Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St Joseph's Care Centre
Name of provider:	Health Service Executive
Address of centre:	Dublin Road, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	14 November 2024
Centre ID:	OSV-0000466
Fieldwork ID:	MON-0044307

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St Joseph's Care Centre provides 24 hour nursing care for up to 65 residents of all dependency levels, male and female, predominantly over 65 years of age. The centre can provide care to a range of needs of various complexity including dementia care and cognitive impairment, acquired brain injury, palliative and palliative respite care. The centre is single storey and comprises of two buildings containing five units. There are communal rooms and internal gardens available to residents as well as a large chapel. The centre's philosophy and motto is to 'add life to years when you cannot add years to life' and aims to address the physical, emotional, social and spiritual needs of all residents with a holistic approach of empathy and kindness. The centre is located in Longford town within easy reach of nearby shops and restaurants. Parking facilities are available on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	57

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 14 November 2024	09:00hrs to 17:15hrs	Catherine Rose Connolly Gargan	Lead
Thursday 14 November 2024	09:00hrs to 17:15hrs	Karen McMahon	Support

What residents told us and what inspectors observed

Overall, the inspectors observed and the majority of residents spoken with confirmed that they were supported to live comfortably in the centre and were adequately cared for by staff who were attentive to their needs for assistance and were aware of their needs and personal preferences. From the inspectors' observations during the day of the inspection, residents' rights and quality of life were impacted by significant restrictions in their environment and limited opportunities available to them to participate in social activities in line with their capacities and interests.

Following an introductory meeting with the person in charge, the inspectors walked around all areas of the premises. This gave inspectors the opportunity to meet with residents and staff, to observe the lived experience of residents in their home environment and to observe staff practices and interactions. During this time, residents were observed to be getting up from bed with the assistance of staff,in the communal sitting rooms and walking on the corridors within the units. Residents appeared to be well-dressed and were neat and tidy in their appearance. Some residents wore items of jewellery. Many staff interactions with residents demonstrated kindness but the inspectors observed that a number of staff interactions with residents were hurried and involved completing tasks of care. The inspectors observed that most staff knew residents well and residents were comfortable in their company, however two staff in one unit were new to the centre and were still getting to know residents.

The majority of residents spoken with by the inspectors said they were happy and content living in the centre, that their bedrooms were comfortable and they were satisfied with their daily routines and quality of life in the centre and commented that the centre was 'a grand place to lice in' and that staff were 'friendly and kind'. However, some residents comments to the inspectors included that they 'do nothing during day', 'don't go out' and ' the day is long'. This feedback concurred with the inspectors' observations. The inspector observed that residents' social activities were facilitated by two social activity coordinators on the day. One activity coordinator was observed facilitating group activities in the sitting room of Padre Pio, for six residents on the morning of the inspection and two activity coordinators facilitated a larger group of residents to take part in social activities in the afternoon, in the assembly room. No other group activities were observed taking place throughout the day on any other unit and inspectors observed that there was a heavy reliance on televisions for residents in the sitting rooms and in bedrooms who did not participate in group activities.

While walking around the centre, the inspectors observed that the doors to each of the five units of residents' accommodation were secured with an electronic keycode lock. The inspectors saw staff assisting and accompanying two residents to exit one of the units. The inspectors were told that the code for each door was displayed for residents' information. However, this information was not available by all exit doors

and the inspectors observed that given the profile of the majority of residents in the centre, they would not be independently able to access this information and unlock the doors independently. The inspectors also observed that while access in the main entrance was controlled by staff, there was unrestricted access from the outside of the designated centre to the day service facility for members of the public who were observed using this service on the day. This entrance to the day services facility was in the designated centre. Furthermore member of the public accessed the physiotherapy and speech and language therapy clinics also located on a corridor that is part of the designated centre and in the residents environment.

Residents' bedroom accommodation was arranged on ground floor level throughout. Sunset and Autumn Lodge units were located in a separate building on an elevated site at the back of the rest of the centre premises. The Lodge units were accessible via steps and a pedestrian sloped walkway. Handrails were fitted along the sides of the corridors and they were wide enough for passage of larger assistive equipment such as large wheelchairs used by residents. The layout of residents bedrooms met their needs and the inspectors observed that a number of the residents chose and were supported by staff and their families to personalise their bedrooms with their photographs and other personal items that were important to them. The communal dining rooms and sitting rooms were bight, spacious and well decorated with traditional furnishings and memorabilia that was familiar to residents. The inspectors observed that no residents were accommodated in OLU 2 unit at the time of this inspection and the bedrooms in this unit was used for storage of excess furniture and other equipment. The furniture had been removed from the sitting and dining room in this unit. One of two assisted showers in OLU 1 unit was been used as a staff locker room and was not available for residents' use. There was storage of residents equipment in a the visitor's room off the reception area and in a number of utility rooms throughout the centre.

Residents could meet with their visitors privately outside their bedrooms or spend time in a quieter area in the visitors' rooms or in the multi purpose room in the reception area.

Residents told the inspectors that they would talk to the staff or members of their families if they were worried about anything or were not satisfied with any aspect of their care or the service provided to them. Residents said that staff always listened to them and any issues they had raised had been addressed to their satisfaction.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.The findings in relation to compliance with the regulations are set out under each section.

Capacity and capability

Overall, the inspectors found that the service provided to residents was not aligned to the centre's statement of purpose and registration conditions. The inspectors found that there was a significant decline in compliance with the regulations since the last inspection carried out in May 2024 and this was having a negative impact on residents' safety, care and supports, rights and quality of life. This inspection found that the management and oversight of this service was not effective and the quality assurance processes in place did not ensure that this service was safe, appropriate and effectively met residents' needs. Furthermore, the provider was not operating the designated centre in line with their statement of purpose and conditions of registration. The provider had breached Condition 1 of their registration as they had changed the registered purpose of a number of rooms without the agreement of the chief inspector. The rooms involved are described under Regulation 23: Governance and Management.

This was an unannounced risk inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and follow up on the actions the provider committed to in their compliance plan to address significant non-compliance with the regulation as identified during a previous inspection carried out in May 2024. This inspection also followed up on both unsolicited and solicited information received to the office of the Chief Inspector.

The registered provider of St Joseph's Care Centre is the Health Service Executive (HSE). The day to day management in the centre was overseen by the person in charge, who was full time in the role and worked Monday to Friday. The provider is represented by a general service manager. As a national provider involved in operating residential services for older people, this centre benefits from access to and support from centralised departments such as human resources, information technology, staff training and finance. The person in charge was supported in their role by an assistant director of nursing, clinical nurse managers, staff nurses, healthcare assistants and cleaning,catering and administration staff.

The Inspectors reviewed the worked staff rosters and observed staff practices and were not assured that the skill mix of staff available ensured adequate supervision and delivery of safe care to residents. This had resulted in poor care practices. Inspectors also found that the provider had not provided adequate staff to replace a high level of unplanned leave in the centre recently by a number of clinical nurse managers. Inspectors found that remaining clinical nurse managers were being primarily used to supplement nursing administration in the centre and as a result were not providing clinical support to staff or supervision of care delivery to residents on their assigned units. This finding was further negatively impacting on the standards of and effective of care that residents were receiving.

There was an ongoing mandatory and professional development staff training programme in the centre. The training matrix provided to inspectors recorded overall high levels of staff attendance at mandatory training including fire training, infection prevention and control and safeguarding training. There was a staff training schedule in place for the year to ensure all training was kept up-to-date. However, the inspectors were not assured that staff were appropriately and

effectively supervised in their roles. These findings are discussed further under Regulation 16: Training and staff development.

The quality assurance systems in place for monitoring the quality and safety of the service were not effective and consequently much of the inspectors' findings on this inspection had not been identified by the provider through their oversight and auditing processes. There was limited evidence that action plans were progressed to completion and there was no sustained improvements found in the overall level of compliance recorded on the audits reviewed by the inspectors since the last inspection in May 2024.

Regulation 15: Staffing

The registered provider did not always ensure that the number and skill mix of staff was appropriate and adequate to meet the needs of residents. For example;

- On one unit there was no senior staff nurses on duty on the day of inspection, both nurses on duty that day had been recently recruited to the centre.
- Contingency plans to cover staff shortages or leave were inadequate with inspectors identifying a number of days where units were left short staffed due to sick leave, this was further impacted by the use of clinical nurse managers to cover the nursing administration office on the campus.

This had resulted in poor care practices and limited opportunity for recreational or occupational activities for residents residing in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that they carried out their work to the required standards. This was evidenced by the following findings;

- Inspectors observed that staff kept their personal consumables including free fluids in resident's communal spaces and along the handrails on the corridor. This posed a risk to residents who were on modified diets or thickened fluids and who may mistake them as being available for their consumption.
- Staff were observed using resident's communal spaces for their breaks, despite access to a large staff canteen on site. This resulted in restricted access to communal spaces for residents.
- Residents' care plan assessments and documentation was not adequately completed by staff to ensure that that their care plans clearly directed staff on the care they must provide to meet each residents' assessed care needs.

As a consequence, the inspectors found that this was impacting on residents' care delivery.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider was not operating the designated centre in line with their statement of purpose and conditions of their registration. The provider had breached Condition 1 of their registration as they had changed the purpose a number of rooms in the centre including residents' bedroom and communal accommodation as follows;

- An assisted bathroom in OLU 1 unit was also being used as a staff locker room.
- The residents bedrooms in OLU2 were being used to store excess furniture and other items. The residents' dining and sitting rooms in this unit were set up as interview rooms for recent interviews. The inspectors observed that this unit and was not accessible to residents and were told by the person in charge that it was not available for accepting admission of new residents.
- The clean linen storeroom in OLU1 was repurposed as a store room for hoists, weighting chairs and wheelchairs.
- A refrigerator designated for storage of food belonging to staff was in place in each of the residents' dining rooms. This reduced the communal space in these rooms for residents use.

The registered provider had failed to ensure that resources in the centre were planned and managed to ensure person-centred, effective and safe services in line with the designated centre's statement of purpose. There was a poor skill mix of staff and contingency plans to cover staff shortages and leave were found to be inadequate, as detailed under Regulation 15: Staffing. Insufficient staffing levels resulted in poor oversight of staff practices which were negatively impacting on residents' care and welbeing. For example;

- A time bound plan was not in place to fill the vacant Healthcare Assistant roles in the centre
- Staff were observed using resident's communal spaces for their breaks, this was a recurrent finding from the previous inspection in May 2024.
- There was a noted increase in pressure ulcers developing on residents' skin in the centre over the past 12 months.
- Residents' social care needs were not being met

The registered provider's oversight and management of risk in the centre was not effective. Consequently, there were poor systems in place to identify, manage and respond to risk. This was evidenced by the following findings;

- failure to ensure residents were appropriately safeguarded from risk of abuse. Risk of unauthorised access to the residents' environment by the public was not identified, assessed and effectively mitigated
- failure to ensure residents' safe nutritional intake. Residents had unsupervised access to unlocked refrigerators in the dining room containing staff meals. This posed a risk to residents with needs for modified consistency food and fluids to ensure their safety and welbeing. This risk was not assessed and effectively mitigated
- failure to oversee infection prevention and control and fire safety measures in the designated centre. The inspectors' findings are detailed under regulations 27: Infection control and 28: Fire precautions

The quality assurance systems in place for monitoring the quality and safety of the service were not effective and had not identified many of the inspectors' findings on this inspection. Furthermore, there was limited evidence where action plans were developed identifying improvements needs, that these improvements were progressed to completion. Consequently, the levels of compliance in audits completed had not significantly improved since the last inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was an up-to-date statement of purpose available which detailed the information as set out under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of accidents and incidents involving residents in the centre was maintained and notifications and quarterly reports were being submitted as required and within the time-frames specified by the regulations.

Judgment: Compliant

Quality and safety

This inspection found that improvements were required to ensure that a safe and good quality service for residents was provided, particularly in the areas of nursing assessments and care plans, residents' rights and protection of vulnerable residents.

Overall residents had timely access to medical and allied health professional expertise to meet this needs and inspectors found that most residents' medical and health care needs were generally met. However, actions were necessary to address suboptimal standards of care provided for residents' at risk of skin breakdown, or with wounds caused by pressure to areas of their skin.

Inspectors observed an unacceptable institutional approach to the provision of care. For example residents in the units did not mix with each other as the doors to each of the units were locked. Furthermore interactions by staff with residents were predominantly limited to providing care interventions with limited evidence of quality person-centred interactions.

Overly restrictive and institutional practices were found on this inspection that prevented residents from accessing communal accommodation or the other units in the centre without the assistance of staff to open secured doors for them. This practice limited residents' opportunities to engage in meaningful social interactions with each other and with staff, was having a negative impact on residents' quality of life and wellbeing and did not uphold their rights to determine how and where they spent their day.

Significant actions were necessary to ensure residents' needs were comprehensively assessed and their care plan documentation reliably guided staff on the care and supports that should be provided for them by staff. Improvements were also required to ensure that those residents with communication needs were able to make informed choices about their menu options.

Several residents' nursing and social care needs were not comprehensively assessed to a satisfactory standard and consequently care plans were not either not developed or updated to direct staff on the care and supports they must provide to meet residents' needs. For example, many of the residents' social activity needs were not assessed and resulted in residents not having access to suitable and meaningful social activities that met their capacities and interests. Care of residents' skin integrity did not reflect evidence based practice and there was an increased incidence of pressure ulcers developing on their skin in the centre. The inspectors' findings are discussed further under regulations 5; Assessment and Care Planning and 6, Healthcare.

Residents had timely access to their general practitioners (GPs), physiotherapy and occupational therapy services. However, there was an increased incidence of residents falling in the centre and while some actions were described to mitigate risk of recurrence, these actions were not consistently implemented. For example, increased supervision by staff was referenced as a measure to reduce the risk of residents falling but the inspectors observed that there were periods of time during the day of the inspection when staff did not remain with residents in the communal rooms.

Residents accommodation in the centre was arranged on ground floor level in five units known as OLU 1, OLU 2, Padre Pio, Sunset Lodge and Autumn Lodge. No residents were accommodated in OLU 2 at the time of this inspection. Residents' bedroom accommodation was provided in a variety of single, twin bedrooms and bedrooms with three and four beds. There was a communal sitting and dining room available in each unit. A sensory room, chapel, smoking room, hair salon, a multi-purpose activity room and a visitor's room were located in and close to the reception area of the centre. Due to the environmental restrictions in place, residents could not access these communal facilities outside of the units as they wished, without the assistance of staff to open the secured unit doors for them.

Notwithstanding improvements made by the provider since the last inspection to protect residents from risk of fire, the inspectors found that action was required to bring the centre into compliance with the regulations and to ensure that storage of oxygen was appropriately risk assessed and risk of fire was effectively mitigated.

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors in a designated visitors room. Visits were encouraged with precautions to manage and mitigate the risk of introduction of COVID-19 infection.

Residents had access to local and national newspapers and radios. While televisions were available in the communal sitting rooms, some residents in multiple occupancy bedrooms shared a television and did not have individual choice of television viewing and listening as they wished.

Although measures were in place to ensure residents were safeguarded from abuse, poor oversight of implementation of these measures did not ensure they were effective. As unauthorised access by the public through the residents' environment was not effectively controlled and managed, the inspectors were not assured that residents' risk of abuse was adequately mitigated.

Inspectors found that the provider had a number of measures in place to protect residents from risk of infection. However, weaknesses were identified in infection prevention and control oversight, risk management, and environmental and equipment management.

Regulation 10: Communication difficulties

Inspectors were not assured again on this inspection that residents with communication difficulties were being facilitated to communicate freely, particularly around meal choices, as there was no robust system in place to communicate meal choices to residents' with communication difficulties. Furthermore, a schedule detailing social activities scheduled for the week was not displayed in a format that was easily accessible to residents with reduced vision or mobility.

Judgment: Substantially compliant

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed visiting residents in the centre on the day of inspection. Residents told the inspectors that their visitors were always welcomed and that they were able to meet with their visitors in a private area outside of their bedrooms as they wished.

Judgment: Compliant

Regulation 17: Premises

A number of areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows;

- Paint was damaged and missing on the wall and wooden surfaces on a number of the corridors, communal rooms and residents' bedrooms. These findings did not ensure that these surfaces could be effectively cleaned.
- There was insufficient designated storage areas available for storage of residents' assistive equipment. The inspectors observed that residents' equipment was inappropriately stored in the sluice rooms, the visitor's room near the reception area, sluices and the cleaner's rooms. This posed a risk of cross infection.
- The floor covering in a number of areas was damaged and in need of replacement.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did meet the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018) to be fully compliant. For example;

- There was storage of a staff member's handbag in the clean linen storage press and staff handbags and personal clothing were stored in the residents' dining room in one unit. Reusable water bottles belonging to staff were stored on the handrails and in the dining rooms in two units. These findings posed cross infection risk to residents.

- An operational fan hand dryer was available in one communal toilet in use by residents and there was no evidence available that this equipment was appropriately risk assessed to ensure any risk to residents of cross infection was effectively mitigated.
- There was dust and grit on the floor surface in an activity equipment storage room. Shelving provided was of a porous material and did not support effective cleaning.
- There was storage of open packs of disposable bedpan covers on the sink draining area in one sluice room. This did not ensure that surfaces could be effectively cleaned and posed a risk of infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not ensured that residents were protected from risk of fire as follows;

- Oxygen cylinders were not stored safely. There were two oxygen cylinders stored in each unit in clinical rooms containing potentially combustible materials. Furthermore, an oxygen cylinder was stored in a free-standing transportable case along the side of a circulating corridor on one unit.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The assessment and care planning processes did not ensure that residents' needs were adequately assessed and the care plans developed were sufficiently detailed to guide practice. Furthermore care plans were not updated when a resident's condition changed. This was evidenced by the following findings;

- There was a disconnect between residents' assessments and care plans. When assessments were completed, care plans were not updated with the revised information, which meant that in numerous instances there were discrepancies between the information contained in the assessments, the care plans and the nursing notes. This could cause confusion and risk to residents. For example the inspectors' found that two residents' care plans directed that their nutrition was delivered by percutaneous endoscopic enterostomy (PEG) tubes. However in the most recent assessments by the speech and language therapist and from the inspectors' observations, this route for their nutrition had been ceased and both residents were eating their food orally. In addition there were a number of residents with care plans

developed to guide staff how to provide care for breaks in the resident's skin. However, these skin breaks had now healed and the resident's skin was intact.

- The recomendations of the dietician, tissue viability nurse specialist and speech and language therapist were not being accurately referenced in residents' care plan to inform staff on the care they must provide to residents further to specialist healthcare reviews.
- There was evidence that care of residents who were at risk of skin breakdown was not adequate and as a result some of these residents were developing pressure ulcers. The inspectors found that one resident had two skin care bundles for the same wound and it was not clear which of these staff should refer to regarding ensuring this resident's skin integrity.
- Care plans for residents with an assessed high risk of developing pressure related skin damage did not adequately inform staff on the care they must provide to ensure their skin integrity. For example, frequency of position changes. Furthermore, records were not available to evidence that residents' position changes were completed by staff.
- Further to the inspectors' review of five residents' care documentation including one resident under 65years of age, care plans were not developed further to their assessments which identified a need for assistance and support from staff with participating in suitable social activities to meet their interests and capacities. As a consequence, these residents did not have a suitable social activity programme developed and were not adequately supported by staff to participate in social activities that met their assessed needs.
- Residents experiencing responsive behaviours impacting on other residents' safety were not sufficiently detailed to guide staff on managing these residents' behaviours. For example, the triggers to one residents' behaviours, although known and the most effective strategies to de-escalate the behaviours were not detailed in their behaviour support care plan. Therefore, guidance was not available for staff to ensure this resident's dignity was preserved by supporting the resident to prevent the behaviours occurring and where they occurred to effectively de-escalate the behaviours.
- The care plan for a resident with diabetes and on insulin therapy did not guide staff on the times or frequency with which they should assess this resident's blood glucose levels, the parameters their blood glucose should be maintained within and the actions staff should take if the blood glucose measurement is outside these parameters.

Judgment: Not compliant

Regulation 6: Health care

Nursing practices in relation to residents' assessment and care documentation did not ensure that residents received a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus

Cnaimhseachais. The inspectors' findings are discussed further under Regulations 5: Individual assessment.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There were a number of overly restrictive practices in place which negatively impacted on the rights of the residents and for which staff could not provide a rational explanation. These restrictions were not in line with national guidance;

- The entrance doors to each of the resident accommodation units were locked by means of an electronic keycode lock. This meant that residents could not exit the unit that their bedroom was located in to go to any other part of the designated centre including the church without the assistance of staff to open the doors for them.

Furthermore residents access to the outdoor area from Padre Pio unit was restricted by locked doors.

Judgment: Not compliant

Regulation 8: Protection

Access by unauthorised persons into the designated centre was not effectively managed. Members of the public had uncontrolled access to the residents' environment through the entrance to the day service unit and the physiotherapy and speech and language therapy clinics. There was no evidence available to provide assurances that risk was assessed and effectively mitigated to ensure residents' safeguarding needs were met at all times.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had failed to ensure that residents were provided with adequate opportunities to participate in meaningful social activities that met their interests and capacities. The inspectors observed that many of the residents sitting in the sitting rooms on the day of the inspection and other residents who spent their day in their bedrooms were not supported to participate in social activities to meet their interests and capabilities. This observation was supported by feedback from a

number of residents who told the inspectors that did not participate social activities and that the day felt long and boring for them. There was no documentation available regarding the social activities residents' participated and engaged in to meet their needs

Residents were not supported to exercise choice in their daily routines. This was evidenced by the following:

- The doors from the centre to the outdoor area for residents' use were secured and this meant that residents could not choose to access this outdoor space as they wished without a member of staff being available to open the doors for them.
- Two residents in multiple occupancy bedrooms shared one television. Provision of one television in for sharing between two residents did not ensure that each resident had choice of television viewing and listening.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Joseph's Care Centre OSV-0000466

Inspection ID: MON-0044307

Date of inspection: 14/11/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The roster across each Unit has been reviewed to ensure the skill mix of staff is appropriate to meet the needs of residents. Newly recruited nurses are now rostered across the three units to ensure an even ratio and skill-mix of experienced senior nurses working alongside newly recruited nurses.

Clinical nurse managers are no longer requested to cover nursing administration duties and their work shifts are dedicated fully to their assigned Units of responsibility.

Contingency plans to manage staff shortages in the event of unplanned leave have been updated through the following actions;

1. Eight (8) WTE permanent HCA posts were offered and accepted by the candidates with with some start dates now agreed.
4.5 WTE MTA posts were offered and accepted via Agency Conversion.

2. A total of 12 WTE Staff Nurses have been recruited. First staff nurse commenced 17/06/2024 and the final candidate commenced 09/12/2024. All new staff nurses have completed the 6 weeks supernumery induction period

3. The daily roster is reviewed by the PIC or A/DON to ensure the planned and actual working roster has a suitable skill-mix with senior staff rostered to ensure clinical oversight in each Unit. The practice of local changes to the roster has been dis-continued and all changes to the roster now have to be approved in advance by the PIC or ADON.

4. A CNM II /CNM1/Senior staff Nurse is assigned and identified on the roster in each unit across the Centre to support staff and ensure clinical oversight and supervision of staff.

In the event of unplanned absences nursing staff and HCA's shifts are covered by

overtime or agency staff. There is a regular cohort of agency staff used who are familiar with residents to manage any shortfall in the actual roster.

The PPIM now visits the Centre on a weekly basis, at a minimum, to review quality and safety within the designated centre. A walk around is completed by the PPIM and the PIC of the Centre to ensure oversight of the quality and safety arrangements and to ensure new practices continue to be embedded within the designated centre.

The planned roster is completed four weeks in advance and reviewed by the PPIM to support contingency planning for any anticipated and unplanned shortfalls and deficits which are escalated to the Provider.

Provider has engaged with HR to ensure recruitment of all HCA and MTA posts on a permananet basis.The Provider has a monthly goverance meeting with the PIC & PPIM. This meeting focuses on governance, quality and safety. A standing item on the agenda is review of staffing including vacancies, agency usage and other staffing issues.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff have been instructed that all staff breaks must take place outside of resident's communal spaces in each Unit across the Centre and all staff's personal belongings, including consumables, must be stored in the staff lockers provided. This is monitored by the CNM or senior nurse on duty in each Unit in addition to daily walk arounds by the PIC & A/DON to monitor staff adherence in this regard.
A refresher care planning Workshop has been organised for all staff nurses facilitated by the Nurse Practice Development Co-ordinator for Older Persons Service. The first workshop is booked 30th Jan 2025.

Each nurse is assigned as a key worker for a maximum of two to three residents for care planning purpose. All nurses have been instructed to review and update the clinical risk assessment and care plans for their assigned residents at a minimum of four monthly intervals or sooner if required based on a change in their healthcare status. The CNM's are now auditing updated care plans to ensure they are person-centered and reflect the current assessed needs of residents.

The PIC and A/DON are completing additional audits with a revised monthly schedule in place. The audit findings will include quality improvement plans which will be discussed and monitored at the nurse management governance meetings to ensure learning for all nurses on care planning development and reviews.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An application to vary has been submitted requesting permission to repurpose the function of rooms within the Centre to ensure the service is operating the designated centre in line with their statement of purpose and conditions of their registration. The variation requested includes removal of OLU2 from the footprint of the designated Centre as it is not presently used to accommodate any residents.

Each refrigerator used by staff has been removed from all the residents' dining rooms and an alternative option provided for staff.

The roster across each Unit has been reviewed to ensure the skill mix of staff is appropriate to meet the needs of residents. Newly recruited nurses are now rostered across the three units to ensure an even ratio and skill-mix of experienced senior nurses working alongside newly recruited nurses.

All nursing staff and HCA's shifts are covered by Agency staff in the event of unplanned absences. There is a regular cohort of agency staff used who are familiar with residents to manage any shortfall in the actual roster.

Eight WTE HCA posts were offered and accepted by the candidates and 4.5 WTE MTA posts were offered and accepted via Agency Conversion. The progress of recruitment is presently at contracting stage and will be finalized by April of 2025 with all staff in post. The full complement of permanent staff will be in place when the 8 HCA and 4.5 MTA's are in post.

A total of 12 Staff Nurses have been recruited. First staff nurse commenced 17/06/2024 and the final candidate commenced 09/12/2024.

The roster in St. Joseph's Care Centre has a built in pool line to cover absences and to ensure the staffing levels are maintained all the time. Long term sick leave and vacant posts are covered by regular agency staff in the interim while progressing recruitment of candidates to permanent posts.

Oversight of wound care is maintained by the weekly monitoring reports on key care metrics which include details of each wound or pressure care issue being managed. Pressure Ulcer Prevention and Wound Management Refresher Training has been provided by Tissue Viability Nurse (6 hour session) with 60% of nursing staff and 41% of HCA's having attended. Further re-refresher training sessions will be scheduled to ensure that all staff have the opportunity to complete this training.

The Tissue Viability Nurse visits every 2 weeks or on a more frequent basis if required. There is an adequate supply of pressure relieving equipment available for residents to include mattresses, cushions and seating. There is readily available access to Allied Health Professionals for guidance to include Occupational Therapists, Dietician and Physiotherapists. Wound care plans for each resident with a risk of skin integrity breakdown have been reviewed and updated.

Residents' safety is of utmost priority. In order to reduce the risk of unauthorized access by the general public a new communication system will be put in place whereby that the public will no longer have direct access to the building. Members of the public will now have to contact the relevant department via an intercom system and they will now be accompanied by a member of staff to the relevant therapy department.

The refrigerator designated for staff in the residents' dining rooms have been removed.

The frequency of governance meetings has been increased by the nurse management team to improve the oversight of the systems for the management of risk and plan and monitor quality improvement from audits undertaken. Actions in audits remain a standing agenda item on the nurse management team.

Daily walk arounds are completed by the PIC to each of the Units to meet with the nurse in charge.

The risk register for the Centre is reviewed by the PIC in conjunction with the PPIM on a regular basis and additional control measures are put in place to mitigate risk. On-going risks in the unit are reviewed and monitored quarterly through the Quality Assurance group which includes PIC, Older Person's Services Manager, Quality & Patient Safety Advisor, and Compliance officer.

An oversight group has been established to provide support and mentorship to the PIC and management team in the Centre. This group meets weekly. This includes the Provider Representative, Older Person's Services Manager, Quality & Patient Safety Advisor, Compliance Officer, and Human Resources manager. Other support personnel are co-opted to the group as required for advice to the team e.g. Nursing Practice Development Co-ordinator.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
The Speech & Language Therapist (SLT) will complete an audit in respect of communication with residents within the designated centre, focusing on those who need additional support to communicate. The audit will include a mealtime observation and

include a review of visual aids including picture menus and appropriate use of same. The SLT is available to support residents who require additional support. Funding is available for communication aids if required to support and augment their communication. Training sessions will be provided, if indicated, to support staff to modify their communication style following the audit.

A Picture Menu was developed and introduced in August 2024. The menus are available in the sitting and dining room areas in all Units and are in a large print/picture A4 and B5 size.

A new picture menu holder will be installed in the Dining Rooms, Day Rooms and Kitchenettes for easy access of the picture menus. The kitchenette staff bring the picture menu with them during breakfast for the residents with communication difficulties to support in decision making in relation to menu choices. The CNM on each ward now monitors the use of the picture menus and white boards to ensure consistency in practice. The PIC and ADON complete a daily walk around each day at different times to observe care and communication practices within each unit.
The format to display the planned Activity Schedule has been reviewed and will be available on large white boards in the sitting room area in each Unit. Key staff assigned to lead on Activities have been assigned responsibility to update the Activity/Information Boards.

The audit findings and the quality improvement plan will be reviewed by the PPIM/ Provider with the PIC and remain a standing agenda item on the monthly governance meetings.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The walls and wooden surfaces on corridors, communal areas and residents' bedroom have been repainted. There is an ongoing program of painting in the center to ensure decorative maintenance is maintained and finishes are easily cleanable

The floor covering in worn areas has been replaced with new flooring covering.

An environmental audit to assess both internal and external areas of the building will be implemented to check for any maintenance deficits. The PIC will provide a report with a quality improvement plan from the environmental audit to the Provider/PPIM and maintenance team to ensure proactive systems are in place to identity, respond and address any maintenance issues.

A maintenance committee will be convened and meet on a monthly basis to plan, review and address all maintenance requirements. Maintenance and upgrade works will be a standing agenda item on the governance meeting between the PIC/PPIM.

The audit findings and the quality improvement plan will be reviewed by the PPIM/ Provider with the PIC and remain a standing agenda item on the monthly governance meetings.

Any deficits in funding or resources which impact on the implementation or timeliness of an agreed maintenance programme /QIP's will be escalated to the Provider with solutions explored, agreed and implemented.

An application to Vary has been submitted to repurpose a room to increase storage space within the Centre for the storage or residents' assistive equipment, Existing storage areas have been decluttered and reorganized to maximize space for the storage of assistive equipment.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A hand hygiene sink was installed in the clinical room in Sunset Lodge in August 2024.

All staff have been instructed that personal belongings, including consumables, must be stored in the staff lockers provided and all handrails are to be kept free of all items. This is monitored by the CNM or senior nurse on duty in each Unit in addition to daily walk arounds by the PIC & A/DON to monitor staff adherence in this regard.

All operational fan hand dryers were decommissioned. The decommissioned hand dryers will be removed from the centre. Alternative hand dryer facilities have been provided by means of a paper towel dispenser.

The storage of equipment in the sluice room has been reviewed to mitigate the risk of any cross infection. All staff have been advised to ensure that the sink draining areas are kept clear all the time to ensure that surfaces are effectively cleaned. A notice to remind staff that sink and surfaces should be kept clear has been displayed. The cleaning schedule for the sluice room has been updated.

The Activity storage room has been cleaned and the cleaning procedure and schedule for this area reviewed to ensure it is detailed to guide staff in their cleaning practices and frequency.

The wooden shelving will be replaced with a non-porous easily cleanable shelving.

An IPC committee will be establised with representatives from each department and chaired by the PIC. The committee will meet on a quarterly basis to oversee and progress any IPC matters arising.

IPC audits are carried out by the IPC Link Practitioner and will be completed throughout the Centre to ensure oversight of both staff IPC practices and environmental/ operational hygiene. Improvement plans from IPC audits and environmental audits will be monitored by PPIM/PIC to ensure issues arising are addressed. The audit findings will be reviewed by the IPC committee and quality improvement plans will be formally implemented. The audit findings and the quality improvement plans will be reviewed by the PPIM/ Provider with the PIC and remain a standing agenda item on the monthly governance meetings.

A IPC Link practitioner is in place in the centre. It is also planned to train a second staff member as an IPC Link practitioner. Updates from the IPC Link Nurse practitioner on new information from audits and actions will be shared with all staff.

All staff are trained in hand hygiene and there is an ongoing refresher program of training on IPC in place and monitored by the PIC.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A review of oxygen cylinder storage arrangements has been carried out by PPIM, PIC, Health and Safety Officer and Maintenance Manager.
The risk assessment in relation to the storage of Oxygen has been reviewed and updated and measures taken to effectively mitigate any risks to residents.
Cylinders will be stored in identifiable rooms. No combustible material will be stored in proximity to oxygen cylinders.
The oxygen cylinder stored in a free-standing transportable case (Emergency equipment) along the side of a circulating corridor has been removed from the case. It has been relocated to the identified Oxygen storage area.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The clinical risk assessments and care plans for each resident have been reviewed and updated by their assigned key nurse to ensure care plans accurately reflect residents' current assessed clinical and psychosocial needs.

A revised schedule of care plan audits has been implemented with care plans in each

Unit being monitored on a monthly basis to include follow up on the action plans identified.

A Care Plan workshop is booked for 30th Jan 2025 to provider refresher training to the nurse team on care plan development. Additional dates will be provided to ensure all staff partake in refresher training on care planning.

Each resident has a PAL assessment completed. Social activity care plans for all residents have been reviewed to refect their current needs and abilities. Daily records are maintained by staff on activites particpated in by residents and these are checked by CNM's to ensure accurate records are maintained.

Care plans for any resident with diabetes and on insulin therapy have been updated to reflect the frequency of blood glucose level monitoring. Nutritional care plans, skin bundles and wound management care plans have been reviewed to ensure they accurately reflect the current assessed needs of residents. Positive behavior support care plans have been reviewed to detail the required intervention and strategies at the most appropriate stage.

Recommendations from MDT members are communicated at shift handover. The care planning audit criteria includes details to assess allied health recommendations are reflected in care plan updates and reviews.

To ensure sustained oversight of Care Planning it is part of the standing agenda for PIC/ Clinical Nurse Manager's meetings and the audit schedule frequency has been increased to monthly audits to include audits by the A/DON & PIC.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A Care Plan workshop was completed on 30th Jan 2025 to provide refresher training to the nurse team on care plan development. Additional dates will be provided to ensure all staff partake in refresher training on care planning.

Care Planning is now a part of the standing agenda for the Clinical Nurse Manager's meetings.

A revised schedule of care plan audits has been implemented with care plans in each Unit being monitored on a monthly basis. The audit will include follow up on the action plans identified. The audit schedule frequency has been increased to monthly audits and reviewed by the A/DON & PIC.

For new admissions, a family/ MDT meeting is organised after 4-6 weeks to ensure that the needs of the residents are being met and for the family to meet the MDT members.

If there is an immediate concern a meeting is organised earlier.

A new guideline has been developed titled ' Best Practice in Documentation of Nursing Practice' and a Guideline on the Development of the Resident's care plan. Staff will be trained on the Guidelines by the Nursing Practice Development Co-ordinator.

Care plan audits are reviewed by the Care Plan Audit committee, chaired by the PIC, and updates provided at the monthly governance meetings with the PPIM to ensure consistency in best practice. In addition a sample of care plans will be presented at the oversight group to ensure consistency and high standard of care plans within the designated centre. The Oversight Group membership includes the providor, PPIM, Compliance Officer, Quality and Patient Safety Advisor and an Older Persons Manager who was formerly a PIC in an approved centre.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
All restrictive practices in the center have been reviewed. The key pads on the access doors to the enclosed gardens have been removed.

The exit door to the enclosed garden in one Unit is being replaced to ensure ease of access for the residents.

Controlled access will be removed from entrance/exit doors to each unit to allow independent movement of residents throughout the designated centre.

A risk assessment will be carried out regarding each resident identifed at risk of leaving due to cognitive impairment to ensure their rights are respected. Control measures are implemented to ensure the safety of those residents who may be at risk of leaving unaccompanied due to impaired judgement. Care plans will be reviewed for residents who may be at risk of leaving the centre unaccompanied and considered at a risk of harm to themselves.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Residents' safety is of utmost priority.

Therapy services will be relocated by the 28th February 2025. Members of the public will cease entering the designated centre to access other services.

In the interim, whilst awaiting this relocation, arrangements will be put in place to ensure that all clients attending the therapy services will be accompanied to and from appointments by a staff member to manage the risk to safeguard residents in their home.

Access control will be in place at the entrance to the Day Care Centre to ensure that there is no unauthorised access for any members of the public into or through the designated centre.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Each resident has a PAL assessment completed. Social activity care plans for all residents have been reviewed to refect their current needs and abilities. Daily records are maintained by staff on activities participated in by residents. The records are checked by CNM's to ensure they are completed and maintained up to date.
The activities program has been reviewed by the PIC and nurse management team with the activites coordinators to ensure suitable oppourtunites for activation are scheduled to meet the interests and capaciites of all residents.
There is a Resident's Forum which meets quarterly with residents and family members. Feedback on the choice and variety of activites is obtained from residents through the residents' committee meetings.
The key pads on the access doors to the enclosed gardens have been removed to ensure residents can access their recreational space independently at a time of their own choosing.

All staff providing direct care have been instructed to complete the HIQA online course on Applying a Human Rights-based Approach in Health and Social Care: Putting national Standards into Practice. Staff details will be recorded in the training matrix.

The number of television available in multi occupancy bedrooms has been reviewed and each resident now has their own individual set with a discreet listening headset.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Substantially Compliant	Yellow	28/02/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/01/2024

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/02/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/05/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare	Substantially Compliant	Yellow	28/02/2025

	associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/04/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/01/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/01/2025

Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/01/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	28/02/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/04/2025
Regulation 8(1)	The registered provider shall take	Not Compliant	Orange	28/02/2025

	all reasonable measures to protect residents from abuse.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	14/02/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/01/2025