Elpha Lodge Residential Care Home Limited

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Inspection report

Elpha Lodge
South Broomhill
Morpeth
Northumberland
NE65 9RR

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Date of inspection visit:
30 January 2023
01 February 2023
16 February 2023

Date of publication:
22 May 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Elpha Lodge is a care home providing accommodation and personal care for up to 24 people with physical disabilities. At the time of the inspection there were 21 people living at the service. Support was provided across two buildings which had been adapted to meet the needs of people.

People's experience of using this service and what we found
The service was not well-led. There had been 3 changes of manager at the home during the last 12 months. The previous registered manager had left their employment after working at the home for a substantial number of years. These management changes had impacted upon the morale of some staff. A new manager had been recruited shortly before the commencement of our inspection. They were applying to register with CQC.

Some records across the service were disorganised and were difficult to locate. In addition, effective systems were not in place to audit and monitor quality across the service. For example, audits had not been completed at the frequency identified by the provider or had not identified the issues we found during our inspection.

An effective system to ensure all notifications were submitted to the CQC in a timely manner was not fully in place. The failure to notify CQC of incidents and other matters in line with legal requirements meant people were exposed to a risk of harm as there had been no overview by CQC to check whether the appropriate actions had always been taken.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Safeguarding systems were not robust enough to ensure people were always protected from the risk of abuse. Staff said they would report any concerns to the management team. However, we were not assured they understood their safeguarding responsibilities.

Safe and effective infection control procedures were not fully in place to ensure people were protected from the risk of infection. Medicines were not always managed safely. There were inaccuracies and omissions with the administration and recording of medicines. Staff were not always recruited safely and there were not always enough staff to meet people's needs. Risk assessments had not been completed for all the risks people were exposed.

Effective systems to ensure staff were supported and received the necessary training to enable them to carry out their job role were not in pace. Training was not delivered to all staff which was specific to the needs of people receiving support. For example, staff had not received training in relation to supporting people with learning disabilities and autism even though they were providing this support.

Consent had not always been assessed and the appropriate applications had not been made to authorise care and support where restrictions were in place for people in line with legal requirements. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The care and support provided by staff was not always person-centred to the individual needs of people and records did not confirm people had regular opportunities to take part in activities which were person-centred to them. In addition, people were not always treated with dignity and respect. We have made a recommendation about this. Systems were in place to investigate and respond to complaints. People were supported with their communication needs and advocacy services were used to support people where people required support to express their views. End of life care plans were not in place to ensure any wishes people had for their end-of-life care were recorded. We have made a recommendation about this.

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

Rating at the last inspection
The last rating for this service was outstanding (published 27 December 2017).

Why we inspected
We received concerns in relation to the treatment people received and the overall management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective, and well-led only.

We inspected and found there was a concern with the management of safeguarding matters, staff training and the overall governance of the service, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of safe, effective, caring, responsive and well-led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from outstanding to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Enforcement and Recommendations
We have identified breaches in relation to person-centred care, need for consent, safe care and treatment,

safeguarding, good governance, staffing, safe recruitment and a failure to notify incidents to CQC at this inspection. We have also made recommendations in relation to dignity and respect and end of life care for people.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Elpha Lodge Residential Care Home

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was undertaken by 1 inspector 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.

Service and service type
Elpha Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Elpha Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 2 months and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service, including the statutory notifications we had received from the provider. Statutory notifications are reports about changes, events or incidents the provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams, the local NHS IPC team, fire service and Healthwatch to request feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 12 relatives about their experience of the care provided. We spoke with 5 members of staff including the manager, deputy manager, care staff and the Nominated Individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We emailed 32 staff to request their feedback about working at the service and received 7 replies. We also emailed 7 health and social care professionals to request feedback about the service and received 1 reply.

We reviewed a range of records, this included care records for 9 people and multiple medicines records. We looked at the recruitment records for 3 staff and reviewed the training records of 4 staff. We also reviewed a variety of records relating to the management of the service, including policies and procedures.

Following the inspection site visits we requested additional information by email and continued to seek clarification from the provider to validate the evidence we found.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Safe systems were not in place to protect people from harm. We were not assured the management team understood their responsibilities in relation to safeguarding people. For example, safeguarding referrals had not always been made following allegations of abuse.

The provider's failure to ensure systems were in place to safeguard people from the risk of abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely; Preventing and controlling infection

- Risks relating to people and the environment had not been effectively assessed and monitored. For example, risk assessments had not been completed for 2 people who had recently moved to the home.
- Medicines were not always managed safely. For example, body map documentation was not in place to guide staff on where topical medicines [creams and lotions applied to the skin] needed to be applied.
- Staff did not always follow safe working procedures for the administration of controlled drugs. For example, two staff had not always checked these medicines prior to their administration.
- Systems were not always effective in preventing the spread of infection. For example, people were not supported to wash or sanitise their hands prior to mealtimes. This included one person who was eating finger foods with their hands.

The above shortfalls were 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 provider updated us action had been taken to ensure all staff who administered medicines had received training to ensure they were competent to complete this task. This was to support the safe administration of medicines.
- The service had engaged with the local NHS IPC team for support. They had offered advice and suggested alternative ways of working to improve the infection control systems in place.
- There were sufficient supplies of PPE for staff use and they had received training in how to use this.

Visiting in care homes

- Systems were in place to support people to maintain relationships with their relatives and friends. This included visits to the home and maintaining contact with the use of technology such as the telephone.

Staffing and recruitment

● Safe recruitment practices had not been followed. Gaps in the employment history for potential employees had not always been considered during the recruitment process. In addition, robust pre-employment checks had not always been completed. For example, checking the information provided in references corresponded to the information recorded in an applicant's employment application.

The provider's failure to ensure staff were recruited safely was a breach of Regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was not always enough staff available to safely meet people's needs. A recognised dependency tool was not used to determine how many staff were required which reflected the needs of people.

● Staff told us the lack of staff affected the care and support people received. A member of staff told us, "After tea you can have 5 or 6 people all wanting support and there is only 2 staff on duty. If 2 staff are supporting someone there is no one else to support the other residents."

● Agency staff were used to cover shifts when regular staff were not available. We received some feedback regarding the skills of some agency staff and that this impacted on the consistency of care provided. The provider told us they had liaised with the agency to request consistent staff were used to support the home.

The provider's failure to ensure there were enough staff to meet people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Effective systems were not in place to learn from situations and events. One member of staff told us, "We don't do reflective practice, so we don't reflect on our interactions with people."

● Accidents and incidents were recorded. However, effective systems were not in place to analyse incidents to assess for any patterns or trends. The management team had not considered if alternative ways of working could be introduced to deliver improvements.

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 our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
- Effective systems to ensure staff were supported and their performance monitored were not in place. Throughout the inspection we saw some staff supported people in ways which were not person-centred. The skills of staff when interacting with people had not been monitored by the provider.
- Staff had not received regular supervision as specified in the providers policy. One staff member told us, "I've had a supervision today but my one before that was a while ago."
- Training considered mandatory by the provider was not always delivered to staff. In addition, from 1 July 2022, all health and social care providers registered with CQC must ensure their staff receive training in learning disability and autism, including how to interact appropriately with people with a learning disability and autistic people. The provider had not implemented the 'Oliver McGowan' mandatory training on learning disability and autism which is the government's preferred and recommended training for health and social care staff to undertake.

The provider's failure to ensure staff were supported, received on-going supervision and received the necessary training to enable them to carry out their job role was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection the provider told us action had been taken to ensure all staff completed the necessary training in learning disability and autism.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions

relating to those authorisations were being met.

● Mental capacity assessments were not always in place. This meant principles of the MCA had not been properly followed by staff or the management team to ensure people understood specific decisions and gave their consent to the care and support they received.
● Processes were not always followed correctly to ensure people's rights were upheld and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions themselves. For example, restrictions were in place for some people who lacked capacity to consent to their care and treatment without the appropriate legal authority in place.

The provider's failure to ensure the principles of the MCA were followed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The management team had not made sure the systems in place had been effectively managed to ensure care was delivered in line with standards, guidance and the law. Regulations, nationally recognised guidance and laws around the MCA, DoLS and Human Rights were not always followed properly.
● Assessments of people's needs had been completed. However, they had not always been evaluated or updated and were not always detailed.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional and hydration needs were met. However, the lunch time meal experience we saw was task orientated rather than person centred. For example, some staff were standing while supporting people with their meal and not communicating with them to explain what they were going to do before delivering support.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records did not always demonstrate appropriate action had been taken to support people assessed as being at nutritional risk. For example, weekly weight monitoring had not always been completed for people assessed as requiring this support. In addition, weight records for one person with a significant weight difference over a 3-month period did not demonstrate what actions staff had taken to address this.
● Staff worked with healthcare professionals to meet people's needs. A healthcare professional told us, "Staff appear to be very attentive to the needs of people."

Adapting service, design, decoration to meet people's needs
● Some areas of the home required refurbishment. A programme of redecoration had begun, and people had been involved in the plans for this. For example, people had contributed their views in relation to changing the colour schemes of communal areas.
● People were able to personalise their bedrooms with items of their choosing which were important to them.

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 our last inspection we rated this key question outstanding. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- The privacy and dignity of people was not always respected. For example, monitors were used to listen to 3 people in their bedroom overnight. The monitor used for 1 person had not been switched off during the day. This meant anyone in the office and corridor could hear what was happening in this person's bedroom.
- Staff did not always demonstrate caring attitudes towards people. For example, we saw some staff not talking to people to explain what they were going to do before doing it. In addition, we also received feedback from 1 staff member who felt some of their colleagues could be more patient with people. They also provided feedback of feeling some staff needed to reflect on their practice to consider different ways of working when engaging with people who were distressed.

We recommend the provider reviews the systems in place to ensure people are always treated with dignity and respect.

- People gave positive feedback about their interactions with staff. One person said, "Ask the staff anything or ask the staff to help you and they'll do it straight away. They are nice friendly and polite."

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

- People's communication needs were recorded in care plans. Staff knew the most effective ways to support people to express their views.
- Referrals had been made to health professionals to assess the communication needs of some people. This helped staff to engage effectively with people who needed more support with their communication needs.
- Advocacy services were used to support some people if this was required. An advocate helps people to access information and to be involved in decisions about their lives.

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question outstanding. At this inspection the rating has changed 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

- An effective care planning system was not fully in place. Care plans had not always been updated to reflect people's needs or been reviewed at the frequency identified by the provider.
- We identified shortfalls in care records relating to medicines, person-centred care, consent, safeguarding and the management of risk. These shortfalls meant people were at risk of receiving unsuitable or inconsistent care because staff did not always have clear guidance about how to support people's specific individual needs.

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

- Person-centred care and support was not always delivered to people. For example, we received feedback from staff that the routine of the home was to start getting people ready for bed at 6pm. This was a staff routine rather than a person-centred choice for people and this routine had been in place for several years.
- People's social needs were not always met. A range of activities were organised. However, we received feedback from staff there were not always enough activities planned which all people could take part in especially at weekends. In addition, we also received feedback there was a lack of opportunity for people to participate in activities outside of the service.
- Records did not demonstrate people had been offered to participate in, or had engaged in regular meaningful activities.

The provider's failure to ensure care and support was person-centred to the needs of each individual was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were met. Information was available in accessible formats. For example, easy read documents had been produced using pictures to support people who could not understand written words.

Improving care quality in response to complaints or concerns

● Complaint procedures were in place. No complaints were raised with us throughout the inspection period.

End of life care and support

● No-one living at Elpha Lodge was receiving end of life care. Care plans were not in place which reflected people's wishes for their end-of-life care.

We recommend the provider reviews the care plans in place to ensure they reflect any wishes people may have for their 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 our last inspection we rated this key question outstanding. At this inspection the rating has changed 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

- We found widespread shortfalls in relation to many areas of the service provided to people living at Elpha Lodge, as detailed throughout this report.
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 are the minimum standards below which care should never fall. The provider's failure to meet these regulations meant that people received a level of care that did not meet relevant legal requirements.
- The provider did not operate an effective governance system. For example, audits had not always been completed at the timescales identified by the provider to properly monitor the safety and quality of the service.
- The service user bands for the service were not always reflective of the needs of the people. For example, supporting people diagnosed with learning disabilities or autism was not listed as a service provided by this service even though the home was providing this support. The management team were not familiar with relevant best practice guidance which should be considered when supporting people with learning disabilities and autism.
- Systems were not in place to ensure the 'Statement of Purpose' for the location was up to date. A statement of purpose is a legally required document that includes a standard set of information about a service. We brought this to the attention of the manager who organised for an updated document to be sent to CQC in line with requirements.

The providers failure to ensure an effective governance system were in place was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- A registered manager was not in post. A new manager had been recruited and had applied to register with CQC. They responded to our feedback and started to develop action plans to improve quality at the service.

- A system to ensure statutory notifications were always sent to CQC was not in place. Statutory notifications are incidents and events which must be reported to CQC by law. This meant CQC did not have oversight of all notifiable events to ensure appropriate action had always been taken.

This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. This is being dealt with outside of the inspection process.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The culture of the service did not always promote person-centred care. For example, routines being in place to accommodate staffing rather than the choices of people.

● Action was taken in response to the inspection findings to deliver service improvements. For example, the manager had a plan in place to ensure all staff received regular supervision.

● The manager was in the process of organising meetings with the relevant heads of department. They were working proactively to develop action plans for the service and to give staff more areas of responsibilities. The manager planned to introduce 'champions' across the service where staff would receive more training in a specific area so they could then offer support and advice to their colleagues.

● Systems were in place for the sharing of information with relevant people. For example, with people, health care professionals or with relatives. One relative told us, "We always have regular questionnaires [to provide feedback about the service]."

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 manager worked in an open and transparent way. Duty of candour policies and procedures were in place. No notifiable safety incidents had taken place.

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 9 HSCA RA Regulations 2014 Person-centred care An effective system to ensure people received personalised care and support was not fully in place. Regulation 9 (1)(3)(a)(b)(c)(d)(f)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Processes were not always followed correctly to ensure that people's rights were upheld and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions themselves. Regulation 11 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment An effective system to assess, monitor and manage risk was not in place. Regulation 12 (1)(a)(b)(c)(d)(g)(h).

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 An effective safeguarding system was not in place. Regulation 13 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system to monitor the quality and safety of the service was not in place. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed An effective system to ensure staff were recruited safely was not in place. Regulation 19 (1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing An effective system to ensure sufficient numbers of suitably skilled, competent and supported staff were deployed, was not fully in place. Regulation 18 (1)(2)(a).