Somerset Care Limited

Critchill Court

Inspection report

Lynwood Close
Frome
Somerset
BA11 4DP

Tel: 01373461686
Website: www.somersetcare.co.uk

Date of inspection visit:
30 May 2017
31 May 2017

Date of publication:
20 July 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 and 30 May 2017.

Critchill Court provides care and accommodation for up to 50 people. At the time of our inspection there were 37 people using the service. There is a separate part of the home known as Cedar Oak which provides care to people living with dementia. The "main house" provides care and support to older people some of whom are living with dementia. The home does not provide nursing care and people who require nursing assistance are supported by the local district nursing team.

The registered manager had been absent from work since 02/05/2017 and prior to this had been absent due to routine annual leave and other leave. Immediately following the inspection we were informed they had resigned. Since the inspection an interim manager has been put in place. We were told the provider is advertising for a permanent manager who will, if suitable, make an application to be the registered manager for 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.

The recruitment arrangements whilst generally safe and meeting required standards in relation to checks did not ensure full employment history was obtained so the provider could be assured there were no gaps in employment history. Such gaps if identified may have questioned the suitability of the perspective employee to work with vulnerable adults.

The manager had, as required, made applications under the Mental Capacity Act 2005 and obtained authorisations under Deprivation of Liberty Safeguards (DoLS) arrangements. However, we identified two people where such applications needed to have made and had not been.

Social activities were an area which needed to improve reflected in comments made by people. There had been a change with new appointments of activities coordinators as previous coordinators had left. This had impacted on the quality of activities provided with lack of a organisation and reduction in the availability of activities particularly one to one activities.

One person was being administered their medicines covertly i.e. disguised in food or drink. This was an appropriate decision and referred to as "best interests decision". However, there was no consultation with the pharmacist to ensure the method used to administer the medicine was safe and retained the effectiveness of the medicine.

Improvements had been made in the arrangements for the administration of "as required" medicines. This had been an area for improvement identified at our last inspection. There was a robust system for the management of medicines which ensured people received their medicines at the time it was required.

All of the people we spoke with said they felt safe living at Critchill Court. One person told us "It is lovely here staff are very kind and look after us." This was also reiterated by relatives we spoke with who also commented on how caring and welcoming staff were.

People spoke of staff being caring and kind. We observed staff supporting people in a sensitive and caring manner. They were confident in responding to people who were distressed or confused and needed re-assurance. They did so in a respectful professional way engaging with people in a positive manner.

People and relatives told us staffing arrangements were good and staff were available at a time they were needed. Staff responded promptly to requests for help and support.

People had access to community health services and their GPs when this was requested. Healthcare professionals we spoke with were positive about the care provided by the service. There were good relationships with outside professionals and people had access to specialist support and advice.

Mealtimes were calm and relaxing occasions with people being offered meal choices and supported to have their meal. On Cedar Oak staff sat having their meal with people which helped ensure people ate their meal and added to the social nature of the mealtime.

There was a welcoming environment where people were able to maintain their relationships with family and friends. People and relatives told us there were no restrictions on visiting.

People felt able to voice their views or concerns about the service. There were regular meetings where people living in the home could give feedback about the quality of care provided in the home.

Staff spoke of an open culture with some areas for improvements specifically around communication and staff performance. The management of the service recognised these concerns from staff and were open to and had taken action particularly around staff performance.

Improvements in the quality of care had been identified through a quality assurance system and action was being taken to address these areas for improvement.

We have made a recommendation about the employment history of perspective employees.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was not consistently safe.

People's medicines were managed, administered and stored safely. However, the arrangement for the administering of convert medicines needed to be improved.

People were supported by staff who had received pre-employment checks to ensure they were suitable for the role. However, improvement was needed to ensure any gaps in employments were identified.

Risks to people were identified and assessments were in place to reduce risks.

People benefited from consistent staffing arrangements.

People were supported by staff who knew how to recognise and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective

People could not be assured their legal rights were always upheld when their liberty needed to be restricted.

People's consent was sought for the use of restrictive equipment and where unable to give informed consent there was were arrangements in place to protect their rights.

People benefitted from being able to access support and advice from community health and specialist mental health services.

Is the service caring?

Good

The service was caring

People benefitted from staff who were respectful and caring.

Staff understood the potential for distressed behaviour because of how dementia could affect people and how to support people in sensitive, patient and quiet manner.

There was a warm and inviting environment where people benefited from friendships and relationships with those who were important to them.

Is the service responsive?

Requires Improvement

The service was responsive

People benefitted from planning of their care which was personalised to their needs.

People would benefit from improved arrangements for activities suited to their needs and interests.

People and their relatives felt able to raise concerns with the registered manager and staff.

Is the service well-led?

Good

The service was not always well led.

The service had quality assurance systems to measure the quality of care and identify improvements. However, they had failed to identify the shortfalls in DoLS application and administering of medicines covertly arrangements.

People and staff benefitted from an approachable and open culture in the home.

People benefitted from a culture which promoted respect and person centred care.

People could be assured of continuous improvement in the quality of care.

Critchill Court

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 25 May and 30 May 2017 and was unannounced. This meant the provider did not know we were going to carry out an inspection on the day. The inspection was carried out by one adult social care inspector and one Expert-by-Experience (ExE). An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. During this inspection, we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We undertook general observations in communal areas and during mealtimes.

During the inspection, we spoke with seven people who lived at Critchill Court, nine relatives, six staff and two health professionals visiting the home. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for five staff, people's medicines records, staffing rosters, staff meeting minutes and quality assurance audits.

Good

Is the service safe?

Our findings

Staff confirmed that as part of their recruitment criminal record checks and references were obtained including references from previous employers. Records confirmed these arrangements. The required checks were undertaken to ensure employees were fit to work with vulnerable adults. However, the application form stated when asking for employment history "Covering period of ten years if applicable." This meant potential employees might not disclose gaps in employment which could impact on their suitability to work with vulnerable adults.

We were subsequently advised by the provider that staff file audits were underway to check all current employees at Critchill Court had full employment history on file and any gaps identified were followed up. Action had been taken to address this issue and re-enforce the need to obtain full employment history from perspective employees.

We recommend the provider refer to Schedule 3 of the Health and Social Care Act 2008 for information as to their responsibilities when recruiting staff in relation to full employment history.

A decision had been made for one person to have their medicines administered covertly. This is where medicine is disguised in food or drink without the person's knowledge. Whilst appropriate and decision made with GP agreement there was no record of consultation with the pharmacist as to how this person's medicines were to be given safely and effectively. The covert administration assessment, linked to the homes medicines policy, did not evidence this consultation. Staff told us how the medicine was administered and this was as recorded in the person's care plan. This meant there was a potential risk the medicine would not be administered correctly ensuring it remained effective.

We observed people being given their medicines. One person was very reluctant to accept their medicines. Despite some encouragement the person continued to decline. The staff member was able to tell us what they would do if this persisted namely the person's medicines would be reviewed by the person's doctor. If after this review there remained some medicines which were required a best interests decision would be made to give covertly.

Improvements had been made where people needed "as required" medicines. This had been identified as an area for improvement at the last inspection. The home has an electronic computerised system for the administering and management of medicines. People's medicines were kept in their rooms in locked cupboards. Some medicines such as insulin and those requiring additional security were stored in the medicines room as well as medicines stock. The system tells you if people required medicines and retains information which can be assessed for monitoring purposes. This information provided evidence people who required time sensitive medicines had received their medicine at the required time. It also identified if people were receiving pain relief within the necessary time period generally every four hours.

Stock records were accurate, including those medicines which required additional security. There was secure storage for medicines with daily checks of fridge and clinic temperatures to ensure they were stored

safely.

People told us they felt safe living in the home. Comments from people included: "Yes I feel safe here: ", "You don't get much trouble here.", and "Never had no trouble. ", "Oh yes I feel safe here. " A relative told us "Safety was the reason why (Name) came here. It was important they were safe after their accident. The home was recommended to us." Another relative said, " We feel it is very safe here. That is the most important thing."

Staff were able to tell us how they would respond if they had any concerns about possible abuse. One told us "I would immediately go the manager and they would report it I am sure." Another staff member said, "I would not work here if I thought there was abuse and people were not safe." They were aware they could report any concerns to an outside organisation such as social services or the police. This meant people could be assured staff understood their responsibility to report any concerns about possible abuse and safeguard the health and welfare of people living in the home.

We had been advised through our notifications system of concerns about two people living in the service. We were satisfied all necessary steps including referrals to the safeguarding local authority team had been taken to protect the health and welfare of the people concerned.

Risk assessments had been put in place in response to people's care needs related to falls, nutrition and moving and transferring people. These outlined specific needs of people in relation to the risks such as use of specific equipment when moving or assisting with transfers. In some there was guidance about how people were to be supported or have their meals.

There were specific behaviour charts in place. These were used to monitor people's behaviour such as agitation or distress and establish any action which could be taken to reduce this behaviour. For one person this was about their response to staff when attempting to provide person care. Staff were very clear how to reduce this behaviour and how best to respond and this was outlined in the person's care plan.

There were personal emergency evacuation plans (PEEP) in place. These identified people's needs so that staff and emergency services could respond as necessary in the event of an emergency.

People told us they felt there were always enough staff on duty to respond to their requests for support. One person said, "Nothing wrong with them. There are enough of them." Another person said, "They would help but I'm an independent person." A health professional told us how whenever they visited they always felt "There were enough staff around to help people."

We observed staff being responsive in a timely way to people who needed assistance. Staff spent time making sure people were settled. Call bells were responded to promptly. Staffing rotas showed consistent staffing throughout the service. Care hours were within benchmarked standards based on care hours per person. Staff told us they felt staffing of the home was good. One staff member told us "There are always enough staff and they will change it if we need extra for any reason for example if someone needs a staff member with them all the time." Another staff member said, "Staffing is good and we generally work in the same part of the home so people get to know us and we them." This meant people received care from staff who were known to them, helping to provide consistent care. This is of real benefit for people who are living with dementia.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest's and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

One person was being accommodated in the home under extended respite arrangements. There was discussion with the local authority about their remaining in the home permanently. We raised with the deputy manager how they needed to urgently make a DoLS application. There was no mental capacity assessment in place and their capacity to consent to their care arrangements was unclear. In these circumstances a DoLS assessment would establish if the person lacked capacity and the service could legally keep the person in the home under DoLS arrangements. Another person has been assessed as lacking capacity and a best interests decision had indicated "residential home is only realistic option". However there was no record of DoLS application being made in their care plan and their name was not included in information provided to us as to those people who had been subject to applications. This information was provided to the deputy manager who said applications would be made. This meant there was a lack of rigorous practice to ensure people's rights were upheld.

During this inspection the deputy manager told us they had made 25 applications under the MCA for DoLS. These applications related to people who were living in the home and needed protection and safeguards because of potential risks to their health and welfare if they left the home independently. To date 16 authorisations had been made with no conditions and one had been rejected as it was deemed the person had capacity. This demonstrated the manager had taken action to protect the welfare and uphold the legal rights of some people in the home.

For one person a door sensor had been put in place so staff could monitor their movements and ensure their safety. Where people lacked capacity to give consent for the use of such equipment best interests decisions had been made. This meant action had been taken in compliance with the MCA to safeguard people's health and welfare and uphold their rights with regard to equipment which could be viewed as restrictive.

Records confirmed people had access to community health services. People told us they could ask to see their GP when they wanted. GPs reviewed people's health where there were concerns about health deterioration or where people's health and wellbeing was variable. There were regular visits from community nurses and psychiatric support. A health professional told us they felt there was good liaison with themselves and the home. They told us "They are very good at involving us where we can help them

support people." They said how they were confident staff would seek advice and support to care for people effectively. Another health profession spoke positively of how staff responded to their advice particularly around skin care. This meant people had access to range of health care support and advice so staff could provide effective care.

We observed the mealtime as part of our inspection. The meal looked appetising and well presented. People told us they had enjoyed the food and there were positive comments made to us about the quality and choice of meals. People told us how much they enjoyed their meals. Comments from people included: "The food is very good." and "There is always more than enough to eat." and "If I did not like it I would ask for something else." People were offered a visual choice of meals to ensure they understood what the choices were. A relative told us "(Relative) gets a bigger meal now because they always eat well. The food is good." Another relative said about their relative, "She is maintaining her weight. She is eating better than ever." On two occasions during the day people were offered ice lollies or ice creams. One person said, "We always get these if it is hot like today." Staff supported people having their meal and this was undertaken in a timely manner and supportive way.

People told us they did not know what was for dinner and a menu board was not completed until shortly before the meal was served. There were no table menus or visual information to tell people what the meals of the day were. There were no condiments on the tables and these were not offered by staff and people had to ask for sauces and condiments. This meant people were not encouraged to maintain their independence or provide opportunities to inform people of meal choices before the mealtime.

Care plans included information about people's nutritional needs and assessment identified any concerns about those needs. There were regular reviews of these elements of the care plan to ensure needs were continuing to be met. People had been referred to specialists for assessment to ensure staff could meet their needs. This included the providing of food supplements, high calorie snacks and ensuring people were able to have their meals safely through having a pureed diet.

One person who required a pureed diet had not been eating well and was not always able to concentrate on eating their meal distracted by other people's meals which were not pureed. The provider arranged for meals to be supplied by a catering company which were presented in "real" food shaped moulds. This made the meal look the same as other people's meals. and had resulted in an improved mealtime experience for the person and others who were not now distracted by the person. There had also been some improvement in the person's appetite weight and general well being.
This demonstrated the service had systems and arrangements in place to meet people's nutritional needs effectively.

Staff told us they received regular one to one supervision and records confirmed this. This is where the staff member's performance, any concerns, individual training and development needs can be discussed. Staff also spoke of being able to raise any concerns or worries informally. There was also a system where staff undertook "Confirmation of Knowledge and Understanding" conversations. These looked at the staff member's views on what was working well in the service and what could be done better. This was an opportunity for staff to comment on the care being provided and how they felt the quality of care could be improved.

Staff received structured induction when first employed at the home and records confirmed this. They told us they had undertaken shadow shifts (only working with another staff member) for two weeks. One staff member told us "I learnt a lot in the shadowing period it helped me a lot." Another staff member told us the two weeks was enough and "We could have asked for more if I wanted it." The induction followed the Care

Certificate (a nationally recognised qualification) undertaken by care staff. This meant staff had the opportunity to undertake an effective induction related to the company's policies and procedures and staff roles and responsibilities.

The provider had reintroduced the "PETALS" dementia champion role. This is a nominated staff member within each home who acts as a lead within the service to promote best practice in care for living well with dementia.

The provider was in the process of re-designing the Main House to enable to offer smaller units. People living in this part of the home were being consulted as to what name should be given to the "suites" being established in this part of the home. This had entailed some decoration and creating smaller dining and lounge areas. This work had not been completed and discussion was ongoing about how people who were living in the home would be accommodated in the new areas of the home to be known as "suites". It was intended that people would be accommodated in an area of the home dependant on their needs. Staff registered some concerns with us about people being able to maintain friendships and still offer people, who wanted to, the ability to move freely around the home. Staff voiced concerns that there had not been sufficient discussion with them about the process of this change and how it would impact on people and staff. We were told by the management that discussion had been taking place but they recognised this needed to be intensified in light of the progress towards this change. Meetings were planned at which these staff concerns were to be discussed.

Good

Is the service caring?

Our findings

People told us "Staff are all very caring and kind." and "I love it here the staff are lovely." One person when asked if staff were caring said, "Definitively 100%." Relatives told us "The staff are always caring and kind. They treat my relative as I would want with respect always." We observed staff interacting with people in a caring and kind way. They had a warm and gentle approach using banter and humour as part of relaxing and interacting with people.

Staff responded in a caring and supportive way when people were confused or upset. In one instance a staff member sat with a person for some time to ensure they had settled and were relaxed. On another occasion a staff member was able to distract a person who was unsure what they wanted to do and where they wanted to go and was becoming upset. They spoke to the person in a sensitive way saying "Do not worry (Name) we can find somewhere for you to sit and I will get you a cup of tea." We heard people expressing their gratitude to staff, "Thank you I was not sure what to do." and "Thank you dear that's lovely."

Staff displayed patience and understanding of how people living with dementia can react to situations and their environment. One staff member spoke of one person who required a specific approach and "Sometimes we have to keep trying but that's because of their dementia." Another said, "For (Name) we have to understand how they can become aggressive and angry but they do not mean to."

There was a positive approach from staff where two people had established a relationship. Staff understood how this was positive relationship, "It has really helped (Name) they are much calmer it is a good thing." However, staff were sensitive to the potential for the relationship to have some negative effects and were aware of how they needed to monitor how it affected the people concerned.

People's privacy and choices were respected. Staff understood how some people chose to remain in their rooms and respected this choice. One person told us "I prefer to be in my room and that is fine. They let me know if there is anything on so I am not left out." A relative told us how the staff respected their relative who generally stayed in their room, "They prefer their own company and staff respect that which is good."

People and their relatives told us visitors could visit at any time, there were no restrictions and they were made to feel welcome. Relatives told us, "Staff are friendly and approachable." and "We are always made to feel welcomed." During our inspection we observed visitors coming to the home throughout the day, there was a visitors signing in book in the reception so the staff knew who was in the building in case of an emergency.

Requires Improvement

Is the service responsive?

Our findings

People told us "There is not enough to do here. Not enough for my brain to do" Other residents said they didn't know what they wanted to do but something would be nice. Some people said they weren't interested and just wanted to be left alone. A relative said how their relative was not someone who liked to join in abut was always given the opportunity to take part in activities.

There had been changes in the activities because two activities co-ordinators had left and only one had recently been appointed. They had been in post for two months. The deputy manager told us they were hoping to recruit another shortly. Staff told us activities needed to be improved.

The activities co-ordinator told us they were still learning and had not had any training about providing activities with people who were living with dementia. As part of their induction all staff completed a two day "Dementia in a Nut Shell" training. This staff member was waiting to go on this training. It was also planned for support to be made available from another activities co-ordinator who was working with people living with dementia.

The activities co-ordinator told us they had no structured programme but had organised activities such as painting, drawing and bingo. On the day of our visit a number of people were taking part in a ball activity. They told us how they were providing one to one activities such as reading and talking with people's about their lives and hoped to increase these types of activities. This approach is recognised as being more suited for some people living with dementia.

The provider had piloted "Our Yesterday" which provides regular newsletters, interactive resources and activities that all staff can us to provoke discussion and reminiscence about topical events and things that happened on this day at different periods in time. Due to the success of the pilot this has now been rolled out across all homes, and although this hadn't started at Critchill Court at the time of the inspection it was to be put in place in the near future.

Meetings had been regularly held with people which provided an opportunity to talk about the care provided. The main topic of discussion was that of activities with people making suggestions for activities such as gardening, seeing more children in the home and film nights. These were all areas being explored with approaches being made to local schools about students coming into the home. However, some visits from local children's nursery and school had taken place and these were, it was hoped, to be continued. People who wished to move to the home had their needs assessed to ensure the home was able to meet them. People's personal preferences and choices were also discussed either with the person or through the involvement of people who knew them best such as family members. Care plans included information specific to the person about their needs and life history. This assessment was then used to create a plan of care once the person had moved into the home. Where the person was living with dementia this was reflected in their care plans for example how it affected the person's speech, orientation and behaviour.

There were systems in place to review care plans. Reviews had led to updated care plans reflecting changes

in people's care needs. For example where a person mobility had changed and required more assistance with personal care. People where able and/or their representatives could be part of an annual review of care needs.

One person told us "I can always to talk with staff if I am unhappy about something." Another person said, "I do not need to make a complaint because staff are so good if I do not like something they will listen and do something about it." A relative said, "They always keep us informed and if I unhappy about anything I just go to the office." Another relative said, "I know I could complain if I needed to but I just talk to the manager or staff and they deal with it." There had been no complaints since our last inspection.

Staff were able to provide examples of how they responded to and provided care to people which was personal to the person. They said how one person's behaviour would change if they had a urine infection and this prompted them to look at a need for antibiotics or increasing fluids. For another person it was how they responded to male and female staff and how this was taken into account when providing personal care.

A health care professional told us how staff had prompted them to take action when they (staff) had observed a change in a person's behaviour and as a consequence it was found the person required medicines for a previously unknown medical condition. A health care professional told us "Staff are very sensitive to people's needs, they know people well. They have a good understanding of dementia from a person centred perspective."

Good

Is the service well-led?

Our findings

Audits were undertaken by the home's management team including care and support plans, medicines and environment. These had identified actions and we noted some had been completed whilst others were continuing to be addressed. However, the "Residential Care and Support Plan Audit" dated 29/03/2017 had not identified the shortfalls in undertaking of DoLS applications or lack of pharmacist consultation when the decision about use of covert administration.

People told us they found the manager and deputy manager approachable and "Someone we can talk to". One person told us how they often saw the deputy manager and "He is nice, easy to talk to." Relatives described the management of the home as good and one told us "I always go to the office if I have something I need to find out. They are always approachable and easy to talk to." Another relative said, "They always keep me informed and I often go and ask how (Name) is."

The home has a "You Said We Did" scheme where people make suggestions about what they would like to see and ideas about improving the service. One suggestion had been a "Steak Night" which had taken place and proved popular.

Staff spoke of the management of the home as being open. One staff member said, "There is an open door policy which is good and we have meetings where we can ask about anything." Two staff members spoke of the need for improvements in resolving an issue related to some staff who they felt were not working as a team. In discussion with the management of the home they recognised this was a concern and told us they were working to address staff poor performance. Other staff felt there was generally good team working. They spoke of how the lack of a manager who had been off work, despite the efforts of a deputy, had had an impact on the running of the home particularly in terms of communication about the changes which were taking place.

Staff told us there were regular staff meeting which they felt were good. One staff member said, "The meetings give us an opportunity to talk about issues we have."

Staff spoke positively on how they viewed the culture of the home and wanting to provided quality care which was about the individual and how "Residents come first." One staff member spoke of how they felt the service was about: "Positive risk taking which improved people's well being and encouraged independence."

There was a management structure in the home which provided clear lines of responsibility and accountability. Currently there was an interim manager, the registered manager having resigned. They were supported by a deputy manager and a team of senior care workers and care staff.

A "Quality Health Check" had been undertaken by the providers' quality assurance team. The last check was dated January 2017 and had identified a number of actions. An action plan was in place and areas for improvement were ongoing.

There were systems in place to review accidents and incidents and identify any improvements such as referral to outside agencies for support and advice and any changes to the environment. The home operated a behaviour management system which was used to record behaviour incidents of concern. These were used to make a judgement about how staff could improve their responses to people's behaviour.

We had been informed about incidents that affected the health, safety and welfare of people in the home. These are known as "Notifications" and inform us of any matters which help us make a judgement about the care being provided and where we may investigate further if we had concerns about the welfare of people.