which identified different types of behavioural and environmental triggers. There was clear guidance which

set out how staff should respond and these were written in a positive way. For example for one of the individuals we looked at, had green and amber strategies which set out what actions staff should take to stop a situation escalating. There was also red strategies outlining actions to take if the situation deteriorated

The input people had from other professionals varied from person to person and depending on the stability of their mental and physical health. Some records evidenced that regular reviews were taking place however this was not consistent and outcomes were not always clearly documented.

The provider told us that regular reviews are undertaken between three and six monthly basis and this covered goal setting. People were involved in this process.
Daily notes kept by staff were limited so it was difficult to evaluate the level of support and input people got from staff around their individual needs and time staff spent with them.

Staff told us that they received handovers when they came on shift and this alerted them to changes in individual's wellbeing. We saw that for some, individuals regular reports were undertaken by the behavioural advisors which explored the incidents and lessons learnt. Weekly summaries were prepared by individual seniors/service managers at each of the projects and sent over to head office. These provided a general overview of the individual, the week's events and details of any incidents.

People were aware of how to make complaints should they wish to do so. One of the people we spoke to was unhappy about the service but we saw that their concerns were being taken seriously and a meeting had been set up with health professionals to discuss and agree a way forward. Relatives told us that they had confidence in the systems in place. We looked at the records of complaints and saw that formal complaints were investigated and where necessary steps such as disciplinary action taken.

We also saw records of compliments for example one professional had written "You had the skills to remain calm, the ability to reduce the risks to keep everybody safe."

Requires Improvement

Is the service well-led?

Our findings

The service had a clear management structure; there was a registered manager who was the managing director and an operational director who oversaw matters on day to day basis. Both were based at the provider's administration office. The manager was also registered as manager for a nearby residential care home but told us that they intended to submit an application to deregister as registered manager of this service, as a new manager was now in post.

As part of the inspection we asked the manager for an update on their statement of purpose. This is a document which sets out the aims and objectives of the service and details of the needs that the service intends to meet. The document we were provided with was insufficiently detailed and did not correspond with the information provided on the provider's website and our observations. For example it did not outline how the service intended to meet the needs of people who required support with their mental health and those with complex physical disabilities.

There were seven different supported living projects and each of the projects were managed by either a senior or a service manager. Staff spoke highly about some of these individuals and described them as "brilliant" and as giving "100% every day." They told us that that the registered manager was not visible but they were approachable and could contact them if needed.

Staff told us that there were clear arrangements outside office hours and the on call arrangements worked effectively. One member of staff said, we had an issue recently in the middle of the night but our service manager came and sorted it. "They are only a phone call away."

Staff morale was better in some projects than in others. In one of the projects we were told that there had been a lot of change and this meant that there was sometimes a lack of consistency. Staff told us that employing "more experienced staff would make a difference" to how the service worked. However overall it was clear the staff in the individual projects supported one another and were largely positive about their role. They told us that that the service was improving, the training was better and the management more visible. Staff told us that the organisation had the right values, but still had some way to go to embed the changes that had been made. This corresponded with our observations and findings as there was a lack of consistency across the service, some areas worked well but others would benefit from further development.

Team meetings were held regularly. The provider told us and we saw that the service had recently commenced meetings with staff to reflect on practice and identify areas which they could improve. This was a positive development and evidenced that the organisation was involving its staff in a meaningful way to drive change and challenge practice inconsistent with their values.

We were told that senior managers meet regularly to discuss areas such as training, strategy and behavioural management. Incident reports were reviewed by the behavioural support manager and each project completed weekly reports on key events and these were collated and reviewed at head office.

We saw that the service undertook spot checks to ensure that staff were carrying out support correctly and adhering to the plan of care. We saw that these were undertaken on an unannounced basis and staff looked at a range of areas including how meals were provided and how people's choices were promoted. A numbers of audits were also undertaken which included reviewing areas such as health and safety, infection control, care planning, staff supervisions and medication. Where shortfalls were identified action plans were in place with dates for completion. However we could not see that some of the areas which had been identified had been followed up to check whether they had been addressed and it was agreed that this would be undertaken.

Registered providers are required to notify the Care Quality Commission (CQC) about events which may affect people who use the service. This helps CQC to undertake its responsibilities with regard to safely of people who use service. We found that during the inspection the provider had not always completed the required notifications. We spoke to the provider about this and they told us that had recognised this and had processes in place to ensure that it would not reoccur.

We saw that the service had systems in place to seek the views of people who used the service, staff and relatives. We saw that there was an action plan in place setting out how the areas identified would be addressed. The provider told us that moving forward they were looking to develop easy read questionnaires which would increase the participation of the people they support.

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
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always deployed in a way that met people's needs