Lancam Care Services Limited

Albany Park Nursing Home

Inspection report

43 St Stephens Road
Enfield
Middlesex
EN3 5UJ

Tel: 02088041144

Date of inspection visit:
20 May 2021

Date of publication:
28 July 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Albany Park Nursing Home is a residential care home providing personal and nursing care to people aged 65 and over, some of whom were living with dementia.

Albany Park Nursing Home accommodates up to 43 people in one adapted building. At the time of the inspection there were 32 people living at the home.

People's experience of using this service and what we found
Throughout the inspection we observed people receive care and support that met their basic care needs. Relatives spoke positively in general about the care and support that their family member received. However, we found significant concerns around how the home was managed, low staffing levels, poor activity provision and aspects of health and safety which placed people at increased risk of harm.

Staffing levels found within the home did not match the levels which should be in place according to the provider's own staffing dependency level assessment. Staff and relatives also stated that there were not enough staff available to ensure people's needs were appropriately met.

People did not have access to activities which would provide stimulation and support their well-being. People did not always receive person centred care and support as per their needs and wishes.

Health, safety and the environment were not always well managed. We found a number of issues which placed people at risk of harm. Some care staff were seen not wearing face masks. Hand sanitising gel and cleaning materials had been left in areas which were easily accessible for people to take and possibly consume. The environment was in a poor state of repair.

There was a lack of managerial oversight of the home. Audits of care delivery were ineffective and did not identify the issues we found as part of this inspection. Written care records were not always a true record of the care people received.

We have made a recommendation about the appropriate use of PPE and the safe storage of chemicals.

Communication between the home and relatives was not effective with relatives telling us that they were not kept updated about their family members health and welfare. Visiting guidance and procedures had not been clearly communicated to relatives.

Risk assessments were comprehensive and detailed. Staff were provided with clear guidance and direction on how to minimise risk to keep people safe from the risk of harm.

People received their medicines safely and as prescribed. Systems and processes in place supported this.

Staff recruitment checks provided assurance that staff employed had been appropriately assessed as safe to work with vulnerable adults. However, we did find that the service did not always review criminal record checks in line with best practice.

Staff understood safeguarding and how to keep people safe from abuse. Staff told us that they received training to support them in their role.

Relatives knew who to speak with if they had any concerns or complaints to raise.

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

Rating at last inspection
The last rating for this service was good (published 18 April 2019).

Why we inspected
We received concerns in relation to poor communication and the registered manager not being available at the home especially during the pandemic. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Albany Park Nursing Home on our website at www.cqc.org.uk

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, responsive and well-led sections of this full report. We have identified three breaches of regulation around person centred care, staffing and good governance. We have also made a recommendation around the use of PPE and the safe storage of chemicals. The failings found are detailed in the main body of the report.

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

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Albany Park Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by two inspectors and a specialist advisor nurse. The inspection was also supported by an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience contacted people's relatives and friends by telephone to request their feedback.

Service and service type
Albany Park Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require

providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service. We spoke with the nominated individual, the registered manager and the deputy manager. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included eight people's care records and 32 people's medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including quality assurance, training records and health and safety were also reviewed.

After the inspection
We spoke with nine relatives of people living at the home. We also spoke with a further 11 care staff. We further reviewed four care plans and associated records. We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- We were not assured that enough staff were available to meet people's needs safely.
- A dependency needs assessment was completed for each person living at the home which calculated the number of hours of support people required on a daily and weekly basis. However, the calculations that we were shown did not match the number of staff available.
- The dependency needs assessment calculated that the home required six care staff and one nurse to be on duty for a 12-hour period. However, on the three-week rota provided we could only evidence four or five care staff with one nurse scheduled.
- At night between 10:00pm to 08:00am the home was to be staffed at three care staff and one nurse nightly.

- On the day of the inspection we observed only four care staff and one nurse on duty. This did not match the dependency tool assessment.
- Staff that we spoke with also confirmed that there were only ever four care staff and one nurse on duty, which was not enough to be able to deliver person centred safe care. Night staff spoken with also stated that three care staff and one nurse was not enough.
- Feedback from staff included, "We used to have five staff before COVID, now we have four staff and sometimes if we are short staff then we have three staff", "We don't have time for the residents" and "Generally people are not safe. When we are few staff and you have to do everything in a rush. I mean everybody is changed and fed but everything is a rush, so it impacts on the resident, the quality of care that is being given to them."
- Relatives feedback also suggested that there was a shortage of staff. Whilst relatives commented that they had been unable to visit the home due to the COVID-19 pandemic, prior to the pandemic they had noted concerns with staff availability and that during the pandemic, the care home did not always answer the phone when they tried to call.
- Relatives comments included, "I am not sure that they have enough staff because sometimes when you phone there is no answer. Also, when I used to visit, I would sometimes tell them that he needed changing and they said they would do it but sometimes we had to wait a long time", "They are short staffed all the time. When I visited before the pandemic, I never saw anybody. The man in the room opposite was not checked up on during the three hours I was there visiting" and "They are short staffed, when I visit there is not enough staff around."
- During the inspection we observed times where there were not always enough staff available to support people with their needs. At 10:42am we observed 13 people sitting in the communal lounge/dining area with only one care staff available to support. However, most people in the communal lounge would require the

support of two care staff.
● At 10:50am one person told the inspector that they wanted to go to the toilet. We informed the staff who was present in the lounge who was unable to support the person alone and required the support of another member of staff. However, there appeared to be no other care staff available. The inspector then informed the registered manager of this situation who asked another member of staff to assist. It took staff over 10 minutes before they were able to support the person.
● We discussed our concerns with the registered manager and the nominated individual, who stated that there may have been occasions that staffing levels may have been less than the assessed needs, however, they did try to ensure that on the days there were less staff, bank or agency staff were available to cover the shortfall.

Systems and processes in place to determine safe staffing levels were not followed. Sufficient numbers of staff were not always available. This placed people at possible risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service followed safe recruitment processes.
● Recruitment checks including Disclosure and Barring Service check (DBS), proof of identification and references from previous employment had been completed. DBS checks inform the service if a prospective staff member has a criminal record or has been judged to be unfit to work with vulnerable adults.
● However, we did identify some staff had not had their DBS renewed within the past three years in line with best practice, we brought this to the attention of the registered manager who agreed to address this immediately.

Preventing and controlling infection
● Policies and procedures were in place to prevent and control infection.
● Most areas of the home were clean and we observed enhanced cleaning taking place to prevent the spread of infections. Current guidance was also available, including policies and risk assessments, around managing COVID-19 safely.
● Staff told us they had access to Personal Protective Equipment (PPE) such as face masks, gloves and aprons, and regular training around infection control. We saw hand sanitiser stations around the home.
● However, we did observe during the inspection some staff not wearing face masks within the home. We also found one bottle of hand gel left accessible to people, where the opening lid was broken. Bottles of cleaning liquids were also left accessible in the communal lounge. These items were observed to be in easy reach of people, living with dementia who could have mistaken them as something to drink or eat.
● These issues were brought to the attention of the registered manager, the deputy manager and the nominated individual during the inspection. However, apart from staff being told to make sure they always wore their face masks, we did not see any attempts made during the inspection to rectify the other issues identified.

We recommend that the provider and registered manager ensure all staff follow current government guidance on wearing the required PPE when in the home as well as ensuring chemicals are stored safely and securely and not left accessible to people placing them at risk of harm.

Systems and processes to safeguard people from the risk of abuse
● Policies and procedures were in place to protect people from abuse.
● One person told us, "I feel safe, I am so contented. Relatives also told us that they felt their family members were safe. One family member said 'I think she is safe as she always seemed it when we used to go in and I never saw any issues, there haven't been any falls."

● Staff had received training and told us how they kept people safe and would report concerns or abuse. One staff member told us, "If you know a resident and go into their room, you may see signs of fear, bruises in the body. I would have to report to the nurse on the duty, let them know what I have seen."
● Where safeguarding concerns had been raised, the registered manager had acted on these and notified the appropriate authorities.

Assessing risk, safety monitoring and management
● People were protected from risks identified in relation to their health and care needs.
● Risks were assessed, monitored and regularly reviewed to reflect peoples changing needs. Care plans were detailed and provided staff guidance and direction on how best to support people safely.
● Records in place showed that the environment and equipment was regularly checked to ensure it was safe. This included fire safety, personal emergency evacuation plans and equipment safety checks.

Using medicines safely
● People received their medicines safely and as prescribed.
● People were supported to have their medicines by trained staff that regularly had their competency checked.
● Medicines Administration Records (MAR) were completed accurately and were regularly audited by the service.
● Medicines were received, stored and disposed of safely and checks showed that medicine stocks matched records.
● Where medicines were prescribed for use 'when required' (PRN) there was sufficient written guidance for staff to know when these medicines should be given. PRN medicines can be prescribed to relieve pain or anxiety.
● The service had a medication policy in place, however, it had not been updated since 2018. We brought this to the attention of the registered manager who agreed to address this immediately.

Learning lessons when things go wrong
● All accidents and incidents were recorded with details of the event, actions taken and any follow up required.
● There had been no recorded accidents or incidents since September 2020.
● The deputy manager explained that any accident or incident would be discussed at the daily handover meeting with all staff on duty to support further learning and service improvement.
● One care staff explained, "It is very important to discuss with colleagues, we need to tell all of our team if there is a history of falls for example. In the handover it is discussed."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; Support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always supported to develop and maintain relationships to avoid social isolation.
- Throughout the pandemic the home had followed government guidance in relation to closing the home to visitors to keep people safe and prevent the risk of infection transmission. However, relatives we spoke with told us whilst the home was in lockdown, suitable arrangements had not been in place to enable relatives to keep in touch with their family member.
- Relatives also told us that when lockdown restrictions were lifted, communication and information about visiting processes had not been forthcoming and relatives were left not able to visit when it was safe to do so.
- Feedback from relatives included, "I had no contact at all, I was told I was not allowed to speak to him on the phone" and "I did phone up to book a visit but was told there were no slots. Other than that I was not offered anything for contact during the pandemic." A third relative explained that there had been no contact from the home during the pandemic and that visiting arrangements had not been explained to them since government guidance had changed.
- People were not supported to follow their interests and take part in activities that were socially and culturally relevant to the them. There was a lack of meaning activities that people could participate in to help stimulate and fulfil their social needs.
- Relatives feedback about the provision of activities was not positive. Comments included, "Regarding activities in the bedroom I did ask the nurse but it's hard for them because they're short staffed and they said they couldn't do as much as they wanted" and "He [person] used to grow things in the previous place there's nothing to stimulate him here. He has got some books but nobody reads to him and I bought him some models but he needs help but there's no one there to do it."
- An activity co-ordinator had been recruited but was currently on long term leave. The provision of daily activities was the responsibility of care staff.
- During the inspection, three different activity timetables were seen on display but each of them appeared to be out of date, two of which were dated 2020. In the absence of a current activity plan, we were unable to see what structured activities had been scheduled for the day.
- Throughout the inspection we did not observe any form of structured activity taking place.
- People were left sitting in their chairs with the television switched on and set to a news channel. People had not been asked if they wanted to watch this channel.
- During the morning of the inspection, one staff member was seen sitting with one person looking through a magazine. There was no conversation or interaction between person and the staff member.
- During the afternoon we observed another staff member sitting with a person making a puzzle. Again,

there was no conversation or interaction between the person and staff member. The puzzle was one which was of cartoon characters, more suitable for a child.
● Activity records that we looked at were not a true reflection of the activities delivered within the home. On the day of the inspection, the activity record documented that at 10:53am, five people played cards with the same staff member. We did not observe any of the named people playing cards with the staff member who recorded this.
● Staff commented that they did not have time to deliver activities within the home. One staff member told us, "Nobody is doing activities, we only take them downstairs, sometimes we do bingo, drawing. We don't have time for the residents."

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
● People did not always receive person centred care that met their needs and preferences.
● Observations of the care and support people received throughout the inspection did not promote person centred care and did not consider people's choices, preferences and needs.
● During lunch time, menus were not available to people so that they knew what choices were available. This was highlighted to the deputy manager, who immediately printed out the menu for the day and placed them on display. One person commented, "I haven't read this [menu] before. It's the first time I have seen it."
● People were not offered a choice of what they wanted to eat. People were not reminded of the meal choice they had made the day before and were not told what food they were being served.
● Care plans were person centred and contained information about the person, their needs, preferences and wishes.
● There was information on people's backgrounds and where possible, family members had been involved. People's likes and dislikes around food, and interests were documented as well as who were important people in their life. However, care provision was not always reflective of people's preferences, wishes, likes and dislikes and interests.

People did not receive care and support that was person centred. There were no structured activities in place to ensure that people were stimulated, and their wellbeing maintained. People were not supported to develop and maintain relationships with their relatives. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives did speak positively about the care staff that supported their family member. Feedback included, "The care staff are amazing, try their best", "He [person] seems content and happy with the staff" and "These guys need a medal, the way they look after them, feed them etc, they're angels."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans documented if people had any specific communication needs and how staff could meet these.
● We observed that staff knew and understood how to communicate with people.

Improving care quality in response to complaints or concerns
● Relatives told us that they knew who to speak with if they had any concerns or complaints to raise. One relative told us, "Yes they told us about the complaints procedure."
● Complaints were documented, with details of the complaint, actions taken, the outcome and lessons

learnt.

End of life care and support

● People's end of life wishes were documented in their care files. Information was detailed and person centred in respect of how the person wished to be supported at the end of their life.

● We saw that, where appropriate, there were 'Do not attempt Cardio-Pulmonary Resuscitation' orders (DNACPR) in place. These had been completed in conjunction with the person and where appropriate, their relatives.

Requires Improvement

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The physical absence of the registered manager at the home throughout the duration of the COVID-19 pandemic had a significant impact on the quality of care people received. The overall running of the home had mainly been the responsibility of the deputy manager with support from the nominated individual. One relative told us, "[Registered manager] needs to be more present, name of technical lead is doing the bulk of it and the seniors."
- Alternative arrangements had not been made to ensure adequate management of the home.
- A variety of checks had been completed to check and oversee the quality of care people received. Whilst certain issues identified during this inspection had been identified by the registered manager, action had not been taken to implement the required improvements.
- Issues identified with staffing levels, infection control and the poor provision of activities had not been identified by any of the internal audits completed by the registered manager or the nominated individual.
- During the inspection, we found certain areas of the home in a general state of disrepair. The home needed attention in terms of decoration and certain pieces of equipment such as apron holders needed cleaning. These areas requiring attention had not been identified through any of the management quality checks.
- Staff rotas seen listed names of staff who no longer worked at the home, as scheduled to work the shift.
- Some staff told us that they had not been tested on a weekly basis and were tested on a monthly basis. There was no oversight of staff testing for COVID-19 as per government guidance. The registered manager gave assurance that all staff were tested weekly however, this could not be confirmed.
- The staff contact list that had been provided to us as part of the inspection process did not match the staff list on the training matrix. At least five staff members names did not feature on the training matrix, but as per the rota were working in the home. We could not be assured that these staff had received the required training to support them in their role.
- Staff training was not always current and had not been refreshed in some cases for over two years. Two staff had not had their safeguarding training refreshed since 2018 and 2019. A further six staff had not had any refresher training for manual handling since 2018.
- Only six members of staff out of a team of a possible 22 had received dementia training. We could not be assured that staff had been provided with the skills and knowledge to deliver care safely and effectively.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people
● The service did not always promote good outcomes for people through person centred care.
● Records of care, activities provision and staff rotas were not a true record of what was taking place within the home.
● Information about people's and staff vaccination status and been placed on display in the lobby area. Visitors who had completed forms in relation to screening questions asked prior to entry to the home had been left in the entrance area. These forms also included visitors' personal information.
● People did not have access to and were not supported to participate in any form of meaningful activity as per their needs and preferences.
● People were not given choices around meals they were offered. The provider and staff lacked understanding around offering choice and recognising people's preferences.
● Relatives told us that the home had not been very proactive in keeping them informed of their family member's health and wellbeing. Communication was often one way with relatives calling the home to obtain updates, which was also hindered by the fact that the telephone on occasions was not answered.
● Whilst we found that people were physically taken care of, we found significant failings throughout the inspection as detailed within this report that impeded the delivery of person-centred care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People using the service were not always engaged and involved in making certain day to day decisions about how they received care and support. There was also no evidence of engagement with people on the overall management of the service.
● We were told that residents' meetings had not taken place throughout the pandemic. These would re-start once the activities co-ordinator returned to work. In the meantime, no alternative methods had been considered to obtain people's feedback about the care and support they received.
● Satisfaction surveys had been completed by relatives and visiting healthcare professionals. This exercise had been completed in February 2020. Feedback was overall positive. However, relatives we spoke with did also state that there had not been any relatives' meetings recently and that they had not completed any recent surveys. The registered manager confirmed that they were in the process of sending out satisfaction surveys to stakeholders to obtain feedback.
● Care staff told us that they did not always feel supported in their role and that short staffing impacted the way in which they were able to support people with their care. One care staff told us, "It is not easy to work here, we are always short staffed, there is only one nurse, a false rota has been given to you." Another staff member stated, "I don't really feel that support, I wish I could get more support. I was supposed to be supervised by [deputy manager] but it's just on paper."

Whilst we found there was no evidence that people had been directly harmed by the issues as identified above, systems were either not in place or robust enough to demonstrate that there was adequate oversight of the home. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives knew the registered manager and felt confident in approaching them where required. However, due to the registered manager not being available at the home, relatives also spoke highly of the deputy manager who they spoke with more frequently.
● Staff meetings were held on a monthly basis where several topics were discussed and included people's care, infection control, cleaning, laundry and training. Staff told us that they were able to contribute where needed.
● The nominated individual stated that due to challenges faced due to the pandemic, there were areas in

relation to the management of the home, staffing and training which had fallen short of the requirements.
● The provider gave us assurances that as the registered manager had now returned to work on site the issues and shortfalls identified would be addressed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager clearly understood their responsibilities around duty of candour and being open and honest when something had gone wrong. Statutory notifications were completed and submitted to the required authorities including CQC. However, a recent safeguarding concern had not been reported to the CQC. We informed the registered manager of this who immediately submitted the required notification.

Working in partnership with others
● The home worked in partnership with other agencies to support people's physical health.
● Records seen confirmed that referrals had been made to varying healthcare practitioners and these were followed up appropriately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care. People did not always receive the required care and support in line with their preferences and interests and which maintained their health and wellbeing. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Management systems in place were not robust or sufficiently comprehensive to demonstrate adequate oversight of the quality of care at the home. This placed people at the possible risk of harm. Regulation 17 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of staff were available to support people's assessed needs. Regulation 18(1)