Independence Matters C.I.C.

Stepping Out

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Stepping Out provides short to medium term residential accommodation for up to seven adults with enduring mental health conditions, who would benefit from a short to medium stay in a residential setting. At the time of this inspection there were five people living in the service.

Stepping Out is a two storey house with five bedrooms on the first floor and two bedrooms on the ground floor. There are communal areas such as a kitchen and two lounge areas, together with outside space and a garden.

Stepping Out is a service that aims to support people to make changes in their lives to become more able to cope with day to day living. The aim is to empower people to reach their goals and develop coping strategies in preparation for independent living.

People's experience of using this service and what we found
People and staff were at risk of avoidable harm; plans to manage known risks to people were unclear and did not provide staff with enough information to keep people safe. There was little evidence of learning from events or action taken to improve safety.

Staffing levels in the service were not adequate to ensure people and staff were safe at all times. Staff told us they did not always feel safe with the number of staff on shift.

People's medicines were managed safely, and staff kept accurate records

Staff received relevant training, but this needed to be extended to include more in-depth training due to the increasing complexity of people's needs.

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

Support plans failed to take into account a full assessment of people's needs. One support plan was blank, despite the person having lived in the service for over three months. Old information was also contained within some support plans. Therefore, staff were not always able to support people in the most effective way as some information was not made available to them.

The provision of meaningful activity did not always meet people's individual needs. Some people told us that they would enjoy group activity, but due to staffing levels this had not always been possible. We have made a recommendation about this.

Governance systems in place were not sufficiently robust to enable the service to identify where safety and quality was being compromised, and to drive continual improvement. Accidents and incidents were not analysed in order to identify trends or patterns and therefore mitigate future risk.

Despite significant shortfalls in the safety and governance of the service, people praised the kind and caring nature of staff. We observed positive interactions between staff and people throughout the inspection. People repeatedly gave us positive examples of how staff had changed their lives for the better and helped them reach their goals.

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

Rating at last inspection
The last rating for this service was Good (Published 31 August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive, and well-led sections of this full report.

The provider took some immediate actions during and following the inspection, such as increasing staffing levels and arranged for a health and safety review of the premises.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stepping Out on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, staffing, person-centred care, governance, and reporting procedures.

Following the inspection we formally requested additional information from the provider in relation to governance systems and processes that will support people's immediate safety.

Please see the action we have told the provider to take at the end of this report.

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

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not always effective Details are in our effective findings	**Requires Improvement**
Is the service caring? The service was not always caring Details are in our caring findings	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below	**Inadequate**

Stepping Out

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors and was announced.

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

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

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service is small and people are often out and we wanted to be sure there would be people at the service to speak with us.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with seven members of staff including a representative of the provider, the registered manager, deputy manager, and support workers. We also spoke with one health professional.

We reviewed a range of records. This included three people's care records and four medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one health professional, and one social care professional.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks around suicide, self-harm, and aggression were not sufficiently robust to provide clear guidance to staff on how to mitigate risks as far as possible. Information about potential triggers and observations to be aware of were not always included so staff could be aware of when harm might occur.
- The service could not demonstrate that they had reviewed risks associated with aggressive behaviour following several incidents which had occurred. Incident forms for three occurrences showed a required action to review the risk management plan and support plan. However, this could not be evidenced on the associated risk assessment.
- Incident forms showed inappropriate and lengthy timescales for actions to be completed by, sometimes as long as two weeks.
- One person had a condition which meant their blood sugars could fluctuate. However, there was no risk assessment in relation to this and what staff should look out for or action they may need to take.
- It was unclear if risks associated with the environment (such as ligature points) posed a risk to people currently living in the service. Items such as heavy furniture were not made secure, and we saw that there had been several incidents of aggressive behaviour over the last few months.
- The registered manager lacked knowledge in ensuring a robust assessment was carried out prior to people's admission and did not consider how risks would be managed, and how this may impact on staff and other people living in the service.
- A recent fire risk assessment was carried out by an external company showing the premises were high risk and were advised of several immediate actions required to make the premises safer. The report also highlighted that routine checks which should be undertaken periodically, had not always been carried out.

Learning lessons when things go wrong

- The service could not demonstrate they analysed accidents and incidents in order to identify trends or patterns and therefore mitigate future risk. For example, the times and locations of incidents were not accounted for.
- Where accidents and incidents had occurred, we saw these had not always resulted in reviews or reassessments of people's needs and risks being completed. Changes to people's support plans were not always undertaken as a result to minimise risk of further harm.

All of the above demonstrates a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the premises owners visited Stepping Out and are in the process of planning for

work to be undertaken in relation to the identified fire risks. The provider had also taken steps to make the premises safer in the interim.

Staffing and recruitment
● Staffing levels in the service were not always adequate to ensure people and staff were safe at all times. Staff told us they did not always feel safe with the number of staff on shift.
● A recent incident had occurred at a time when both staff on duty were occupied with other tasks (meal preparation and medicines administration). Staff told us that there were times when there were not enough staff on shift to manage the risks.

This demonstrated a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On day two of the inspection, a representative of the provider immediately increased staffing levels during the day and at night. This will need to be reviewed to ensure the number of staff on shift is appropriately assessed.

● Safe recruitment procedures were in place to ensure staff were suitable for the role.

Systems and processes to safeguard people from the risk of abuse
● Although the registered manager had reported safeguarding incidents directly to the local authority, they had not always notified CQC of events involving the police, which is required by law.
● People were protected from the risk of abuse. Staff had received training in this area and were knowledgeable about how and when to report any safeguarding concerns.

Using medicines safely
● Medicines were safely managed. Staff administered medicines as prescribed and kept robust medicines records.
● Stock levels were accounted for daily, and all were correct when we checked these. Where medicines were prescribed 'as required', there were protocols in place giving staff guidance on when these might be needed.

● A recent medicines error had occurred, but we saw that action had been taken to reduce a repeat recurrence, such as re-training of staff and putting new protocols in place to ensure staff are given time and a quiet environment to work in.
● People were supported to manage their medicines independently. One person said, "I'm self-medicating now. Staff remind me and audit them. They ask me to show them [my medicines]. I feel completely included. They discuss risk with me."

Preventing and controlling infection
● There were checks in place to prevent legionella bacteria developing in the home's water supply.
● The home was visibly clean. There was personal and protective equipment such as gloves, aprons and antibacterial gel for staff to use to prevent the spread of infection.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- There was a need for a more considered approach as to whether people were suitable to live at the service and ensuring that all risks, both historical and current, were known and understood.
- The decision-making process in relation to who would be suitable for a placement at Stepping Out was inconsistent. In several cases we found that appropriate background information was not gained prior to people moving into the service. This meant that not all information relating to risk was known, placing people and staff at risk of harm. One staff member said, "People can present well at assessment, so it's really important we have the history and risks planned for."
- The lack of a defined criteria resulted in the service accepting referrals where they struggled to meet the needs and manage the risks robustly. Equally, we observed the registered manager refusing a referral where they could potentially meet the risks and needs.
- There were plans to review the current criteria with commissioners, based on the limitations of the premises, level of facilities and staff competency.
- The provider advised us following the inspection that they have placed a hold on any new admissions to the service.

Staff support: induction, training, skills and experience

- Staff received training in relevant areas such as, safeguarding, medicines, fire safety, first aid, and mental health. However, given the increasing complexity of people living in the service, more specific training was required to ensure staff had the knowledge and skills to support people with complex mental health needs. One staff member said, "We do get training but could benefit with more [mental health] training. We are offered the chance to do [qualification] in mental health. We have mandatory and other training but feel mental health training is lacking."
- A representative of the provider told us that they had already identified more specific training as a need for staff, and had begun looking into sourcing more advanced training such as, mental health, drug misuse, risk management, personality disorder, suicide management, and self-harm.
- Staff received supervision and confirmed with us that these sessions were held regularly.
- There was an induction procedure for new staff in place.

Supporting people to eat and drink enough to maintain a balanced diet

- People had enough to eat and drink. People were able to help themselves to drinks and snacks during the day.
- People were supported to choose weekly menus. People were asked about the food options in surveys

which were issued periodically.
● One person was diabetic and prepared their meals independently. However, their support plan made no reference to this or their dietary needs so staff were aware of potential high blood sugars and how this may present.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with health and social care professionals to plan and monitor people's well-being. However, closer working was required to manage specific risks robustly, and gain advice and support in a timely manner.
● Staff supported people when required and accompanied them to health appointments.

Adapting service, design, decoration to meet people's needs
● Changes to the environment were not always considered in consultation with people. When we discussed potential changes to the communal areas to ensure people's safety, the approach of the registered manager was to make the changes immediately without any formal assessment of the level of risk or consideration of what people's views may be about any changes.
● Staff were aware that changes should be discussed with people and intervened to ensure they asked people's views and included them fully before making any changes.
● People arranged their bedrooms as they wanted them with personalised objects, photographs and individual furniture.

Ensuring consent to care and treatment in line with law and guidance
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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

● People's records made reference to decision making, and how staff should encourage this.
● One support plan we reviewed was very clear about the importance of involving the person in all decisions relating to their care.
● People had been asked for their consent to share information about them and have a photograph taken for their care records. Where people had not consented to this, we saw this had been respected.
● Where capacity to make decisions was in doubt, relevant professionals had been contacted to assess people.
● No applications for DoLS had been required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has changed to Requires Improvement. Although people were treated as individuals and respected by staff working directly with them, known risks were not always reviewed promptly by management to ensure people's safety. This does not reflect a fully caring approach.

Ensuring people are well treated and supported; respecting equality and diversity

- Despite the failings highlighted in other areas of this report, all of the people we spoke with told us that staff working directly with them were kind and caring and treated them with respect.
- People repeatedly gave us examples of where staff had gone the extra mile and changed their lives for the better. One person told us, "Every single member of staff genuinely cares. They are happy to be here and happy to help. I can always speak to people if I have problems. They are not judgmental. They promote you to do things and support you. I stabilised really quickly due to the support I have had here. I don't think I would have got to where I am without this space. I would be in [hospital] or dead." Another told us, "Stepping Out is like walking from the darkness into hope."
- We observed over two days that staff always treated people with kindness and gave them effective support when they needed it.
- Staff demonstrated they acted in people's best interests and spoke positively about people living in the service. One staff member said, "The whole team is supportive. We know each other so well. I feel people get a good level of care and it's rewarding. Staff really care. To see someone come from a place of trauma to achieving, is rewarding."

Supporting people to express their views and be involved in making decisions about their care

- People, where they were able, generally contributed to care planning, and their preferences for how they wished to be cared for were respected by staff. However, one person had no support plan in place, despite having lived in the service for over two months.
- Resident meetings took place quarterly, and minutes from these meetings showed that relevant items were discussed and people's views were documented.
- People were asked for their views via surveys. We saw that any comments were followed up with people via a letter, or via a discussion.

Respecting and promoting people's privacy, dignity and independence

- Staff respected people's privacy and dignity. We saw that staff knocked on people's doors before entering.
- Staff communicated with people in a way they understood and asked for permission before offering help and support.
- People were encouraged to be independent. This included how they managed their laundry and domestic tasks with a view to living independently. Staff had supported people to be more confident with accessing the wider community and undertaking voluntary work.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's support plans did not provide sufficient detail to enable staff to deliver care in line with people's care and treatment needs. Care plans contained old information in some cases, and in others, a lack of information regarding historical events which could impact on their current presentation and treatment needs.
- We found one person's support plan was blank, and they had lived in the service since September 2019. Staff told us of individual triggers that could cause distress to people in certain circumstances, but this important information was not documented so staff less familiar with people would know.
- Risks affecting people were not sufficiently detailed, and important aspects of people's mental health history were not always included in support plans to enable staff to understand people better and deliver the most effective care and support.
- Health information, such as diabetes, was not referred to. For one person there was no information about their diet, and how their mood influenced what they ate.
- Although there was a core group of staff who knew people's needs, agency staff were working in the service at times, which meant an even greater need for accurate and up to date information.
- Support workers were expected to update care records; however, they did not have protected time for this. One staff member said, "We don't have enough time to complete paperwork in an appropriate timeframe, we are always dealing with incidents on the ground and monitoring."

This demonstrated a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- It was not always clear how the service was ensuring people had contact with friends and others that were important to them. Two support plans we reviewed held limited information. For example, one support plan made reference to a friendship they liked to maintain when they felt able, but no other information about how often, or how this would be facilitated.
- People told us that staff supported them to take part in activities which would enhance their confidence and ability to integrate into the wider community. One person told us, "I have had support. [Staff] will drop me off for my volunteer work to help my anxiety. They encourage me, it's a great, great place. They promote you to do things and support you."
- Other people felt that group activities were currently lacking and would be beneficial. One person said, "Id like more group events, like a gardening project, or to all go out somewhere together." Given the staffing

levels, and people's increasingly complex needs, this had not always been possible to achieve.

We recommend that the provider reviews the current provision of group and individual activities, to ensure they are meeting people's individual needs.

Improving care quality in response to complaints or concerns

● There was a complaints procedure in place, and people told us they would tell staff members if they had concerns to raise. One person said, "I feel happy to raise any concerns, [registered manager] is alright, I can speak with them."

● No recent complaints had been made.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's records made reference to how they communicated, and any supportive methods staff should use. For example, in one case the person responded best when they were involved in any decisions regarding their care and needed staff to be clear when communicating with them to create boundaries.

● The service was able to provide information in alternative formats, such as large print, to meet people's needs if this was required.

End of life care and support

● No one using the service required end of life care and support at the time of our inspection. However, if required the service would liaise with health and social care professionals and specialised services to provide people with appropriate care and support.

● Staff had received training in end of life care.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were at risk of not receiving safe care. The provider failed to ensure a robust process was in place to assess people's needs prior to moving into the service. Staff told us they were unaware of some people's needs placing them at risk of unsafe care and treatment being delivered.
- Staff were not provided with clear guidelines on how to support people. For example, care plans were not always sufficiently detailed or reviewed, and one person had no care plan in place. The lack of robust recording of people's care needs and associated risks placed people at significant risk of harm.
- The governance framework had not ensured the delivery of high quality and safe care. Audits being completed were not sufficiently robust to enable the service to identify where safety and quality was being compromised, and drive continual improvement.
- The registered manager lacked knowledge of their responsibilities as a registered person. Staff lacked confidence in the registered managers' ability and felt at times this placed them at risk.
- Effective systems were not in place to allow continuous learning and improving care. For example, accidents and incidents had not been robustly investigated to identify further risks or triggers or prevent recurrence and to help ensure people's safety.

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

- The provider had identified the current systems to monitor quality were weak, and were in the process of implementing a new electronic governance system which senior managers will have full oversight of. This will include the monitoring of accidents and incidents.

- Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The registered manager had not submitted notifications to CQC for five incidents that had occurred and which they had reported to the police.

This was a breach of Regulation 18 (notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Whilst we acknowledge other external professionals and agencies had ongoing involvement in people's care, improvements are needed to ensure they work more collaboratively to contribute to individualised risk assessments and care planning.
● Staff did not always feel safe; they had raised concerns during a staff meeting that Stepping Out was becoming more of an alternative to hospital due to the increase in high risk referrals.
● Support workers were expected to update care plans and risk assessments but did not always feel confident to do this and did not have protected time for this work. One staff member said, "We do risk assessment training but no others like [how to complete] care plans. Feels like you are making it up as you go along."
● Resident meetings were held to hear people's views on the service and any concerns they might have. People spoke highly of staff who worked directly with them.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Staff spoke passionately about delivering person-centred care and we observed positive interactions between staff and people throughout our inspection.
● Despite the failings highlighted in this report, people gave us repeated examples of how staff had helped them overcome various difficulties and achieve a better life. Staff were committed to providing a high quality of care, despite them often working under pressure to meet all of their duties.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider and registered manager demonstrated that they understood, and would act on, their duty of candour responsibility.
● A recent incident demonstrated that the provider had adopted an open and transparent approach with other agencies during an investigation.

Working in partnership with others
● Staff told us they worked in collaboration with all relevant agencies, including health and social care professionals to help ensure there was joined-up care provision.
● Commissioning reviews are in progress to agree what Stepping Out are able to provide as a service, which ensures effective care and the safety of people and staff.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had not notified us of incidents relating to police involvement. 18 (1) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Support plans did not contain accurate and detailed guidance for staff to deliver effective care. 9 (1) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people and the environment were not being assessed or managed effectively. 12 (1) (2) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not sufficiently robust to identify where quality and safety was being compromised.

17 (1) (a) (2) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not sufficient to ensure the safety of staff and service users. 18 (1)