Mr J & Mrs D Cole

# No 11&12 Third Row

## Inspection report

11 & 12 Third Row
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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

The service was last inspected on 24 September 2014 where there were two breaches of Regulations 12 and 17 related to safety and governance of the service. At that time there were no checks on small electrical appliances, and window restrictors were not fitted to first floor rooms. The provider was not carrying out formal audits of the quality and safety of the service. At a follow up focused inspection on 18 December 2015 we found that these regulations were now being met.

11&12 Third Row is one of two locations owned and run by Mr J & Mrs D Cole and is situated in the village of Linton, near Ashington. It provides accommodation for up to three people with a learning disability, who require assistance with personal care and support. At the time of the inspection there were three people living at the home. There was no registered manager in post at the time of the inspection but plans were in place to appoint a registered manager to the service. A general manager was in day to day charge of the service.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We checked the management of medicines and found that appropriate procedures were in place for the ordering, receipt and administration of medicines. Medicine audits were carried out daily to ensure medicines had been given as prescribed. A competency checklist used to assess staff competency was basic, and records of when to give as required medicines could have been more detailed. We have made a recommendation about this.

Risk assessments and safety checks on the premises and equipment were carried out including electrical, legionella, and the oil tank storage. Fire procedures were in place. Staff received fire safety training and alarms and equipment were tested regularly.

Individual risks to the safety of people had been assessed and mitigated. Records of accidents and incidents were maintained and appropriate action taken where possible to prevent reoccurrence.

There were suitable numbers of staff on duty. People's needs were responded to in a timely manner and staffing took into account people's needs such as the requirement of two staff to go out. A manager was on call 24 hours a day to support staff.

Recruitment practices were appropriate and the suitability of applicants to work with vulnerable adults were carried out prior to employment. This helped to ensure that people were protected from abuse. Staff had received training in the safeguarding of vulnerable adults and knew what to do in the event of concerns. There were no concerns of a safeguarding nature at the time of the inspection.

Staff received regular training including related to the specific needs of people who used the service. Appraisals were carried out, and a system of staff supervision was in place. There were some gaps in supervision records and the general manager told us they had a plan in place to address these. Staff told us they felt well supported. Due to the small size of the service and number of staff employed the general manager had contact with staff on a regular basis.

People had access to a range of health professionals, including their GP, nurses and chiropodist. The health needs of people were responded to in a timely manner.

People were supported with eating and drinking. A menu was in place which had been reviewed and amended. People were offered a range of choices and healthy options were promoted. Some people had limited preferences of food choices and these were catered for by staff. Daily records of food and fluid intake were maintained and people's weights were monitored.

The premises were homely and generally well maintained. There was a rolling programme of redecoration and refurbishment. New carpets, a new handrail and improvements to the garden had been made since the last inspection. A lounge area had also been redecorated.

We observed kind and caring interactions between staff and people throughout the inspection. Staff knew people well and often responded to their needs through their interpretation of non-verbal cues from people who had difficulty communicating verbally. There had been a reduction in behavioural disturbance of one person which was partly attributed to the skilled approach and consistency of the staff team. The privacy and dignity of people was maintained.

The individual needs of people were responded to promptly, including a decline in physical health. People were supported to transition to the home from another service and relatives and care managers told us that people had settled well into their new surroundings.

Person centred care plans were in place which were up to date and regularly reviewed. Plans were in place to support people exhibiting behavioural disturbance or distress.

People took part in a variety of activities in line with their personal wishes and preferences. Staff were prepared to be flexible with activity plans based on people's wishes at the time. Routines met the needs of people who used the service.

A general manager was in day to day charge of the service. They carried out regular checks on the quality and safety of the service including on a daily basis and spot checks out of hours. A daily handover sheet had been introduced which recorded care and other safety checks. This was signed by staff and gave staff additional responsibility and accountability. Monthly audits had been introduced following the last comprehensive inspection, and we found some gaps in these at this inspection. We have made a recommendation about this.

Staff told us they felt well supported by the general manager and relatives also told us they were approachable and helpful. The general manager told us they were looking forward to the new registered manager providing greater oversight and support to strengthen the current management systems in place.

At this inspection we found one breach of Regulation 13 Safeguarding service users from abuse and improper treatment. This was because applications to deprive people of their liberty had not been submitted to the local authority of authorisation in line with legal requirements. You can see what action we

told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

There were safe procedures in place for the management of medicines and staff competency to administer medicines safely was monitored on a regular basis.

Risks were assessed in relation to the premises and environmental risks and individual risks to people were also assessed and mitigated.

Safe procedures were in place for the recruitment and selection of staff which helped to protect people from abuse.

### Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Applications had not been made to deprive people of their liberty in line with legal requirements.

Staff received regular training and appraisal. Despite gaps in supervision records, staff told us they felt well supported. Supervision sessions were scheduled by the manager to address these gaps.

People were supported with eating and drinking. Records of food and fluid intake were maintained, and choices and preferences were catered for. Menus had been reviewed and a healthy balanced diet was promoted.

### Is the service caring?

Good

The service was caring.

We saw that staff spoke kindly with people and treated them with respect.

Dignity was preserved and personal care was offered discreetly and sensitively.

People were involved in decisions about their care and

information was provided in an easy read format. Staff also used their knowledge of people's non-verbal communication to interpret their feelings and wishes.

## Is the service responsive?

Good

The service was responsive.

The service was responsive.
Person centred care plans were in place and these were reviewed and updated regularly.

A range of activities were available including trips into the local community. Activities were planned to suit the needs of people and were flexible to change when necessary.

A complaints procedure was in place but no complaints had been received. An easy read version was available to people who used the service.

## Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

There was no registered manager in post at the time of the inspection but plans were in place to appoint a registered manager to the service. A general manager was in day to day charge of the service.

Daily checks of the quality and safety of the service were carried out but there were some gaps in monthly audits.

Staff and relatives told us the general manager was helpful and approachable.

Feedback systems were in place to obtain people's, staff, relative's and visiting professional's views such as surveys, although these frequently weren't completed. We received positive feedback from staff relatives and professionals about the quality of the service.

# No 11&12 Third Row

**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 12 January 2017 and was announced. The provider was given 48 hours' notice because the location was a small care home for adults who were often out during the day; we needed to be sure that someone would be in. The inspection team consisted of one inspector.

Prior to the inspection we spoke with the local authority safeguarding and contracts teams and took the information they provided into account when planning our inspection. Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with all three people who used the service, two general managers, and one member of care staff. Following the inspection, we spoke with one relative and a staff member by telephone who provided feedback about their experiences of the service. We also spoke with two care managers from the local NHS trust.

We observed care and support being provided, and examined three care records and three staff recruitment files. We also examined a variety of records related to the quality and safety of the service.

Good

# Is the service safe?

## Our findings

We spoke with people who used the service. One person told us they were happy living in the home but other people had limited verbal communication and so we were unable to directly question people about the safety of the service. We spoke with a relative who told us, "I think [name of relation] is safe there. I don't have to worry about them now." A staff member told us, "People are safe here. I wouldn't work anywhere people weren't looked after, I wouldn't be here."

We checked the management of medicines and found there were safe procedures in place for the ordering, receipt, storage and administration of medicines. New medicine administration records [MARs] had been introduced which included space to write comments such as information as to why a medicine had not been given. There were no gaps in MARs including the recording of creams and lotions applied to the skin. Staff had received training in the safe administration of medicines, and their competency to do so was checked on a regular basis by a general manager. The staff competency checklist was basic and the general manager could find no record of medicine competency assessments carried out in 2016. These were completed with staff following the inspection and forwarded to CQC for our information. We also found that instructions for medicines to be given 'as required' such as pain relief or laxatives, could have been more detailed, particularly in relation to the non-verbal signals that someone might display when they required their medicines. These signs were well known to permanent staff but unfamiliar staff would not be aware of these.

We recommend that staff competency assessment records and instructions for as required medicines meet best practice guidelines.

Daily audits of medicines records were carried out to ensure any discrepancies could be picked up and addressed the same day. The general manager explained they had tried to reduce the number of strong medicines one person had been receiving for a number of years in consultation with their GP. During this time they monitored carefully the person's presentation and well-being and were able to advise the GP what was working and what did not work so well to ensure the safety and comfort of the person. This showed that staff were following best practice advice to review these medicines on a regular basis.

Records confirmed and staff told us they had received training in the safeguarding of vulnerable adults. One staff member told us, "I have done safeguarding training. It was easy to follow and informative. I wouldn't hesitate to whistle blow without a doubt, but I have never seen anything but proper care here." There were no safeguarding concerns at the time of the inspection. robust safeguarding procedures were in place.

Risks in the environment had been assessed. We found that a five year electrical safety check had been carried out and visual checks of equipment continued to be carried out. A legionella risk assessment had found that checks were not required as there was no standing water in the home and an electric combination boiler was in use. There was no gas in the premises and regular servicing of the oil storage tank was carried out. We noted that new equipment such as new Christmas lights had been added to the list to check. A fire safety risk assessment was in place and equipment checked on a regular basis. Mains linked

and battery operated smoke detectors were in place. Individual risks to people had been assessed including risks associated with behavioural disturbance, accessing the community and use of public transport. These were individualised including, for example, that one person should only have hot drinks served in a cup which was three quarters full and not too hot due to their risk of scalding. There was no equipment for the moving or handling of people in use in the home as this was not required by people.
We noticed that one bath panel was damaged although this was not immediately noticeable. When we pointed it out, the general manager replaced it straight away. One room was quite bare for safety reasons and we were told that there were plans to make the room more interesting but free from hazards.

There were suitable numbers of staff on duty. There were three staff on duty during the day and one staff member on sleep in duty at night. The general manager and staff confirmed, that there was a manager on call out of hours. We saw that there had been occasions when they had been called at night and immediately attended the home to support staff when someone was unwell. Two staff were required to take some people into the community safely, and we were told that none of the people using the service liked to routinely access activities in the community in the evenings, but additional staff would be provided if they wished to do so.

We checked staff recruitment records and found that safe processes had been followed to help protect people from abuse. References were sourced and checks were carried out by the Disclosure and Barring Service [DBS]. The DBS carries out checks on the suitability of applicants to work with vulnerable people helping employers to make safer recruitment decisions.

Accidents and incidents were recorded and staff told us they knew how to do this. We saw records of incidents in people's care files which demonstrated that appropriate action had been taken. For example, one person had fallen twice and was referred to their GP who checked their blood pressure. A new handrail had been added to the staircase in response to one person becoming less steady on their feet. This meant that the environment was adapted to maintain the safety of people in keeping with their changing needs.

Requires Improvement

# Is the service effective?

## Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 2005. There was some reference to capacity assessments and best interests decision making in care records but applications had not been made to deprive people of their liberty in line with legal requirements, despite some restrictive practices taking place. Staff in day to day charge were not fully aware of the DoLS status of people who used the service. One application had been made previously when one person lived at another address, but authorisation had not been received for this. The general manager told us they were going to reapply with details of the new address and circumstances. Another person that used the service was subject to constant supervision when accessing the community and we judged that this may amount to restrictive practice which should be considered in line with the MCA.

This was a breach of Regulation 13. Safeguarding people from abuse or improper treatment.

Staff told us and records confirmed that staff received regular training. This included training in moving and handling, infection control, fluids and nutrition, health and safety, record keeping, emergency first aid, and medicines. Training specific to the needs of people who used the service was provided including epilepsy, learning disability, and mental health awareness. The general managers had qualifications in leadership and management.

A system for staff supervision and appraisal was in place but supervision sessions had not been carried out as regularly as planned. Supervision sessions provide staff with the opportunity to meet with their manager to discuss any support and development needs. We spoke with staff who told us they felt well supported. One staff member said, "I think we have supervision every three to six months but we work with [name of supervisor] all the time so we can speak to them if we had any problems." The general manager was aware that they were behind with scheduled supervisions but had a plan in place to address this. They were also confident that staff had opportunities to speak with them as they worked closely with staff on a daily basis due to the small size of the service.

We recommend that staff supervision is carried out regularly in line with best practice.

People were supported with eating and drinking. A four week menu cycle was in place but people could

choose alternatives to the menu if they wished. Breakfast choices included cooked options such as bacon, scrambled egg and beans. Lunches included soup and sandwiches and a cooked dinner in the evening with choices such as mince and dumplings, hunters chicken, and chicken and vegetable pasta were on the menu. People were also offered supper in the evening and we saw this included toast or cereal, 'cup a soup' or 'ready' oats. Fresh fruit and vegetables were available and staff attempted to promote a healthy balanced diet. This could be difficult due to some people having very limiting likes and dislikes. Staff accommodated people's preferences, to ensure they had enough to eat on a daily basis even though these were not always conventional. For example, one person wanted to have sponge and custard for breakfast.

Food and fluid records were fully completed. One person was at risk of dehydration as they could not speak and would not therefore ask for drinks. Staff monitored their fluid intake to ensure this did not occur. Another person had lost weight due to an underlying health condition. They were referred to a dietitian who provided advice and support before discharging the person, and staff continued to weigh them twice per week.

People had access to a range of health professionals including district nurses, GP, and chiropody. We saw that people had been supported by staff to attend hospital appointments when necessary. Hospital passports were in place for each person. These contain details about people's individual needs and the level of support they would require if admitted to hospital, in which case the document would be taken with them.

The premises were homely, and clean and tidy. Some areas of the home had been redecorated and an on-going programme of redecoration was in place. A new stair carpet was in place and bedrooms were homely and personalised; taking onto account people's tastes and interests.

A second sitting room was available which had been redecorated in bright colours and multi-sensory items to add interest. This meant people had a quiet area to spend time alone if they wished to do so. There was also a conservatory which opened out onto a large garden. The lawn was re-laid in 2016 and there were garden ornaments and numerous solar lights as one person was particularly fond of them.

Good

# Is the service caring?

## Our findings

We observed kind and caring interactions between people and staff. Staff introduced us and told us discreetly if anyone might be uncomfortable with our presence to enable us to minimise any potential upset we might cause.

It was clear from conversations with staff that they knew people well. A care manager told us the person they visited had formed close bonds with staff which meant they accepted support from them quite readily. A relative told us that "without exception" they found all staff provided care which was centred around their relation. They were very happy with the care provided and told us the care was, "As good as it gets." They also told us their relative always appeared happy when returning to the home from visits with them.

The general manager told us there had been a lot of staff changes and the new staff worked well with people and that people responded well to their approach. As a result, they had noted an improvement in engagement with staff and other people who lived in the service. A reduction in behaviour disturbance had also been noted and attributed to the consistent approach of staff. A care manager echoed this and told us the support team managed the person's behaviour well, and that there were familiar staff present when they visited. They said the person also appreciated having access to a male carer. One person had begun mixing more with other people and would join outings which they would not have done previously.

The privacy and dignity of people was supported. A staff member told us, "When I support [name of person] with personal care, I pull the blind down for them and wait outside to ensure no one goes into the bathroom. In the evening we have a system whereby if I am unable to stand outside the bathroom door, I hang a towel on the handle and the other two people know it is occupied."

Care plans also paid attention to privacy and dignity. Staff were asked to remind one person to wear their dressing gown and slippers when walking around the home for their dignity and comfort. A policy was in place related to privacy and dignity, which recognised that "Life in communal care can be invasive to people's ability to be alone, dignity and independence, and civil rights and choices." Staff practices we observed showed that staff were considerate to people needing time on their own.
People's records were held securely to ensure that confidentiality of information was maintained.

People were involved in decisions about their care, and easy read format information was available. Some people had very limited communication and staff therefore had to use their knowledge of people and their non-verbal communication to interpret the reactions of people. We heard staff offering choices at mealtimes for example, and responding to the needs and preferences of people. They explained to us in private, people's particular routines, habits and preferences and we saw that staff supported and respected these throughout the day. This showed that staff knew people well.

Staff told us they enjoyed working in the service and that in their opinion people were well cared for. The general manager was very passionate when describing her role in the service and commitment to the people they cared for.

There was no one accessing any formal advocacy service at the time of our inspection but staff knew how to access this if required. An advocate provides impartial support to help make decisions on behalf of a person who lacks capacity to do so themselves.

Good

# Is the service responsive?

## Our findings

We spoke with relatives and care managers who told us that the needs of people were responded to. We observed that people's needs were responded to in a timely manner by staff during our inspection and in line with their preferences.

Two people had lived in another property owned by the provider; a care manager and relative told us they had been concerned about the impact the transition of moving people to their current address might have. They said, however, that people had settled well into their new home and that they appeared happy with their new living arrangements which included living with a third person. The general manager told us that they thought carefully about how people would respond to a new person moving into the home and they took care to assess how well people would get along. They were conscious that communal living in a smaller home could cause difficulty if the views and preferences of people weren't taken into account.

Person centred care plans were in place. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. Care plans recorded people's daily routines and how they liked to spend their time. Staff told us people could choose when they went to bed and when they got up. One person enjoyed a lie in and staff checked them every half hour to see if they were ready to get out of bed. Staff confirmed that breakfast time was flexible in order to meet the preferences of people getting up at different times. People were consulted about their care plans where possible and we saw that they were supported by relatives if necessary. We spoke with one relative who told us they attended regular meetings with a care manager and staff in the home to discuss care plans. They said these meetings did not occur very often as their relation was quite settled, but said they were informed of any changes to the care plan or issues about care by the general manager.

Detailed information about the level of support people needed was provided. This meant that staff were aware of when to encourage people to be independent, or when they required assistance, which helped to maintain people's skills. Care records showed that people's physical health needs had been responded to in a timely manner. Daily records were maintained which outlined how people had spent their day, contained food and fluid records, and any specific information to be handed over to the staff coming on shift. This included, for example, that someone had appeared hot and clammy and were given Paracetamol. Another person was noted to have been scratching, and this was recorded to hand over to other staff including a body map indicating the area of skin affected. A body map is a diagram of the body used to indicate where an injury or bruise has occurred on the person's body or to highlight the correct place to administer creams or other medicines. One person had episodes of being unwell, and we saw that staff had responded appropriately at these times. Due to the person being unable to communicate well with staff, they were thoroughly checked by a health professional after these events as they were unable to say if they felt better.

A care manager told us staff were quick to identify changes in the condition of people. One person had a change of their medicine, and staff quickly spotted they were becoming unwell and took prompt action. The care manager pointed out that this was because staff knew people well and said, "Overall the current service is very good. They know [name of person] very well." Appropriate care plans were in place to respond to

behavioural disturbance. Staff were able to describe the potential triggers to behavioural disturbance or distress, and the action they should take.

A range of activities were available to people. These included trips out in the car, walks and events in the community. There were activity plans in place but these were flexible depending on how people felt on the day. We spoke with a staff member who told us, "We can be on the way somewhere and [name of person] changes their mind about where they want to go so we just turn around and go there. It is their time, so it's their [people's] choice." Activity plans indicated the level of support people needed when they were out such as one or two staff members. This ensured their safety was maintained and that they got maximum benefit from the activity. Staff were conscious that some activities weren't appropriate due to the attention span of people. One staff member told us, "We wouldn't take people to do a large weekly food shop, as they would lose interest and become restless. We would take them out by themselves on shorter visits to the shops for their personal items instead."

A care manager told us, "[Name of person] appears to engage in the local community as per their care plans and chooses where they want to go and if they don't want to go they don't."

We observed staff offering choices to people throughout the inspection including where they wished to sit, what they would like to eat or drink and whether they wished to join in activities.

A complaints procedure was in place including in an easy read format. No complaints had been received by the provider. Relatives we spoke with told us they were happy with the care provided and that they would speak to the general manager if they had any concerns.

Requires Improvement

# Is the service well-led?

## Our findings

There was no registered manager in post at the time of the inspection. A general manager was managing the service on a day to day basis. The general manager told us there were plans to add the location to the registration of a manager working in one of the provider's other services, this application had not been submitted at the time of the inspection. We spoke with the provider by telephone who advised that they were in regular contact with the service. The general manager confirmed they had weekly contact with the provider, they knew what was happening in the service, and that they visited the home on a regular basis.

At an inspection in September 2015, we found a breach in Regulation 17. Good governance. When we carried out a focused inspection in December 2015 to check whether legal requirements in this area were being met, we found that more robust systems to monitor the quality and safety of the service had been introduced.

At this inspection we reviewed records of audits and checks carried out by the general manager. We found that daily audits of medicines, cleanliness, hygiene and care continued to be carried out. We found, however, there were gaps in monthly audits that had been commenced following the last comprehensive inspection. As there was evidence of daily checks and due to the size of the service, we judged that the impact this had on people was minor, but felt there could be a risk of a decline in the governance of the service. They had also had not picked up the issue related to DoLS which we found during our inspection. We spoke with the general manager about this who said they would ensure systems were followed or amended to more appropriate timescales due to the size of the service. They also felt the addition of a new registered manager would strengthen governance arrangements as currently the general manager worked directly with people which impacted upon the management time available to them.

We recommend that systems to monitor the quality and safety of the service remain under review.

A daily handover sheet included entries about tasks and checks to be carried out. Staff were given responsibility for these and signed them when complete which meant there was an audit trail of who had been accountable for aspects of care and safety each day.

There were six staff employed in the service. Staff we spoke with told us they felt well supported by the general manager who was described as approachable. Staff felt that working closely with the general manager gave them opportunities for regular communication. One staff member told us, "The manager is very approachable. If I needed anything I would just ask." Another staff member said, "I feel absolutely well supported by the manager, no concerns at all." The general manager told us they observed practice and the standard of care on a daily basis and would act on any concerns immediately if necessary, or would make a note of more general concerns to discuss with staff during supervision, or in private at another time. They also visited outside normal working hours such as very early morning or in the evening to ensure they had a view of what was happening out of hours. This showed the general manager monitored standards of care and competency. A manager was on call 24 hours a day to support staff if required. We saw that the general manager had attended the home during the night when staff contacted them to say a person was unwell.

The views of people, relatives and visiting professionals were sought via a survey. An easy read format was available for people who used the service. There had been none returned, and the general manager told us they had a poor response to these because relatives tended to communicate with them on a regular basis and feedback from professionals was usually given verbally during care reviews. The care managers and relatives we spoke with were happy with the service provided. The views of people were ascertained on a daily basis through observing their reactions and non-verbal communication. We were able to ask one person about their experience of the service who told us they were happing living in the home.

There were links with the local community although the activities people wished to participate in locally were limited. People had been invited to a Christmas lunch at the local community centre for example.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Applications to deprive people of their liberty had not been sent to the supervisory body at the local authority in line with legal requirements.<br><br>Regulation 13 (4) (b) 13 (5) |