Quality Care Home (Midlands) Limited

Nelson House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The inspection was unannounced and was carried out over two days on 6 and 7 October 2014.

The last inspection on 25 October 2013 identified that the provider was not meeting legal requirements in respect of systems to support staff development. At this inspection we saw that improvements had been made.

Nelson House provides personal care to up to 21 people who may have needs due to old age, physical disability and dementia. At the time of our inspection 17 people lived at the home. A registered manager was employed at the service. 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 and their relatives consistently told us they were happy with the service provided and that staff understood their needs and they felt safe.
The recognition and reporting of safeguarding issues was

Summary of findings

not consistent. A recent incident in the home demonstrated the provider had not involved other professionals which they are required to do under safeguarding procedures in order to keep people safe.

Staff had the training to manage people's medicines. Staff were aware of the precautions to take where medicines had to be given in a specific way, although written details to support these practices were not always evident. Staff managed the agitation of some people very well without relying on additional medication. Audits of medicine stocks showed that errors were being identified, and repeated. The action taken therefore to reduce risks to people was not effective as the cause of errors had not been identified.

Safe staffing levels were maintained and people were cared for by staff who knew them well so that they received the right care at the right time to meet their needs and promote their safety.

Improvements were needed to ensure that people were not placed at risk due to the layout of furniture that partially blocked the fire exit door. Obstacles in the hall and lounge could potentially cause accidents.

People's needs were assessed and care plans were detailed to provide guidance for staff. People's care was effectively planned because staff supported them to access health care services so that they received care based on their individual needs.

People were supported to follow their individual interests both in the home and out in the community. However opportunities for people with dementia could be strengthened to meet their specific needs. People told us that staff were friendly and that they were supported to maintain relationships that were important to them.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA) and report on what we find. We saw people were given choices about their care and support. The manager was following the requirements of this legislation so that decisions are made in people's best interests when they are unable to do this for themselves. Staff were aware of those people who needed protection and were taking the least restrictive approach to protect them. This meant that people could be confident that actions and decisions were being made in their best interest and only by people who had suitable authority to do so.

Risks to people's health and wellbeing were well managed. They were supported to eat and drink well, and arrangements for managing risks to people's skin were well established so that people were supported to remain healthy.

Staff were provided with the skills and knowledge to provide safe and appropriate care to people, and we saw that systems were in place to support the staff to do this appropriately. There were a range of ways people could raise their concerns or complaints and they told us they were confident they would be listened to and acted upon. The manager was open to managing people's complaints although the recording of these could be improved.

The views of people that lived there and their relatives were looked at regularly by the manager to look at any areas for improvement.

We saw that there were systems to monitor and check the quality of the service although some risks had not been captured by the systems in place.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

Staff were aware of how to recognise and report signs of abuse and were confident that action would be taken to make sure people were safe.

Risks to people's safety had not been fully considered because there were environmental risks related to fire safety evident within the premises.

Repeated errors in the management of people's medication meant that risks to their health may not be reduced.

There were sufficient numbers of staff available to meet people's needs and ensure that their rights were protected.

Requires Improvement

Is the service effective?
The service was effective.

People received care which met their needs and staff had received training and on-going support to meet people's needs.

People were supported to make their own decisions. Where people lacked capacity decisions were made in their best interests and only by people who had suitable authority to do so.

People were supported to eat and drink enough and received nutritional support from external professionals. People told us they were happy with the food. People were referred to appropriate health care professionals to support their health and welfare

Good

Is the service caring?
The service was caring.

People told us staff were very caring, kind and patient. We saw staff listened and talked with people and knew people well.

Staff understood how to provide care that respected people's needs, preferences and personal circumstances.

People had the support they needed and this was provided in a respectful, calm and unhurried manner that protected their dignity and showed respect.

Good

Is the service responsive?
The service was responsive.

Good

Summary of findings

People received support as and when they needed it and in line with their care plan. People's social interests and preferences were addressed. Opportunities for people with dementia could be strengthened to ensure people had interesting things to do.

There was a range of ways people could raise any concerns or complaints they had. People said that the manager listened and acted on their views

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and their relatives felt the home was well run, staff were approachable and the manager was supportive.

Monitoring of the service had not always been effective in identifying where improvements were needed.

The manager had not consistently reported accidents or incidents to the relevant external agencies so that risks to people could be fully considered.

The needs of people with dementia had not been fully considered in relation to providing clear signage and décor to support them to recognise distinct areas of the home.

Nelson House

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 checked 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 6 and 7 October 2014. The inspection team included two inspectors and an Expert by Experience, (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service. The ExE had knowledge of the needs of older people and spent time with people and relatives to gather their views about life at the home.

The first day of our inspection was unannounced. On the first day of our inspection we focused on speaking with people who lived in the home, staff and observing how people were cared for. One inspector returned to the home the next day to look in more detail at some areas and to look at records related to the running of the service.

Before the inspection, we asked the provider to complete 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 received the PIR within the required timescale and used the information from this to help inform our inspection process.

We checked the information we held about the service and the provider. This included notification's received from the provider about deaths, accidents and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

We requested information about the service from Dudley Local Authority and NHS Commissioning Group. Both have responsibility for funding people who used the service and monitoring its quality. They did not share any concerns about the service.

We spoke with 14 people living at the home, three relatives and a visitor. Some people were not able to tell us about their care so we spent time observing them being supported by staff. We spoke with the provider, manager, three care staff and the cook. We looked at the records related to the care of four people, and sampled records such as accidents, training, menus, complaints and compliments, quality monitoring and audit information.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with said that they felt safe living at the home. A person said, "I'm not concerned about safety, I have a buzzer to call if I needed help". Another person told us, "I'm not worried about getting hurt, staff are always around so even if some people get distressed staff help them so I'm not worried in that way". A visitor said that they felt confident that their relative felt safe. People told us they felt at ease with other people they lived with and the staff who worked there and did not have to worry about their possessions.

The risks of abuse to people were minimised because there were clear policies and procedures in place which staff confirmed they had access to. Discussions with staff showed they were aware of the various forms of abuse that people were at risk of and they told us they were confident the manager would report concerns to external agencies where necessary. One member of staff told us, "If I saw or thought there was any risks to people of abuse or harm I'd report it to the manager and she would act on it". The manager told us staff undertook training in how to safeguard people. Training records showed the majority of staff had up to date training in this area. A recent accident in the home was not reported to the local authority until directed by us. This meant the procedures for reporting actual harm had not always been understood or followed which indicates otherwise good practice was not sustained. However the person's safety was not compromised because the manager had taken appropriate action to keep them safe.

Risks to people's safety and welfare had been identified for example, assessing what support people might need to help them change position with the use of a hoist or move around the home safely with the use of walking aids. We observed ways in which staff worked to manage known risks that people may experience such as choking on food, or the risk of not eating or drinking enough. The manager had sought advice from health professionals in assessing how such risks could be reduced. Staff had been informed if people needed equipment to keep them safe and we saw staff supported people in line with their care plan. A person told us, "They [staff] never rush me, always take their time otherwise I would fall".

People told us there was always staff available to help them. Visitors told us they were satisfied there were enough staff to care for people and keep them safe, one said, "I'm more than happy and would definitely recommend the home to others". Staff said that there was enough staff on duty to meet people's needs and we saw there was enough staff to respond to people's needs, including providing one to one support at specific times for people who needed this. The turnover of staff was very low and people were supported by staff who knew them well. The manager told us they used a tool for identifying the level of staff needed to meet the dependency levels of people and that this could change if people's needs increased. There was a clear 'on call' system and arrangements in place for covering staff sickness or holidays so that safe staffing levels were maintained.

Arrangements were in place to ensure that medicines were available for people when they needed them. One person told us, "I have regular medication but I also have other medication when I need it and the staff always asks me if I need it". Medicine records showed people had received their medicines as prescribed by their doctor. We saw that medicines were administered safely; staff checked each individual medication and checked people had taken it prior to signing the records. Staff we spoke with confirmed they had appropriate training to do this safely.

We saw that there were avoidable interruptions and distractions to the staff member who administered medication which could cause errors. The provider was carrying out checks on medication including the stock. Records of the checks on medication stock showed repeated errors with no cause identified. The manager told us although the errors were in stock checks people were given the right medication. However the count of stock was not accurate and the audit process did not show how they intended to reduce risks to people. Information about how when required medicines should be managed needed to be improved so that staff had all the information they needed to ensure people had their medicines in the right way.

There were some potential risks evident within the premises. The layout of the lounge furniture partially blocked a fire exit which could make it difficult for people to exit safely. The manager told us the fire exit that was blocked was no longer in use; however the fire risk assessment did not reflect this. The manager

Requires Improvement

Is the service safe?

informed us post inspection that furniture had been rearranged. Although the manager had taken action to rectify this they had not consistently followed fire protection measures to safeguard people who lived there.

A dis-used dryer in the hallway was covered with a fabric that was similar in colour to the hall carpet. This could cause confusion to people with sight impairments and or dementia as it was an obstacle in an area in which people walked regularly.

Good

Is the service effective?

Our findings

People who lived at the home told us they had confidence in the staff. One person said, "I'm quite happy with how they look after me, they know what they are doing". A relative told us, "I'm pleased with the care that care staff and health professionals have provided every step of the way". People told us they received care that they had agreed to as confirmed by their involvement in their care plans. We looked at four people's care files and saw these provided detailed information about people's health and social care needs. We saw they were individual to the person and included lots of information about people's likes and preferences. Observations of staff supporting people living at the home showed that they knew people well. We saw that staff provided people with support as described in their care plans.

At our inspection in October 2013, we identified that not all staff had received regular supervision to monitor their progress and performance. At this inspection staff told us they had regular supervision in which they discussed their practice and training needs. We saw there was a yearly appraisal system in place to support staff development. This was confirmed from records we looked at. A staff member told us, "I feel supported and I could ask the manager anything". We saw that training specific to the needs of people, such as, dementia, mental health, moving and handling and nutrition was booked to ensure staff had the necessary refresher courses. This showed a system was in place to plan training for staff in key areas so that they could develop the skills necessary to meet people's needs.

Where people were unable to provide consent to their care there was evidence that representatives had been consulted and contributed to decisions on their behalf. We saw that staff obtained people's consent before providing them with support by asking for permission and waiting for a response, before assisting them.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so. The manager demonstrated their understanding of the DoLS. We saw she had identified people who lacked capacity to make decisions and was applying to the supervisory body. Staff we spoke with were aware of DoLS and records showed that staff had received training in the Mental Capacity Act. Staff were aware of those people at risk and we saw they took the least restrictive approach to protect people. This showed that the manager was taking action to ensure that the human rights of people who may lack mental capacity to make decisions were protected. People could be confident that actions and decisions were being made in their best interests and only by people who had suitable authority to do so.

People told us that they were happy with the food and said that it was "'Nice" and "Good". People told us that there was always something they could choose to eat. We saw the cook asked people about their choices and prepared this on the day. We observed staff supported people correctly with food at a consistency they could manage and drinks were prepared with thickener to ease swallowing. The mealtime was relaxed and people were given plenty of time to eat their meal, it was not taken away without asking each person if they had finished and whether they could 'manage a little more'. We saw people's individual needs for direct support with eating had been addressed by having their meal at a different time enabling staff to provide unhurried one to one support. The arrangements for managing the needs of those people at risk of not eating enough were effective and had included advice from the doctor, dietician and speech and language therapist. Records for food and drink consumed and weight records showed staff were effectively supporting people to eat and drink enough. Discussions with staff showed they understood how to prepare and support people who needed prescribed food supplements to improve their nutritional intake. We saw there was an effective response to people who required regular small snacks to support their limited food intake.

People we spoke with confirmed they had access to health care professionals when they needed them. One person said, "They don't hesitate when you're ill". We saw staff took appropriate steps to refer people to the district nurse, dentist, optician and chiropodist. We saw staff ensured

Good

Is the service effective?

they followed the recommendations of health professionals to maintain people's health. For example in relation to providing appropriate pressure care relief as part of people's care plan. This showed people's health needs were effectively promoted. People's health issues had been identified and appropriate risk assessments had been reviewed and the care plan updated. For example we saw in the records that a person's anxiety had been reviewed by health professionals and a management plan was in place to help the person's distress. Medication records showed a minimal use of optional medication had been used. Staff understood and used the agreed strategies to calm the person so that there was an effective response to their needs. Records showed that the manager had ensured people's medication was regularly reviewed by the GP where this was causing an impact on their safety or well-being.

Relatives told us they were updated on health issues and involved in discussions. One relative said regarding a health issue, "A clear plan has been put in place". The person using the service said, "The nurse comes out to see me so I get the care I need". The arrangements in place helped staff to reduce a similar health risk for the person.

We looked at how the adaption, design and decoration of the premises met people's needs. The layout of the premises meant people had access to a spacious rear lounge and a smaller front lounge. It was clean and comfortable and people told us it was homely. People confirmed they had room for their own possessions and that their bedrooms were comfortable. Outside areas were accessible via ramps and steps. However the provider had not fully considered the needs of people with dementia in relation to providing clear signage to help people locate toilets or bedrooms. The décor was similar in all areas which meant the décor did not support people to recognise distinct areas of the home. This may improve people's day to day lives.

The provider and manager were able to describe the improvements they were making which included a communal garden for people to sit and enjoy. Plans had been agreed for a community project to undertake this.

Good

Is the service caring?

Our findings

People we spoke with were positive about the caring approach of the staff. One person said, “That’s [staff] she’s so kind, well they all are”. Another person told us, “They [staff] know me well and know when I’m not myself, always checking I’m ok”. A relative said that they were, “”More than happy with the service that was being provided”. Another relative told us, “I would definitely recommend the home to others because the staff do care about people”.

Observations showed that people’s care was delivered in a caring manner. For example staff spoke with people politely and quietly when offering personal care and explained what they wanted to do before they did it. The atmosphere was very calm and relaxed and we saw staff take the time to ask people, “Are you alright?” or “How are you today”. We saw staff sitting with people, holding their hand or stroking their arm in a reassuring way and people responded to this and were relaxed in the company of staff. Relatives told us staff were kind and respectful in the manner that they spoke to people. One relative said, “Staff are caring and patient and cope very well”. We asked staff how they made sure people were cared for in a way they preferred and one said, “I ask them. You care for them as you would your parents”.

Some people had dementia related conditions and were unable to express their needs. We saw for one person their care plan identified their ‘comfort needs’ and how the person may express this. This had been agreed with the person’s family as well as health professionals as part of the person’s care. This supported staff to understand how the person communicated their distress. We saw staff understood how to make the person comfortable. We saw staff consistently provided a caring, supportive and sensitive response to this person’s needs.

We heard staff chatting with people in a friendly manner and these discussions demonstrated staff had a good knowledge of people’s lifestyles and interests. We heard a person struggled to remember events when talking to staff about their hobbies and past work life. The staff member encouraged the person by reminding them of these events; this resulted in the person smiling and saying, “Oh yes I remember now”. This showed staff took the time to listen and talk with people and make them feel they mattered. We saw examples of staff going beyond their role to ensure people felt cared for which clearly demonstrated people had positive relationships with staff. One such person told us, “They are wonderful, so kind”.

Staff supported people to express their views by involving them in making decisions about their care. People told us they had discussed the care and support they wanted. One person said, “I told them [staff] I prefer to not mix and they know I need help with some things but not others”. We saw people’s care records had taken into account people’s personal preferences; a detailed life history and information about their needs and how they communicated. This approach was similar for people who had memory loss or dementia which meant staff had information about how to support people in expressing their views. The manager had displayed advocacy leaflets in the home. However this had not been promoted because people we spoke with were not aware of how they could use this service. We saw people were given choices for example, “Would you like to eat here or come to the table?” which showed staff paid attention to people’s preferences.

We saw staff promoted people’s privacy by ensuring bathroom and toilet doors were closed and protective clothing was offered to people at mealtimes to promote people’s dignity. Some people told us they independently used equipment such as walking frames and that their wish to be independent with some aspects of their personal care was respected.

Good

Is the service responsive?

Our findings

People told us that staff supported them in the ways they wanted and staff knew where they could do things for themselves. For example one person told us, "I like to get washed and dressed by myself and staff help me with areas I can't reach". Relatives we spoke with were positive about how staff responded to people's needs. One told us they were, "Very happy with the level of care my relative is receiving".

All the staff we spoke with were able to tell us how they responded to people's needs. For example staff told us how they responded if a person displayed anxiety, if a person needed support to eat and drink enough and how to manage people's fragile skin. We saw staff had the information they needed to respond to people's health needs by for example ensuring people had regular bed rest to protect their fragile skin.

We spoke with people who told us staff were responsive to their preferences. One person said, "I can have a shower when I want one the staff always ask me, I choose when I go to bed and get up". Another person told us, "There is staff during the night they always come if I press the buzzer". A person told us staff understood their needs for example by choosing to stay in their bedroom, "I don't like mixing and the noise, but the staff come regularly to check me or chat". During the day we saw staff responded to people when they wished to use the toilet without delay. We saw staff supported people to move from one area to another for example at lunch time and that they anticipated people's needs such as one to one time to eat their meal. This meant that people received support and care that was personalised and reflected in their care plans.

We saw some people were involved in various activities within the community. Individual preferences and needs had been addressed by supporting people to attend adult literacy classes and a healthy eating class. People's personal preferences had been considered and acted on to ensure they had support to continue to follow their own lifestyle choices. A person had been supported to attend a community day centre to maintain links with people from their cultural background. Religious and spiritual beliefs had been explored with people who had access to visiting spiritual leaders.

We saw there were a variety of activity resources available, such as arts and crafts. People told us they enjoyed movies, music dominos and quizzes. We saw some people reading books and one person said, "We have a library of books here to use", and another person said, "I love to read the newspaper and staff buy it for me". For some people who had dementia there was an observed lack of stimulus. Improvements were needed so that all people's needs were responded to and that they were not disadvantaged because of their mental health needs. Staff told us and we saw from the training records that the majority of staff had no recent dementia awareness training. The manager showed us that training in dementia awareness had been booked to develop staff skills and ensure people who had dementia had a personalised plan to address their needs. Actions to improve the quality of people's social needs had not been fully explored so that staff were focussed on the needs of all of the people who lived there.

People were confident their complaints would be addressed, one person said, "I would complain if I wasn't happy but I don't need for anything". Relatives felt confident they could raise concerns and get responses. We heard from a relative a complaint had been listened to and acted upon and that processes had been put in place to prevent it from happening again. People we spoke with were not aware of the complaints procedure which was displayed on a notice board. It was not in a format suited to people with poor vision and or dementia. The arrangements for recording complaints were not consistent as there was no record to show how a person's concerns had been followed up or responded to. The manager explained how and why decisions had been made in relation to complaints but the lack of records meant it was not clear whether people were satisfied with responses to their complaints.

We saw an advocate had been sought regarding a change to a person's 'do not resuscitate' agreement (DNAR). These agreements provide staff with a person's wishes regarding resuscitation. They are authorised by medical practitioners, and consented to by the person, and or their representative. This meant people could be confident that the manager followed correct procedures where people might need support with a 'DNAR' and that this would be authorised by the appropriate people.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place who had worked at the service for a number of years. We saw the manager worked closely with the provider and both played an active part in the running of the home. People who lived at the home and relatives told us both the provider and the manager were in the home daily and that they individually spoke to each person to see how they were. One person who lived at the home told us, "Everyone's on first name terms here", another person told us, "The manager is very good, I've told her today I felt a little off colour and if I was at home I'd drink a hot whiskey, so she's bringing me some whiskey in later today, they are marvellous". A relative said, "I can't fault the place, if I have any worries at all I raise them and the manager is very approachable and friendly".

People had the opportunity to share their views on the quality of the service via meetings. One person said, "Yes we have regular meetings and every day they ask us how we are, if there's anything we want". Regular communication with people in the home enabled them to express their views. People had been consulted with about changes and developments of the service. One person said, "We are having the back garden landscaped". People told us they had meetings to discuss the home and their views on the service. Relatives told us they were able to openly share their views with the manager and staff. One told us, "I'm sure if improvements were needed we could say so and they would try".

We saw surveys had been sent to people and their families. One relative told us, "I did complete a survey recently but I haven't heard anything since". A sample of completed surveys showed people's feedback was sought on the care they received. The manager told us they were looking at how to feedback results to people. There were a number of 'Thank You' cards displayed on the wall in the hallway. These expressed thanks and gratitude from family members and ex-residents who had stayed at the home. Feedback from these cards was very positive in terms of the care people had received.

Discussion with the manager, staff and records we saw, confirmed systems were in place to ensure communication and a clear understanding of expectations. For example we saw that there were handovers at shift changes, staff meetings and regular meetings for people. All the staff we spoke with told us they were very happy working at the home.

We saw staff had access to policies relating to whistle blowing and safeguarding and that they understood their role in keeping people safe. Staff told us they felt confident they could speak with the manager about any concerns. Staff told us that the manager was supportive and listened to any concerns they raised and that they received regular training.

Systems were in place to monitor and check the quality of the service. We saw there was a regular review of care practices such as managing pressure care needs, medication, health and safety and infection control. Action plans were evident to show improvements had been made to ensure people had a better service. However the monitoring of falls needed some improvement. For example the manager was monitoring accident numbers but there was no analysis of trends or actions identified to minimise falls. The review of falls did not include the person's records. For example one person's records showed they had been unsettled at night when the falls had occurred. The person told us they had been experiencing pain which led them to try and get out of bed. Their relatives told us they did not have a history of falling and could not understand why the person had had several falls. The management of the person's pain could help to reduce the risk of falls. We saw that the frequency of falls in the home had increased over the last three months which showed the monitoring had not been used as a means of reducing the risk of people falling.

Audits were in place but did not fully capture shortfalls or identify action needed to improve the service. For example the errors in the stock of medication and in identifying the partially blocked fire exit door in the lounge. This indicates monitoring of the service required more focus to avoid potential risks to people's safety.

The provider has a good history of informing us of notifiable events. The manager told us that an incident that had not been notified to us did not occur in their service. The duty of care to report potential neglect even if it happened in another service should take priority to protect the person concerned.

Requires Improvement

Is the service well-led?

There had been one accident where the provider had not met the requirements for reporting to the safeguarding team. Although action had been taken to prevent a similar accident, external agencies must be involved in order to assess any impact on the safety of people.

The manager and staff had promoted a positive atmosphere in the home because people told us they were happy and their relations with staff were good. However improvements were needed in considering the needs of people with dementia. This included clearer signage to help people locate areas, and décor to recognise distinct areas of the home. More focus on the social needs of people living with dementia was needed to ensure they had opportunities and stimulation.

We saw there were links with the local community and that these had been used to improve the service. For example plans for the garden to be landscaped were underway via a community garden project. The manager told us they wished to have more regular meetings and look at ways of getting more feedback from people. This showed that the provider and the manager were looking to continually improve the service for the benefit of people living there.