The Priory Hospital North London

Quality Report

Grovelands House
The Bourne
Southgate
London N14 6RA
Tel: 020 8882 8191
Website: www.priorygroup.com

Date of inspection visit: 23 & 24 October 2018
Date of publication: 05/12/2018

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services well-led?	

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

As this was a focused inspection, the provider's overall inspection rating or core service ratings were not altered.

We undertook this focused inspection of the child and adolescent wards to check the progress the provider had made in addressing the breaches of regulation identified at the previous inspection in April 2018.

At this focused inspection on 23 and 24 October 2018, we found the provider had made good progress regarding our concerns identified in the April 2018 inspection. The provider had made improvements in all 14 areas we asked them to address. We also report on additional concerns found with the safety of the clinic room.

We previously inspected this service in April 2018 as part of our on-going comprehensive mental health inspection programme. As a result of our findings at the inspection in April 2018, we provided feedback to the provider regarding our serious concerns of young peoples' safety on the child and adolescent wards.

The provider immediately transferred an experienced child and adolescent service manager to provide leadership to the child and adolescent wards. The provider also developed a detailed action plan to address our concerns. We were assured that the action plan demonstrated risk was either removed or was being removed in a timely manner to ensure people's safety on the on the child and adolescent wards.

At the April 2018 inspection, we found the following concerns on the child and adolescent wards:

- Ligature risks were present on all of the wards, including high risk ligatures in young people's bedrooms.
- Young peoples' risk assessments were not detailed and risk management plans did not always identify how staff could minimise risks effectively.
- Young people did not always have a full physical health assessment on admission to the hospital.
- Emergency alarms and call buttons were not always responded to in a timely manner.
- Paediatric early warning scores were not completed correctly. Possible deterioration in a young person's physical health may not have been escalated appropriately.
- Staff on the child and adolescent wards did not understand what constituted restraint. There was inconsistent recording of restraint of young people, and a lack of planning of how to support young people in the least restrictive way possible.
- The out-of-hours doctor did not carry an alarm or pager. Staff may not have been able to contact the doctor in an emergency.
- The prescription of 'as required' medicines on the child and adolescent wards did not always clearly describe the route for administration. There was not always a recorded rationale for the administration of 'as required' medicines.
- The provider did not ensure that appropriate medical equipment was within its expiry date and was suitable for the client age group.
- Young peoples' care plans did not always reflect their needs. Care plans were not always personalised, holistic or recovery-orientated.
- Young people told us that some staff did not treat them with respect and dignity. They found some staff patronising and unsympathetic.
- The governance and risk management systems and processes had not been effective. Potential risks to young people had not been proactively identified and addressed. Monitoring of the quality of care on the child and adolescent wards had been ineffective.
- Staffing levels for nursing on the child and adolescent wards were not safe. On a number of day shifts, there was one registered nurse rather than the minimum of two. Young people did not always receive one to one nursing sessions and their escorted leave was sometimes cancelled due to staffing levels on the wards.
- Staff had not received suitable training to meet the specific needs of young people in their care. Nursing staff on the child and adolescent wards had not received specialist training in epilepsy, autism or eating disorders.

At this inspection, we found that the service had made the following improvements:

- Leaders had a good understanding of the child and adolescent wards and had improved governance systems. An experienced child and adolescent service

Summary of findings

manager provided supernumerary support to the wards, and senior managers had a good oversight of the wards. There were improved systems in place to identify potential risks and to monitor the quality of care on the wards. However, the provider needed to ensure that the quality of the leadership was maintained and the implementation of the new governance systems was embedded.

- Staff completed risk assessments that were detailed and risk management plans identified how staff could minimise risks effectively.
- Staff completed a full physical health assessment for patients on admission to the hospital.
- The provider regularly tested response times to emergency alarms and call buttons via a rolling programme of staff emergency scenario drills.
- Staff completed paediatric early warning scores correctly, which ensured they were able to identify and escalate deterioration in a young person's physical health.
- Staff understood what constituted a restraint and they used verbal de-escalation techniques first to ensure young people were supported in a least restrictive way. Staff completed restraint records to a good standard.
- The out of hours doctor carried a pager to ensure they could be contacted in an emergency.
- The prescription of 'as required' medicines clearly described the route for administration. Staff always recorded a rationale for the administration of 'as required' medicines.
- Staff ensured that young people's care plans reflected their needs, were personalised, holistic and recovery orientated.
- Staffing levels for the children and adolescent wards were safe. The provider had processes in place to ensure the correct number of registered nurses was on each shift.
- Nursing staff on the CAMHS wards had received specialist training required to deliver their role safely. For example, staff had received suitable training to meet the specific needs of young people in their care, which included epilepsy, autism and diabetes.

We also found that the service needed to continue to make the following improvements:

- The provider had addressed our previous concerns regarding the clinic room. Staff checked medical equipment was within its expiry date and was suitable for the client age group. However, we found additional concerns with the clinic room. The provider did not have a robust system in place to ensure that all clinic rooms items were within its expiry date or to ensure that the clinic room environment was cleaned regularly.
- The provider needed to complete its planned work to reduce potential ligature anchor points. Since our last inspection, the provider had removed high-rated risks, but they still had environmental work to complete to minimise all of the ligature points. The provider needed to ensure that they met the timescales for this work.
- Young people told us that agency staff did not always treat them with dignity and respect, but told us permanent and bank staff were caring and understanding. At the last inspection, young people told us that staff did not always treat them with respect and dignity. At this inspection, all six patients were positive about how permanent and bank staff treated them. However, three out of six patients told us that agency staff did not always treat them with dignity and respect. Particularly agency staff did not always knock on their toilet door before entering.
- The provider needed to ensure that staff worked with young people to understand their rights as an informal patient.

Summary of findings

Contents

The Priory Hospital North London

Services we looked at
Services for children and young people

Summary of this inspection

Background to The Priory Hospital North London

The Priory Hospital North London is a 49 bed independent hospital in North London, which provides care and treatment for people with mental health problems and substance misuse problems.

Lower Court is a 27 bed ward for male and female adults with acute mental health problems, obsessive disorders and substance misuse problems.

Birch Ward is a 13 bed ward for children and young people up to 18 years of age. The ward provides care and treatment for males and females with acute mental health problems.

Oak Ward is a nine bed ward for children and young people up to 18 years of age. The ward provides care and treatment for males and females with acute mental health problems.

The NHS commissions beds for adults and children and adolescents at The Priory Hospital North London. Clients at the hospital also have their care and treatment funded by insurance companies, or are self funding.

The provider is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

There was a registered manager in post.

Our inspection team

The team that inspected The Priory Hospital North London comprised one CQC inspection manager, three CQC inspectors and one specialist advisor. The specialist advisor was an experienced child and adolescent mental health nurse.

Why we carried out this inspection

We inspected this service in April 2018 as part of our on-going comprehensive mental health inspection programme. As a result of our findings at the inspection in April 2018, we provided feedback to the provider regarding our serious concerns of young people's safety on the child and adolescent wards.

The provider immediately transferred an experienced child and adolescent service manager to provide leadership to the child and adolescent wards. The provider also developed a detailed action plan to address our concerns. We were assured that the action plan demonstrated risk was either removed or was being removed in a timely manner to ensure young people's safety on the on the child and adolescent wards.

We carried out this focused inspection of the child and adolescent wards on 23 and 24 October 2018 to check that the provider had followed their action plan and had addressed the breaches of the following regulations found at the April 2018 inspection:

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9 (person-centred care)
- Regulation 10 (dignity and respect)
- Regulation 12 (safe care and treatment)
- Regulation 17 (good governance)
- Regulation 18 (staffing)

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

As this was a focused inspection, we looked at the areas where there had been a previous breach of regulations. We only looked at specific parts of the service being safe, effective, caring, and well-led. Before the inspection visit, we reviewed information that we held about the service. During the inspection visit, the inspection team:

- visited the wards and observed how staff were caring for young people
- spoke with the hospital director, director of clinical services, the experienced child and adolescent service manager, two child and adolescent ward managers and the quality improvement facilitator
- spoke with seven other staff members including the consultant psychiatrist, health care assistants and nurses
- spoke with six young people on the child and adolescent wards
- reviewed seven young peoples' care records
- and looked at a range of policies, procedures and other documents relating to the running of the wards.

What people who use the service say

We gave young people the opportunity to speak to the inspection team during the two day focused inspection. All six young people we spoke with were positive about the way permanent and bank staff treated them. One young person said the psychiatrist and the activities co-ordinator were very good. One young person said some staff were like best friends and one young person said the nurses were good. However, three young people fed back that sometimes agency staff did not always treat them with dignity and respect.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the provider had made the following improvements:

- Staffing levels for the child and adolescent wards were safe. The provider had systems in place to ensure the correct number of registered nurses was on each shift.
- Staff completed risk assessments that were detailed and risk management plans identified how staff could minimise risks effectively.
- The provider regularly tested response times to emergency alarms and call buttons via an ongoing programme of staff emergency scenario drills.
- The out-of-hours doctor carried a pager to ensure they could be contacted in an emergency.
- Staff understood what constituted a restraint and they used verbal de-escalation techniques first to ensure young people were supported in the least restrictive way. Staff completed restraint records to a good standard.
- The prescription of 'as required' medicines clearly described the route for administration. Staff always a recorded rationale for the administration of 'as required' medicines.

We found the following issues that the provider needs to continue to improve:

- The provider had addressed our previous concerns regarding the clinic room. Staff checked medical equipment was within its expiry date and was suitable for the client age group. However, we found additional concerns with the clinic room. The provider did not have a robust system in place to ensure that all clinic rooms items were within its expiry date or to ensure that the clinic room environment was cleaned regularly.
- The provider needed to complete its planned work to reduce potential ligature anchor points. Since our last inspection, the provider had removed high-rated risks, but it still had environmental work to complete to minimise all of the ligature points. The provider needed to ensure that they met the timescales for this work.

Are services effective?

We found the provider had made the following improvements:

- Staff ensured that young people's care plans reflected their needs, were personalised, holistic and recovery orientated.

Summary of this inspection

- Staff completed a full physical health assessment for young people on admission to the hospital.
- Staff completed paediatric early warning scores correctly, which meant they could identify a deterioration in a young person's physical health and escalate to a doctor if needed.
- Nursing staff on the child and adolescent wards had received specialist training required to deliver their role safely. For example, staff had received suitable training to meet the specific needs of young people in their care, which included epilepsy, autism and diabetes.

We found the following issue that the provider needs to continue to improve:

- The provider needed to ensure that staff worked with young people to understand their rights as an informal patient.

Are services caring?

We found the following issue that the provider needs to continue to improve:

- All six young people were positive about how permanent and bank staff treated them. Young people said these staff were caring and understanding towards their needs. However, three out of the six young people told us that some agency staff did not always treat them with dignity and respect. Particularly one young person said agency staff did not always knock on their toilet door before entering.

Are services well-led?

We found the provider had made the following improvements:

- Leaders had a good understanding of the child and adolescent wards and had improved governance systems. An experienced child and adolescent service manager provided supernumerary support to the wards, and senior managers had a good oversight of the wards. There were improved systems in place to identify potential risks and to monitor the quality of care on the wards. However, the provider needed to ensure that the quality of the leadership was maintained and the implementation of the new governance systems was embedded.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- During the April 2018 inspection, we found ligature risks were present on all of the wards, including high risk ligatures in young people's bedrooms. Staff did not complete actions outlined on the ligature risk assessment to mitigate ligature risks. During this inspection, the provider had made improvements to the environment and had removed immediate ligature risks, but still had environmental work to complete to ensure minimisation of all ligature points.
- At this inspection, the provider had removed all weight-bearing curtain rails from young people's bedrooms, fitted anti-tamper screws in bedrooms, and refurbished two bedrooms to 'safe' rooms. Safe rooms were fitted to specification and contained minimal ligature anchor points to ensure patient safety. At the time of inspection, there were two 'safe' rooms on Oak Ward, and six 'safe' rooms on Birch Ward. The provider had plans in place to refurbish all bedrooms to 'safe' rooms, with plans in place to refurbish two 'safe' rooms in November 2018, and remaining rooms by the end of 2019. The ward managers and maintenance manager completed a recent ligature risk assessment and had actions in place to mitigate identified risks. The provider had ordered convex mirrors to mitigate the blind spots on the ward. At the time of inspection, the mirrors were being manufactured. The provider needed to ensure that the outstanding environmental ligature work was completed in a timely manner. Staff demonstrated a good understanding of the ligature risks on the wards and how these were safely managed via individual patient observations and risk assessments.
- During the April 2018 inspection, we found emergency alarms and call buttons were not always responded to in a timely manner.
- At this inspection, we found the provider had made improvements. The provider regularly tested response times to emergency alarms and call buttons via an ongoing programme of emergency scenario drills.We saw records of these drills, which happened in August and October 2018. The drills involved scenarios where a patient had a bleeding wound, and a patient who had suffered a severe allergic reaction. Staff discussed the learning from each drill to improve their response in a future emergency. Young people also fed back that staff responded very quickly when alarms were set off, and spoke about recent examples. The provider had also added a nurse call alarm panel to Oak Wards nursing stations to improve response times when alarms were activated.
- During the April 2018 inspection, we found out-of-date equipment in the grab bag on Oak Ward. Birch Ward only had the adult size of blood pressure monitoring cuffs, which meant that young people who were underweight or small may not have had accurate blood pressure readings taken. There was also no system in place to alert staff to the dates by which physical health monitoring equipment needed to be either replaced or calibrated.
- At this inspection, the provider had made improvements by ensuring all medical equipment had been serviced, was cleaned daily and was suitable for the client group.
- However, we found some additional concerns to the safety of the clinic room environment. The provider did not have robust systems in place to ensure all clinic room items were within its expiry date. We found out-of-date items on both wards. We found vacutainer bottles in the clinic room that had expired in September

2018. On Birch Ward, we found out-of-date needles that had expiry dates between 2011 and May 2018. The out-of-date needles were mixed with the in-date needles, which meant there was a risk of staff using an out-of-date needle. This was raised with staff during the inspection who immediately removed out-of-date items. Medication prescribed to young people was all in date.

- The provider also did not have effective systems in place to ensure that the clinic room environment was cleaned regularly to maintain cleanliness. Both clinic rooms were visibly dusty. On Birch Ward, the medicines fridge was not clean. There was no documentation in place to demonstrate that the clinic room environment had been cleaned. Staff told us that domestic staff cleaned it daily, but we could not be assured this was the case.

Safe staffing

- During the April 2018 inspection, we found staffing levels on the wards were not safe. The provider did not always ensure there were two registered nurses on duty during the day. This was a particular issue on Oak Ward, where there had been 14 shifts in March 2018 where there had only been one registered nurse working during the day shift.
- At this inspection, improvements had been made. We reviewed the rota for both wards between 3 September 2018 and 22 October 2018, and found that there had been two occasions where there was only one registered nurse on duty during the day shift. Staff had reported these as formal incidents. We reviewed the incident reports and saw that the provider had attempted to recruit agency nurses, but were unable to fill the shift. The provider had increased the number of healthcare assistants during these emergency situations to improve the safety of the wards. Managers held daily morning meetings, in which they discussed the rota and put plans in place to manage any gaps. The registered nurse allocation across the hospital had been reviewed and two permanent registered nurses and one healthcare assistant were deployed to the child and adolescent wards on 3 May 2018 to replace agency staff.
- During the April 2018 inspection, we found that the out-of-hours doctor did not carry a pager or have a mobile phone so if they were not in their office they had to be located. This meant that they may not be able to attend the wards quickly in an emergency.
- At this inspection, improvements had been made. The out-of-hours doctor carried a pager to ensure they could be contacted in an emergency.

Assessing and managing risk to patients and staff

- During the April 2018 inspection, young peoples' risk assessments were not detailed and risk management plans did not always identify how staff could minimise risks effectively.
- At this inspection, improvements had been made. We reviewed seven risk assessment that demonstrated staff completed risk assessments that were detailed and risk management plans identified how staff could minimise risks effectively. Staff completed risk screenings at least once a week, and considered many potential risks. Young people had risk management plans integrated into their care plans. The multidisciplinary team updated young peoples' risk assessments during weekly ward rounds. The ward managers completed weekly audits of risk assessments to ensure they were in place and appropriate.
- During the April 2018 inspection, staff on the child and adolescent wards did not understand what constituted restraint. There was inconsistent recording of restraint of young people, and a lack of planning of how to support young people in the least restrictive way possible.
- At this inspection, we saw improvement. Staff knew what constituted a restraint and knew that an incident form would need to be completed. All staff talked about using de-escalation first to young people during times of distress. Staff said they had time to reflect after an episode of restraint, and discussed with their manager what went well and what could have been improved. All staff confirmed that they had recent restraint training. Training records showed 85% of registered nurses and 80% of healthcare assistants had been trained in restraint. We reviewed three incidents where young people had been restrained by staff. All were filled out a

good standard and had the necessary information recorded. For example, rationale for restraint, position of restraint, and if the young person was seen by a doctor.

- During the April 2018 inspection, staff did not complete paediatric early warning scores (PEWS) correctly. Therefore, if young peoples' physical health deteriorated, staff may not have picked these up in a timely manner.
- At this inspection, the provider had made improvements. We reviewed seven PEWS charts. Staff had completed all of them correctly. The multidisciplinary team reviewed patients' PEWS charts in weekly ward rounds. All staff had refresher training in PEWS, and staff said they felt confident in using the PEWS tool.

Medicines management

- During the April 2018 inspection, the prescription of 'as required' medicines on the child and adolescent wards did not always clearly describe the route for administration. There was not always a recorded rationale for the administration of 'as required' medicines.
- At this inspection, the provider had made improvements. We reviewed seven patient medicines charts that clearly described route for administration and a recorded rationale for the administration of 'as required' medicines.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- During the April 2018 inspection, young people did not always have a full physical health assessment on admission to the hospital. The admitting doctor did not always record young people's height, weight, medicines for physical health care needs, and their cardiovascular status.
- At this inspection, the provider had made improvements. We reviewed seven young peoples' care records, which demonstrated all young people had a completed physical health assessment by a doctor upon admission. The wards consultant psychiatrist completed weekly audits of young peoples' physical health assessments on admission to ensure they were complete.
- During the April 2018 inspection, young peoples' care plans did not always reflect their needs. Care plans were not always personalised, holistic or recovery-orientated.
- At this inspection, the provider had made improvements. The provider had supported staff to develop their care planning skills. The experienced child and adolescent mental health services ward manager had held weekly care planning training and one-to-one coaching sessions for staff to improve care plans. We reviewed seven patient care records. The records showed that staff completed detailed care plans for young people, which contained comprehensive assessments of risk and care needed. Each care plan had the young person's goals and actions stated, with a corresponding section in the care notes section where their progress was reviewed and updated daily. Staff had worked with young people in developing their care plans. Six young people we spoke with told us they were involved in producing their care plans. Staff used the words and sentences from young people in the plans, and the plans stated whether the young person had agreed with their care plan. Staff recorded when they offered young people a copy of their care plan.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- During the April 2018 inspection, the ward did not have a record that they had informed young people aged 16 and 17 that they could leave the ward freely. This was not in accordance with the Mental Health Act Code of Practice.
- At this inspection, the provider had made some improvements and had displayed an informal rights poster in ward communal areas. However, an informal patient told us that they were unaware of their rights and thought they would be detained if they left the ward.

Child and adolescent mental health wards

Are child and adolescent mental health wards caring?

Kindness, privacy, dignity, respect, compassion and support

- During the April 2018 inspection, young people on the child and adolescent wards told us that some staff did not treat them with respect and dignity. They found some staff patronising and unsympathetic.
- At this inspection, the six young people we spoke with were mostly positive about how staff treated them. They said permanent and bank staff were caring and understanding towards their needs. However, three young people told us that agency staff did not always treat them with dignity and respect. One patient said agency staff did not always knock on their toilet door before entering and one agency staff member used their en-suite toilet without asking. We fed back these comments back to the provider during the inspection.

Are child and adolescent mental health wards responsive to people's needs? (for example, to feedback?)

Are child and adolescent mental health wards well-led?

Governance

- During the April 2018 inspection, there were insufficient governance systems in place to ensure that the wards were managed safely and effectively. Senior managers had not ensured that there was sufficient leadership on the wards to enable systems and processes to be effective and in place, which minimised potential risks to young people.
- At this inspection, the provider had made improvements to the leadership, governance and risk management of the child and adolescent mental health wards. Immediately after the April 2018 inspection, the provider transferred an experienced child and adolescent mental health service manager to the wards to provide clear leadership. This experienced service manager offered support to the wards three days per week and provided staff training in care planning, room searching and risk assessments. At the previous inspection, Oak Ward and Birch Ward did not have permanent ward managers. At this inspection, there were permanent ward managers in place for each ward, and they were supported by charge nurses, the experienced child and adolescent service manager, the hospital's associate director of clinical services and the hospital's quality improvement facilitator. The ward managers conducted weekly audits of the wards to ensure quality of the wards. These audits included care plans, risk assessment, and clinic room medical equipment checks. Although, we found there were no systems in place to ensure items in the clinic room were in date, or that the clinic room environment was cleaned regularly.
- Managers had good oversight of the wards. The leads on the child and adolescent wards had weekly meetings to discuss progress on the wards in accordance with the concerns found in the April 2018 inspection. Senior leaders also had good oversight of the wards via weekly calls with the ward managers to discuss progress with action plans. Senior leaders also conducted monthly quality walk-rounds of the wards, to assess the environment, patient documentation, physical health management, and patient experience.
- Despite the improvements made, we recognised that since our last inspection the wards had received intensive senior management support, and the provider needed to ensure that they embedded the new systems and processes and that ward managers continued to be supported with their leadership and development. These concerns were highlighted with senior managers during the inspection, who confirmed that the experienced child and adolescent service manager would continue to provide support to the wards for a further two months, and that the quality improvement facilitator would continue to provide weekly leadership support to the teams and ensure systems were embedded. Senior managers would continue to provide local leadership development for the ward managers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are robust systems in place to ensure all clinic room items are within its expiry date. The provider must ensure that there are effective systems in place to ensure that the clinic room environment is cleaned regularly.

Action the provider SHOULD take to improve

- The provider should continue to ensure there is effective leadership of the child and adolescent wards.

The provider should continue to ensure systems and processes are effective in identifying potential risk and in monitoring the quality of care on the child and adolescent wards.

- The provider should ensure that they meet timescales for the minimisation or removal of all ligature points on the child and adolescent wards to create a safe environment.
- The provider should ensure that agency staff treat young people on the wards with dignity and respect.
- The provider should ensure that staff work with young people to understand their status as an informal patient.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have systems in place to ensure that all items in the clinic room were within its expiry date. The provider did not ensure the clinic room environment was regularly cleaned to maintain infection control. This was a breach of Regulation 12(1)(a)(b)(e)(h)