Akari Care Limited

# Park House

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This inspection took place on 27 September 2017 and was unannounced. A second day of inspection took place on 28 September and was announced.

Park House is a residential home which provides nursing and personal care for up to 50 people. At the time of our inspection there were 44 people living at the home, some of whom were living with dementia. 30 people required nursing care and 14 people required residential care.

A registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We last inspected this service on 13 May 2015 when it was rated 'good.'

During this inspection we found breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks associated with people's care were not always identified and mitigated, and the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided to ensure people received appropriate care and support.

You can see what action we told the provider to take at the back of the full version of the report.

People and most relatives spoke positively about the service and said it was a safe place to live.

Staff had received training in safeguarding and knew how to respond to any allegations of abuse. Safeguarding referrals had been made to the local authority appropriately, in line with set protocols. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who used the service.

The premises were clean and largely well-maintained although some walls and handrails needed repainting. The provider had not responded to repeated requests from the registered manager to address specific maintenance issues.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Records relating to controlled drugs had been completed accurately.

Regular planned and preventative maintenance checks and repairs were carried out and other required inspections and services such as gas safety were up to date.

Accidents and incidents were recorded accurately and analysed regularly. Each person had an up to date personal emergency evacuation plan should they need to be evacuated in the event of an emergency.

Staff received regular supervisions and appraisals and told us they felt well supported by the manager.

People had maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us staff were kind and caring. People said their choices were respected and their dignity was upheld.

Each person who used the service was given information about how to make a complaint and how to access advocacy services. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions.

People we spoke with knew how to make a complaint. They told us they would speak to a member of staff or the manager if they had any issues. Relatives had mixed views whether complaints they had raised had been dealt with appropriately.

Staff had a good understanding of people's care preferences but care records did not always contain up to date and relevant information about people's care needs.

People we spoke with knew who the registered manager was and said they liked them. Staff said the registered manager was approachable and supportive.

## 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.

People were put at risk of pressure damage as pressure relieving mattresses had not been used correctly.

The guidance for staff on 'when required' medicines was not always clear.

People told us they felt safe.

Thorough background checks had been carried out before staff began their employment.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People were brought to the dining room some time before meals were served which caused some people anxiety.

People were supported to eat in a dignified way and individual needs and preferences were catered for.

Staff training in key areas was mostly up to date.

The provider supported people in line with requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Although the staff team were kind and caring, the provider did not deliver care in a manner which was caring, as they had not ensured risks associated with people's skin care were reasonably mitigated.

People said staff treated them with respect and dignity.

People were supported in a discreet and dignified manner.

People were given information about the service and how to access an advocate.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Some care plans lacked detail about how people needed to be cared for.

People were not always meaningfully engaged during the day.

People and relatives knew how to complain.

Some relatives felt complaints were not handled appropriately.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

The provider's quality assurance system had not identified all of the concerns we identified during this inspection.

The provider had not responded to repeated requests from the registered manager in relation to premises issues.

There was a registered manager in place.

People knew who the manager was and spoke positively about them.

# Park House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 27 and 28 September 2017. Day one of the inspection was unannounced which meant the provider did not know we would be visiting. Day two was announced so the provider knew we would be returning. On 2 October we contacted other agencies to seek their feedback on this service. The inspection team was made up of one adult social care inspector, a specialist nurse advisor with expertise in tissue viability (with specialist knowledge of how to prevent and treat skin pressure damage) and one 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 service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We did not receive any information of concern from these agencies.

During the inspection we spent time with people living at the service. We spoke with 12 people and six relatives. We also spoke with the registered manager, a representative of the provider (regional manager), three nurses, five care assistants, the activities co-ordinator, one maintenance staff, two kitchen staff and two domestic staff.

We reviewed 12 people's care records and five staff files including recruitment, supervision and training information. We reviewed medicine administration records for 10 people as well as records relating to the

management of the service. We also checked the building to ensure it was clean, hygienic and a safe place for people to live.

Requires Improvement

# Is the service safe?

## Our findings

Risks associated with people's care were not always identified and mitigated. For example, there were eight out of fourteen people who had an airflow pressure relieving mattress in place which had been set to the wrong setting for their weight. There was no information about what setting mattresses should be on in people's care records which placed people at risk of pressure damage. This had not been identified by staff or management. When we spoke to the registered manager about this they immediately asked the nursing team to review everybody who needed a pressure relieving mattress, to ensure they were at the correct setting and the setting was clearly documented in care records.

Two people did not have the use of an appropriate mattress. Their beds consisted of two stacked mattress overlays. Mattress overlays are designed to give additional pressure reducing qualities to an existing standard mattress and should always be used in conjunction with another mattress and not instead of a mattress. Whilst no harm had resulted, these individuals should have been given a standard high specification foam mattress or a standard mattress with this overlay on top.

People did not always receive the care they needed to help keep them healthy. Records of positional changes for people at risk of pressure damage showed that people had not always been repositioned when they should have been. Long periods of not being repositioned put people at risk of developing pressure damage. For example, one person who was at high risk of pressure damage had not been repositioned every four hours. NICE guidelines on reducing the risk of pressure damage state, 'For safety reasons, repositioning is recommended at least every six hours for adults at risk, and every four hours for adults at high risk'. We noted that care records for people at risk of pressure damage did not specify how often each individual should be repositioned to reduce their risk of pressure damage. This meant people who had been assessed as at risk of skin damage were placed at a greater risk as we could not be sure people had been repositioned when they should have been.

Medicines were not always managed effectively and safely. Topical medicines application records (TMARs) and body maps to highlight where staff should apply prescribed creams and ointments were in place, but two records we viewed relating to topical medicines were incomplete. Staff told us where people's creams needed to be applied and how often, but incomplete records meant we could not be sure prescribed creams had been administered in the right way or at the right frequency, in line with the instructions on people's prescriptions.

People's medicine records lacked detailed guidance for staff relating to 'when required' medicines. Several people were prescribed pain relief such as paracetamol to be taken 'when required', but there was no detailed guidance in place to assist staff in their decision making about when it could and should be used. The manager told us there were five people who were prescribed 'when required' medicines who could not always communicate their needs. Staff described when they would administer 'when required' medicines but there was no clear guidance for them to refer to. This meant people could be at risk of not receiving medicines when they needed them, particularly those who could not always communicate their needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines that are liable to misuse, called controlled drugs were recorded and stored appropriately. Records relating to controlled drugs had been completed correctly. The temperature of treatment rooms and the clinical fridges were checked daily and were within recommended limits. Staff who administered people's medicines had received training and been assessed to check they were competent to carry out this role.

Medicines were recorded as administered on an electronic hand held device. We saw people received their medicines at the time they needed them. We found no gaps in relation to routinely prescribed medicines.

The service employed 50 staff. On the day of our visit the registered manager, two nurses and seven care assistants were on duty. Staff rotas we viewed showed these were the typical staffing levels for the service. Other staff such as an administrator, activities worker, laundry staff, kitchen staff and domestic staff were also on duty. Three staff members said staffing levels were inconsistent. On the days of our visit people's needs were attended to in a timely manner.

Pre-employment checks had been carried out on staff. We saw prospective staff members were required to complete an application form detailing their past work experience and learning. Two references were sought and checks were carried out with the author of each reference to ensure they had provided the information. Disclosure and barring service (DBS) checks were carried out. DBS checks help employers make safer recruitment decisions by minimising the risk of unsuitable people from working with vulnerable people. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. This meant there was a robust recruitment process in place.

People and most relatives we spoke with spoke positively about the service and said it was a safe place to live. One person commented, "I do feel safe in here, because there are people around if I need anything." Another person said, "I feel very safe in here as I am not on my own and I always have help here." A relative told us, "I feel my family member is totally safe and well looked after."

The provider had a staff disciplinary policy in place. We found the registered manager had implemented the policy when the need arose to ensure people using the service were safe.

The premises were clean and largely well-maintained although some walls and handrails needed repainting. We noted that the manager's audits had identified the store room in the kitchen was too warm and the flooring in one of the bathrooms needed replacing, but this had not been actioned by the provider. We have asked the provider to give us an update on this.

One relative told us, "The home is clean, the décor is nice and [family member] has a nice room."

Regular planned and preventative maintenance checks and repairs were carried out. These included daily, weekly, quarterly, and annual checks on the premises and equipment, such as window restrictors, bed rails and hoists. Other required inspections and services included gas safety and electrical testing. The records of these checks were up to date.

Accidents and incidents were recorded accurately and analysed regularly in relation to date, time and location to look for trends. Although no trends had been identified recently, records showed appropriate action had been taken by staff, such as referring a person to the falls team or obtaining assistive technology

to prevent recurrence.

Each person had a Personal Emergency Evacuation Plan (PEEP) which contained details about their individual needs should they need to be evacuated from the building in an emergency. They contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation.

Requires Improvement

# Is the service effective?

## Our findings

We observed lunch time in two dining rooms (on the ground floor and first floor) on the first day of the inspection. There were enough staff to support people to eat. Tables were nicely set with tablecloths, cutlery and condiments. On the first day of inspection lunch was a choice of mince and dumplings or chicken served with potatoes and vegetables followed by syrup sponge and custard or ice cream. Other options were available if people preferred an omelette, sandwiches, soup or something else. Hot and cold drinks were readily available depending on people's preferences.

We noted that in both dining rooms people were supported to move to the dining room between 45 minutes and an hour before their lunch was served, while staff supported some people to eat in their rooms according to their choice. Several people in the dining rooms asked, "Where is my meal? Will I be getting my food soon?" and similar questions. This meant this caused anxiety for some people.

There were enough staff to support people to eat and this was done in a dignified way. People were offered dignity aprons to protect their clothes. People's individual preferences were catered for, such as how much gravy they preferred, and the chef asked people if they had enjoyed their lunch.

Most of the people we spoke with were happy with the quality of food they received. People's comments included, "I really like the food here. There is always plenty to eat and drink if you want it, as long as I get fried eggs in the morning I am happy," "We are well fed and watered here. I have no complaints with the food" and "We get lots to eat and drink." One person told us they didn't like the food but acknowledged that they didn't have much of an appetite at the moment and staff regularly offered them a variety of options.

Menus were not available in picture format which meant information was not always provided in a format appropriate to people's needs. The majority of people did not need information in picture format, but some did. When we discussed this with the registered manager they said they would address this.

The registered manager and chef spoke positively about the recent introduction of 'smooth food', which is a new way of making and presenting pureed food to ensure it is more visually appealing and palatable. We spoke with the chef and kitchen assistant who knew people's nutritional needs and preferences well. The chef told us how a new menu had been introduced in May 2017 following feedback from people that they would like some changes. This meant people's feedback about the food was acted upon.

We reviewed people's records relating to nutrition. People were weighed when necessary and their BMI (body mass index) calculated. Food and fluid charts were in place for everybody, irrespective of whether they had needs in this area which was unnecessary. Fluid charts were not always completed fully as a person's target daily intake range was not always specified and charts were not always checked for completeness. When we mentioned this to the registered manager they took immediate action to address this.

The provider used an electronic matrix to monitor and record staff training. We reviewed the training matrix

and found training in key areas was mostly up to date. However, 17 staff had not completed up to date pressure care training. When we spoke to the registered manager about this they said they would arrange this as soon as possible.

Staff received regular supervision and appraisal. Supervisions are regular meetings between a staff member and their supervisor to discuss how their work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. The staff we spoke with said they could raise issues at any time and they didn't have to wait for supervisions.

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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications to the relevant local authority to ensure they were able to deprive people of their liberty lawfully and keep them safe. Mental capacity assessments had been carried out and best interest decisions recorded for specific decisions such as the covert administration of medicines. This means disguising medicine by administering it in food and drink where it is deemed in the person's best interests because of serious risks to a person's health or wellbeing if the medicine is not taken. Staff had completed training in the Mental Capacity Act and the Deprivation of Liberty Safeguards. Staff we spoke with understood how this applied to people they supported.

People had access to health care when necessary. We found evidence of attendance to hospital, and reviews by dieticians, district nurses and GPs.

Requires Improvement

# Is the service caring?

## Our findings

All of the people we spoke with told us staff were kind and caring, and they were happy with the care they received. Their comments included, "The staff are lovely they will always help you if they can," "They are kind and do what they can to help you," "The staff are just great" and "The staff are first class."

All of the people we spoke with felt staff acknowledged their privacy and demonstrated respect. For example, people told us how staff ensured curtains were pulled across and doors closed to ensure privacy was maintained when people were supported with personal care.

Most relatives spoke positively about staff and the care and support provided. One relative told us, "The staff here are really nice. I feel my family member is looked after well." Another relative said, "The staff all do a great job here." One relative told us they felt care was not of a good standard. Most relatives told us they felt fully involved in the care planning of their family members and were kept updated about any changes. A relative commented, "Staff always call and let us know if there are any changes to discuss."

Staff we spoke with told us they enjoyed working at Park House. One staff member said, "I like the work here as the residents are nice. That is the best thing about my job." Another staff member commented, "I love the residents." On the first day of our visit the manager told us how a staff member had taken the day off to attend a resident's funeral. Staff spoke fondly about this resident who had lived at the service for some time.

We observed staff spoke with people in a kind, caring and respectful way, taking time to listen to people and understand what they were communicating. Staff were attentive to people's needs and reassured people if they were upset or distressed. During this visit we saw lots of interaction between staff and people. For instance, some people were sitting with staff having a chat over a cup of tea or coffee.

People who needed physical assistance at meal times were provided with this in a dignified way. When people requested assistance to go to the toilet they were supported immediately. We saw this was done in a discreet way that maintained their dignity and without others knowing. Staff were kind and polite when supporting people, and clearly knew people well. We observed a lot of laughter in the home with staff having a joke with people in an appropriate manner.

People told us their choices were respected. One person told us, "I'm as happy as Larry here. I love it. The staff are always on hand and they're marvellous and I can do exactly what I want when I want. It was the best move I ever made coming here."

Each person who used the service was given a residents' guide (an information booklet that people received on admission) which contained information about the service.

Information about advocacy support from external agencies was available. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions.

Whilst we found the staff team were kind and caring in their approach to supporting people, the provider did not deliver care in a manner which was caring, as they did not ensure risks associated with people's skin care were reasonably mitigated.

Requires Improvement

# Is the service responsive?

## Our findings

People had a range of care plans in place to meet their needs including personal care, eating and drinking, medicines, continence and mobility. Care plans were personalised and included people's choices, preferences, likes and dislikes. However, not all care plans contained relevant detail and clear directions to inform staff how to meet the specific needs of each individual. For example, we noted that care records for people at risk of pressure damage did not specify how often each individual should be repositioned to reduce their risk of pressure damage. This meant care records did not always contain relevant information about people's care needs. When we spoke with the registered manager about this they said they would address this.

People and relatives told us they were involved in reviewing care plans. One person told us, "I feel involved in the decision making about me."

The staff we spoke with had a good understanding of people's preferences and wishes and we observed staff using this information in their day to day role when supporting people. People's records contained information about their social history, likes, dislikes and preferred routines. It is important staff have access to this information so they can get to know people as individuals.

People and relatives confirmed there was a choice of activities available. Two activities co-ordinators were employed and an activities programme was advertised throughout the service. Several months ago the provider had received feedback from people who used the service that activities needed to be improved. The provider acted on this by increasing the activities provision to seven days a week.

One of the activities co-ordinators we spoke with said activities included quizzes, sing-a-longs, skittles, hand massage, manicures, karaoke and a curry night. Trips out included going shopping in Newcastle, having fish and chips at Whitley Bay and going to the Great Yorkshire Show. Each person had an activities file which contained details of people's hobbies and interests. Detailed records of what activities people had participated in were kept.

On the first day of our visit we noticed 'movie time' was advertised as the morning activity but this didn't take place. When we asked people about this they said sometimes they liked to watch a movie, but on this particular day they had chosen to watch a game show on the television instead and this had been respected. This meant that staff were flexible when people's preferences changed.

One person told us they had been on a caravan holiday with staff members and other people who used the service. They told us how they had enjoyed this very much. Another person said, "We play bingo here on a Wednesday. I like that, last week I won twice."

Some people we spoke with said the choice of activities had improved but could be improved further. Other people said they preferred their own company as that was their choice. We found that although people appeared settled they were not always meaningfully engaged during the day.

People and relatives we spoke with told us they knew how to complain. People told us they had no problems raising concerns with staff or the manager, but had never needed to. Most relatives we spoke with had not needed to complain. One relative said, "I don't have complaints here I am happy with everything. My family member is happy here and loves the staff." Another relative told us, "We have never had any complaints."

However, two relatives we spoke with said they had reported "numerous issues over the years" and were not always happy with the outcome. One of them told us, "I reported an issue several weeks ago. Although changes were made after we pointed it out we were never given an apology."

We looked at the providers records of complaints. They had a system to log all complaints and concerns and show what action they had taken. There was evidence they had responded and investigated these. We saw evidence of investigations and where action had been taken. This action included disciplining and retraining staff for example.

Requires Improvement

# Is the service well-led?

## Our findings

The provider had a quality monitoring or audit system in place to review areas such as safeguarding, complaints, medicines and care plans. Recent audits identified some issues relating to health and safety. However, the provider had not identified all of the areas for improvement that we found during this inspection such as: pressure relieving mattresses not being set correctly; people at risk of pressure damage not being repositioned in line with their needs; the administration of topical creams not being recorded accurately; people's medicine records lacking detailed guidance for staff relating to 'when required' medicines; meals not always being served in a timely manner; and staff training not always being up to date.

Whilst people had not suffered any pressure damage as a result of pressure relieving mattresses not being set correctly for their individual weights, their risk of pressure damage was increased. Over inflation and under inflation of pressure relieving mattresses can cause skin damage due to the mattress being too hard or too soft, and can be uncomfortable for a person to use. This meant the provider's quality monitoring system was ineffective in identifying and generating improvements within the service. The provider had not identified that people had been placed at risk of harm.

The provider lacked effective systems and processes to maintain accurate and complete records relating to people's care. This placed people at risk of receiving unsafe or inappropriate care. There was a lack of information in care records to evidence people had received the care they needed to keep them safe. Care plans did not always contain relevant information about people's care needs for staff to follow, such as how often people at risk of pressure damage needed to be repositioned.

Care records were not stored securely. Records were kept in two open cupboards in two offices which we found open several times during our visit. This had previously been identified as an issue but the office doors were still being left open despite key pads or a lockable door being in place.

The provider had not responded to repeated requests from the registered manager to install an air conditioning unit in the store room in the kitchen (as it was too warm) and replace the flooring in one of the bathrooms. This meant the provider was not taking timely action to improve the quality and safety of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we spoke with the registered manager about the issues we found during this inspection they took immediate action to address these.

The registered manager had initially come to the home in a peripatetic role but had been the permanent manager since September 2016 and was registered with the Care Quality Commission. The manager was a registered nurse and had worked in the care sector in management roles for more than 20 years. The registered manager said, "This is a lovely home. I love the staff."

Services that provide health and social care to people are required to inform the Commission of important events that happen in the service in the form of a 'notification'. The provider had made timely notifications to the Commission when required in relation to significant events that had occurred in the home.

People and most relatives spoke positively about the registered manager. People we spoke with knew who the registered manager was and said they liked them. One person told us, "She's approachable and friendly and you can have a laugh with her." One relative said, "I am happy with the staff here and the manager. I feel my family member is in a good place and that they do a good job."

Staff said the registered manager was approachable and supportive and had been good for the home. One staff member said, "The manager is good here. She listens, is supportive and runs the home smoothly. She is the best manager I've worked for." A second staff member told us, "[Manager] is a lovely person, always there to help you." A third staff member said, "She's very understanding and always helpful."

Staff meetings were held regularly. Minutes of staff meetings were available to all staff so staff who could not attend could read them at a later date. Records of discussions held and actions needed were clearly captured. Staff told us they had enough opportunities to provide feedback about the service.

A residents' committee was in place which met regularly. People told us it was "a proper committee" with a chair, secretary and treasurer in post. At the most recent meeting food and activities had been discussed. People fed back that they had enjoyed a wine and cheese social event and would like another, so this was being arranged. This meant people's feedback was acted upon.

People's views were also sought via an annual survey which had been completed recently, the results of which were positive.

There was a business continuity plan in place should emergency situations occur such as a loss of electricity or flooding. This was in the process of being reviewed and updated as the provider had changed some of the external contractors used.

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 | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks associated with people's care were not identified and mitigated, specifically in relation to checks on pressure relieving equipment and records relating to people's positional changes. Records relating to the administration of prescribed topical creams were not accurate.<br><br>Regulation 12 (2) (a) (b) (e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider's quality assurance system was not effective in identifying areas of concern around pressure care, the administration of topical creams, guidance for staff relating to 'when required' medicines, meals not always being served in a timely manner and staff training not always being up to date.<br><br>Regulation 17 (2) (a) (b) (c) |