Mr B O & Mrs C N Ogbakaeko

Langdale House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced inspection of the service on 12 August 2015.

Langdale House provides accommodation for younger adults. There were 11 people receiving care at the home at the time of our visit.

There was a manager registered with the Care Quality Commission (CQC). 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.

Risk assessments were in place, but not robust enough to protect people from all potential risks.

People felt the service was safe and the provider had arrangements in place to identify the possibility of abuse and to reduce the risk of people experiencing abuse.

Summary of findings

Staff numbers were adequate and reflected the numbers of staff on the rotas to make sure people were supported appropriately. Staff had undertaken relevant safety checks and the provider had a robust recruitment process in place. Medicines were not always managed appropriately.

Most people consented to the care and support they received, but it was not clear what action the provider had taken when a person lacked the capacity to make decisions for themselves. People could not be assured that any restrictions would be appropriately identified or that decisions would be made in their best interest.

Care plans did not always contain information relevant to the person, such as those who suffered with dementia. However, they did, include people's individual life stories to make their care personalised to them. People were encouraged to be independent and received relevant information on how the service was run. People felt that they could express their views about the service that they received.

People were treated with respect and the staff provided the care in a caring way.

People were involved in decisions related to their care and support. Care plans contained information that reflected people's needs, but it wasn't always clear if the information was current.

People were comfortable to raise concerns. There was a complaints policy available and people told us their complaints had been responded to in a timely manner.

Systems in place to monitor the service were not effective to make sure a quality service was provided at all times.

People were encouraged to express their views and comment on how the service was run.

The management team worked well together and supported staff accordingly. The service worked with other professionals and the care commissioners, but recommendations were not always followed in a timely manner.

We have made a recommendation to ensure the provider follows guidance on reporting appropriate incidents to ensure they comply with CQC regulations.

Overall, we found shortfalls in the care and service provided to people. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 consistently safe.

Risk assessments were in place, but not robust enough to protect people from potential risks.

People felt safe with the staff who cared for them and with the care they received. The provider had arrangements in place that supported people who used the service against the risk of abuse.

Staffing levels were sufficient to meet people's needs. Recruitment processes were in place to help support suitable staff to be employed.

People were not always protected from the risks associated with managing medicines. Staff did not always follow processes that were in place to ensure medicines were handled and administered safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

People received care from staff who felt fully supported by the management team

Staff obtained people's permission before they provided care and support.

Staff had awareness of the Mental Capacity Act, but it was not clear they were following appropriate guidance to ensure people who lacked capacity were not restricted.

Staff training and development was reviewed and updated appropriately during the course of their employment.

People were encouraged to be independent and where necessary they were supported to have sufficient to eat and drink.

Staff had a good knowledge and understanding of how to meet the needs of the people they cared for. Referrals were made to other healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were positive about the staff and the care they received.

People were treated with respect, compassion and in a dignified way at all times by the staff who cared for them.

Staff were encouraged to form caring relationships with staff and other people to make sure their experienced good care.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Staff understood what people's needs were and responded to their changing needs in a positive way, but their care plan did not always reflect this. .

People were aware of the complaints procedure. There were no audit trails to evidence if complaints were responded in a timely manner.

Care plans were reviewed with people on a regular basis to ensure they received personal care relevant to their needs.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

Robust systems and procedures were not in place to fully monitor and improve the quality of the service provided.

Policies and procedures associated with the running of the service were in place, but not always reviewed in an appropriate time frame.

The service worked with other health care professionals, but did not always act on recommendations in a timely manner.

Langdale House Care Home

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 August 2015 and was unannounced. The inspection team consisted of two inspectors and an Expert by Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited we reviewed the information we held about the service including notifications. Notifications are about events that the provider is required to inform us of by law. We looked at the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our visit we spoke with five people who used the service, two members of staff and the registered manager.

We looked at the care plans for six people, the training and induction records for staff, three people's medicine records and the quality assurance audits that the registered manager completed.

We also consulted commissioners of the service who shared with us their views about the care provided.

Requires improvement

Is the service safe?

Our findings

Risk assessments were in place, but were not robust enough to protect people from potential risks when smoking in designated areas of the home or regarding falls.

A number of the risk assessments had been completed when people first came to the home, but they had not been reviewed recently. For example, risks to the health and safety of one person had not been reviewed since 2010. We found a designated area within the home for people who wished to smoke. There was a policy in place to support this. We looked at four care files that contained risk assessments relating to people who smoked, but they were not robust enough to identify all the risks for people and others. There were no risk assessments in place for the people who did not smoke. Risks had not been incorporated into the premises full risk assessment for fire. Precautions had been put in place when the provider identified people who did not always use the designated area. However, we found the risks for people had not been fully identified or documented in their care plan. We contacted the fire protection service to share our concerns.

We saw documents relating to accidents and incidents and the action that had been taken as a result. For example, one person had had a fall near a radiator. The risk assessment completed after the incident stated all bedrooms would be assessed and any potential risks to individual people would be addressed. Uncovered radiators would be protected with radiator covers within four weeks of the risk assessment. The long term risk assessment and management policy stated all radiators will be covered whether there was a potential risk or not. We found a number of radiator covers were not fixed to the wall and three areas of the home had no radiator covers at all.

People's needs had been assessed for the equipment they required to meet their needs. Appropriate equipment had been purchased to help support people when mobilising from their bed to their wheelchair. However, we found the equipment was not being used.

This was a breach of Regulation 12.The provider had not properly assessed risks to people's safety and had not fully responded to previously identified risks, to help keep people safe from harm.

Staff on each shift completed reports which were used as part of the hand over meetings. One member of staff told us they completed a general hand over and then one on each individual to minimise and manage risk for people.

Not all areas of the premises had been maintained to an adequate standard. We found a number of maintenance issues, such as the down stairs bathroom sink coming away from the wall. In one of the bedrooms we found a wardrobe door was hanging off its hinge. In another bedroom the cold tap would not turn off and a number of other issues that had not been addressed. The registered manager agreed to address these concerns immediately and we saw this was done during our inspection visit. The registered manager told us they undertook the appropriate safety checks, including tests on the electricity system, portable appliances, fire alarms and gas safety checks. We saw documents that reflected these checks had taken place.

People were protected from the risk of abuse, as the provider had systems in place to identify the possibility of abuse and to reduce the risk of people experiencing abuse.

People told us they felt the service was safe. People said they felt safe with the staff who supported them. One person said, "The building is secure and the staff are supportive, I feel safe here." They went on to say, "I feel able to tell staff if I feel unsafe and I am sure they would help me." Another person also commented that the building was secure and that they felt safe living at the home.

Staff understood how to recognise the possibility of abuse and how they should keep people safe. They confirmed and records we saw that safeguarding training had been completed. We saw policies and procedures were in place. We saw resident meetings had taken place and safeguarding was part of the agenda. The manager and staff describe the processes they followed when dealing with safeguarding issues or reporting any concerns. However we found no systems or audit trail to identify what action had been taken when safeguarding issues had been raised. The provider told us they had addressed any issues, but we could not find any evidence that actions had taken place when safeguarding had been reported by outside professionals.

Requires improvement

Is the service safe?

People commented that the numbers of staff was sufficient. One person said, "I think there is enough staff on duty." Another person told us they felt well supported by staff." A third person said I don't need to use my call bell as there is always a member of staff around when I want one."

Staff confirmed the numbers of staff were sufficient to meet the people's needs.

Systems were in place to ensure there were enough skilled and experienced staff to meet people's needs safely. The registered manager told us that staffing levels were based on people's dependency levels. They told us that any changes in people's dependency were considered to decide whether staffing levels needed to be increased. We looked at records which confirmed that the provider had assessed that staffing levels were being met. We observed that people received care promptly when requesting assistance in the lounge areas and in their rooms.

People were not always protected from the risks associated with managing medicines, because the processes in place were not followed appropriately to ensure medicines were managed safely.

People told us the staff made sure they take their medicines. One person said, "I receive my medicine from staff at regular times of the day. Other people confirmed they received their medicines in a timely manner.

Staff told us they had received training to administer medicines, but their competencies were not regularly assessed. From the four sets of staff records we viewed we found only one staff member had completed a competency test for administering medicines, despite all four of these staff being required to administer medicines as part of their roles. Staff did demonstrate to us that they had a good understanding on how to complete a medicine administration record (MAR), which were used to record when a person had taken or refused their prescribed medicines. When we reviewed a selection of MAR charts we found, in general, they had been accurately completed. There was one omission, which related to the records for a person who sometimes self-administered their own medicines. This person's care plan and risk assessment had not been completed to say when self-medication occurred. We spoke with the manager and they told us they would address this.

However, we did see the service was using medicines guidance and procedures from the local authority and staff had signed to say they had read and understood them.

We did not observe any medicines rounds during our visit, but staff described to us how they administered medicines safely and what action they would take in the event of an error. We found a medicine audit had been undertaken by another healthcare professional and a number of recommendations identified. The manager provided an action plan, which showed what action they had taken to ensure they had followed up on these recommendations, which included the recording and maintaining the temperature of the room where the medicine trolley was kept to ensure the effectiveness of the medicines was not compromised.

Requires improvement

Is the service effective?

Our findings

People's rights were not always protected under the Mental Capacity Act 2005.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We looked at whether the service was applying DoLS procedures appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are authorised by the relevant authority to ensure they are lawful. The registered manager told us that no applications had been made for people as no one was being deprived of their liberty. However, we were told they kept the front door locked at all times. Staff told us this was for security reasons only and no one was restricted if they wished to leave the home. We saw one person trying to get out of the front door without success. When they and other people asked to go outside the staff accommodated this. We found policies and procedures relating to DoLS were in place, but they were not up to date. Staff had some working knowledge of deprivation of liberty safeguards and the key requirements of the Mental Capacity Act. However, they did not always put them into practice effectively. The manager and staff did not have a good understanding of the recent guidance regarding DoLS following a recent court ruling. This showed people may be at risk of being unlawfully restricted. Staff may not be aware if people's liberty and rights had been restricted, because they were following out of date information.

People consented to care and support they received. Five people we spoke with told us staff asked their permission before providing any care or support. We looked at six care plans and saw on four of the care plans people had given their consent by signing documentation to say they agreed to the care and support they received from the staff. However, one of the care files we reviewed was for a person who was living with dementia. There was no care plan detailing what living with dementia meant for this person. The person's capacity had not been appropriately assessed and they had not been involved in planning their care. The staff senior told us this person may not have capacity to make some decisions. On another person's care file we saw that a capacity assessment had been completed and indicated this person did not have capacity, but there was no follow up or a decision on what action would be in the person's best interests. There was no record that the provider had followed appropriate processes and involved relevant people to ensure they came to the best decision for this person.

The concerns we found in relation to DoLS and capacity assessments meant people could not be assured that any restrictions would be appropriately identified or that decisions would always be made in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had access to healthcare services, but were not always supported to maintain good health.

People told us they could see a doctor or optician whenever they wanted. One person said, "The doctor will visit the home." They also confirmed they received weekly check-ups including their blood. Another person said, "If I need to see a doctor I would ask staff to make an appointment for me."

Referrals were made to external health professionals, such as Dentist or GPs when required. However, we found when action had been recommended by other professionals, such as an Occupational Therapist (OT) these recommendations had not always been followed through, or recorded in people's care plans. There was a risk that people may not always receive effective support that ensured they had good quality care.

We saw when significant changes had happened in people lives or about their care were not always changed in the main care plan, even though monthly updates were completed. This meant that people might not receive effective care relevant to their needs as records were not always accurate or current.

One person had use of a wheelchair and their care plan stated they walked with a stick and they had had no falls. We looked at the accident book and found this was not the case. The person had a fall in their bedroom, but had no means to call for assistance as their call bell was tied up. We noted that during our visit the call bell was still tied up. There was no explanation recorded in the persons care plan why the call bell was out of use. We saw recorded that a physiotherapist had suggested the use of a sensory mat

Is the service effective?

for this person. We spoke with the manager and they told us they were struggling to get hold of the equipment, but this was not documented in the persons care plan or evidenced that this had been followed up.

The manager also told us they were waiting for staff to attend training in regards to moving and handling and could not use equipment, such as the hoist until the training had been completed. Two staff demonstrated how they used unsafe procedures when moving a person from their bed to a chair. This showed the provider was not following recommendations and safe care practices to train staff to support people effectively

There was an instruction for staff on people's care files to identify changing needs for people with a medical condition that was controlled by diet or tablets. However, we were told by staff that one person was now insulin dependent and this was administered by the district nurse. This information was recorded on the person's fluid chart. There was a risk that all staff may not see this information and care for the person effectively. We saw it was recommended dietary management be undertaken, but this was not included in the person's care plan.

People told us they felt staff knew what they were doing. One person said, "I think the staff have the correct training to care for me." Another person said, "Staff appear to be properly trained to look after me."

Staff told us they received supervision and an appraisal of their work on a regular basis. We saw supervision had taken place and staff had completed an induction when they first started their role. We found staff were knowledgeable about the people they cared for and how they should provide people with effective care. The provider told us they were responsible for all staff training and we saw training records the training was up to date. The registered manager told us they undertook observation of care practices, but this was not recorded.

People received support to eat and drink enough and maintain a balanced diet.

People told us staff either made their drink for them or they were able to make the drinks themselves. One person said, "Whatever you want the staff will get it for you, but I can also make my own drink if I want to." Another person said, "Staff ensures I get enough to drink throughout the day."

We received mixed comments about the food. Two out of four people we spoke with told us they were not impressed with the food choices. One person said, "Sometimes it was not cooked very nicely." They went on to say they would like more variety on the menu. However, one person said the, "Food is all right." We looked at the menu, which was also written on the board in the dining room. Staff told us the menus were rotated every four weeks to provide choice and variety.

We observed lunchtime in the dining room. People were offered protection for their clothes. We felt the presentation of the food was good and people were offered an alternative should they want one. The atmosphere in the dining room was calm and the food was served efficiently. Everyone seemed to enjoy their meal. Some people had health conditions which meant their diets had to be carefully managed. Staff knew which people needed this support and were knowledgeable about their individual dietary requirements, including appropriate foods and substitute sweeteners. Six people we tracked had their weight recorded monthly and this was documented in their care plan and we noted their weight was stable. This showed the service took people's individual needs into account when supporting them to eat and drink.

Good

Is the service caring?

Our findings

People were encouraged to develop positive relationships with other people, their families and staff. One person told us their family member visited them and staff made them welcome. A staff member commented how proud they were of the relationship between the people who use the service and staff.

People were treated with kindness and compassion. One person said, "I feel staff genuinely care for me and they treat me with respect." Another person said, "They are very caring and help me to be independent by accompanying me on walks outside."

Staff demonstrated a kind and caring attitude. Staff talked about how they respected people's wishes. They understood people's needs and life goals. We observed good interaction with people and staff members. The staff listened to what people had to say and supported them to make day to day decisions. Such as going to the toilet or activities.

Care plans reflected people's individual needs and included information about their life history, so staff could talk about what was important to the person. However in one file we found there was insufficient information for people diagnosed with dementia. There was a missed opportunity to provide information staff could rely on in the future when a person may be less able to communicate effectively.

Staff had knowledge about the people they cared for. They were aware of their individual communication abilities and preferences. Staff communicated well with people who used the service. The manager told us and we saw leaflets and booklet in the main foyer that identified how people could access an advocate if they required more support. An advocacy service is used to support people or have someone speak on their behalf. Advocates are trained professionals who support, enable and empower people to speak up. However staff were not familiar with this service and told us they had not had experience in sign posting people to these services, but would ask the manager for details if needed.

Overall people told us their dignity was respected at all times. One person said, "Staff treat me with respect and observe my dignity. Although two people we spoke with raised concerns. They both told us that there were times when staff entered their room without knocking. One staff member said, "I respect people's privacy and knock on their door and wait for a response." However, this conflicted what the two people had told us. We raised this with the registered manager and asked them to investigate these concerns which they undertook to do. Two staff members described how they made sure people's dignity was kept intact when they provided personal care. Another member of staff said, "I speak to people in a calm way and call them by their preferred name. I make sure I respect their privacy when required or asked."

Requires improvement

Is the service responsive?

Our findings

Most people received care that was responsive to their needs, but this was not always consistent especially if the person had more complex needs. We observed staff encouraging one person to walk with a walking aid whilst they walked in front of them and gave encouragement and instructions. However, when another person needed equipment to help them mobilise, as recommended by visiting professionals this was not in place. There was no call bell available for this person to call for assistance if they required it. This may cause a delay in the person getting assistance.

Each person had a set of care records to provide staff with guidance and information on how to meet their needs. Some plans were reviewed and updated, but others had not reviewed or updated on a regular basis. One person had made an agreement with staff to have limited access to their cigarettes and lighter, so they could maintain their health and wellbeing. However other people's care plans had not been updated. We could not tell if the information in their care plan was current and correct.

We saw individual assessments had taken place. The manager told us assessments were carried out to gather information and identify people's needs. The provider told us that people receive a yearly review with involvement of other health care professionals. They told us they discussed and supported people to achieve their goals and aspirations.

Care plans contained personal information relevant to the person. Staff told us they checked people who required support every two hours and if needed. The night staff completed their own checks. However, we could not find any information recorded to back up how the staff responded to individuals. Staff completed their daily routine and documented the general tasks they completed for all people living in the home, but not on an individual basis. A staff member told us they completed verbal handovers as well as the minimal written ones. These reports were shared with all staff at the beginning and end of the day. The information contained in these daily handover notes were not sufficient in all cases to identify changes to people needs. The information was repetitive and limited. Such as, 'person slept well and had breakfast. This meant people may not receive the care and support relevant to their needs.

One staff member spoke about how the care plans identified people's choices and interests. They told us they supported people to do what they wanted to do. Another member of staff described interests people had, such as music. They told us people had use of a piano and a guitar within the home. We noted in one person's care plan that they liked to play the guitar and when we spoke to them they confirmed this is something they spent time doing .Other people told us they also participated in things that interested them such as reading the bible or going out to college. We observed people reading, watching television and going out for walk in the garden. Staff told us this was what they liked to do. We looked at two people's care plans and the activities they liked to participate in were recorded. This showed people were supported to follow their interests.

Systems were in place for people to feedback their experiences of the care they received and raise any issues or concerns they may have.

People told us they had attended resident meetings on a regular basis. One person said, "Staff asked if I'm happy with my care. We saw meetings were recorded and took place regularly.

We observed people were comfortable speaking to the manager and staff about any concerns they may have. People told us they knew how to raise a concern and who they should contact if the need arose. One person said, "The manager is always available and easy to talk to, they always listen." Another person said, "I once complained about the food and the complaint was dealt with rapidly and efficiently."

There was a complaints policy available and people told us their complaints had been responded to in a timely manner. We saw guidance on how to make a complaint was contained in the guide for people who used the service and displayed in the main reception.

Requires improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality and safety of the service, but these had not always been effective. Medication audits completed by external professionals highlighted some recommendations to improve how medicines were managed. The provider told us they completed checks and audits of the home environment . However, there were no records to confirm these checks took place or to show how the staff responded to individuals support needs. We found staff documented the daily routines they followed and the general tasks they completed for all people living in the home, but not on an individual basis. This meant people's individual needs may not be met.

Staff told us they checked people at two hourly intervals during the day and night to ensure they received any support they needed. However, there were no records to confirm these checks took place or to show how the staff responded to individuals support needs. We found staff documented the daily routines they followed and the general tasks they completed for all people living in the home, but not on an individual basis. This meant people's individual needs may not be met.

There were processes in place to explain how complaints issues were to be handled, but we found no evidence of any complaints being logged. There was no audit trail to show how complaints should have been dealt with if and when any complaints had occurred. The provider told us they had not received any complaints, but what people told us suggested this not to be the case. People told us they had made formal complaints, but we found no audit trail for these complaints that had been raised. We could not tell if these concerns had been of an historic nature or if they had been followed up successfully.

Policy and procedures were in place, but we found some that had not been reviewed. This meant staff were potentially following policy and procedures that were out of date.

The concerns we found in relation to monitoring the quality of the service and the systems that were in place for monitoring and reviewing policies, and complaints were not robust. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they were confident to raise any concerns they had about the running of the home or the quality of the service. They felt they would be supported by the manager through the process should this need arise.

People received information regarding the service provided, such as a statement of purpose and service guide. People were involved with the service by completing questionnaires on a monthly basis. The provider gained people's views and experiences through their feedback. We found feedback was positive and complimentary about the staff and the care they received. Staff and people who used the service were encouraged to voice their views and concerns with the management. The registered manager told us they openly encouraged people and staff to discuss any concerns they may have. We observed staff interacted with people and spent time with them. They spoke to people in an appropriate manner and were involved in day to day conversations with people about their health and wellbeing.

A registered manager was in post. All staff we spoke with felt the manager was approachable and listened to their views or concerns. One staff member told us they felt the manager was supportive, if they had any problems they were confident they would be addressed. Another staff member said "I feel supported." People and staff were complimentary about the manager and the way the home was run.

The registered manager told us the vision and values of the service were to promote people's independence and make sure they received good quality care that protected their dignity and privacy. They said that this was demonstrated by people living at the home on a long term basis and staff consistency.

We found some incidents and notifications were reported to CQC, however, we found one incident where the police were called had not been disclosed to us. We felt this incident should have been reported to us. The provider had reported to other professional bodies, but we could not find any notification to notify us that the incident had occurred, so that we could ensure all appropriate action had been taken to keep the person safe.

We contacted the local care commissioners who told us the manager was responsive and proactive when addressing any concerns that they (local authority) had raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Concerns in relation to people's capacity and whether their liberty had been restricted meant people could not be assured that any restrictions would be appropriately identified and dealt with in their best interest. **11(1) Care and treatment of service users must only be provided with the consent to the relevant person.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessing risks to people's safety and doing all that is reasonably practical to mitigate any such risks that had previously been identified to help keep people safe from harm. 12 1 2 (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to concerns and complaints. Regulation 17 (1) (2) (a)