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 Hospital
Name of provider:	Bon Secours Health System CLG
Address of centre:	Mount Desert, Lee Road, Cork, Cork
Type of inspection:	Announced
Date of inspection:	23 October 2023
Centre ID:	OSV-0000284
Fieldwork ID:	MON-0039141

About the designated centre

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

St Joseph's Hospital, Mt. Desert is a purpose-built designated centre situated in the rural setting of the Lee Road, Cork city, a short distance from Cork and Ballincollig. It is registered to accommodate a maximum of 103 residents. There is a large comfortable seating area and main 'Village Green' restaurant dining room at the main entrance. Communal areas include the Beech room which facilitates functions, the large activities room and Chapel, and occasional resting areas along corridors for residents' relaxation. Bedrooms accommodation comprises five twin bedrooms and the remainder are single occupancy; all with full en suite facilities of shower, toilet and wash-hand basin, with additional toilet facilities throughout the centre. Accommodation is set out in four wings: 1) Daffodil: 26 bedded unit with two living rooms and seating areas with direct access to the secure garden, and the Patel room dedicated private family room 2) Bluebell: 26 bedded unit with a living room and glass seating area 3) Lee View: 26 bedded unit with living room, two glass seating areas with direct access to the secure garden 4) Woodlands: 25 bedded unit with two living room. St Joseph's Hospital, Mt. Desert provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite, convalescence and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	96

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
Monday 23 October 2023	09:30hrs to 17:00hrs	Breeda Desmond	Lead
Tuesday 24 October 2023	08:15hrs to 16:45hrs	Breeda Desmond	Lead
Monday 23 October 2023	09:30hrs to 17:00hrs	Anna Delany	Support
Monday 23 October 2023	09:30hrs to 17:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

There was a relaxed atmosphere within the centre as evidenced by residents moving freely and unrestricted throughout the centre. Inspectors met with many residents during the inspection and spoke with eight residents in more detail. Residents spoken with were complimentary in their feedback and expressed satisfaction about the standard of care provided. Residents appeared to be relaxed and enjoyed being in the company of staff. Many interactions were observed to be respectful towards residents. All residents spoken with were happy with the standard of environmental hygiene.

There were 97 residents residing in St Joseph's Hospital Mt Desert at the time of inspection. On arrival for this announced inspection, inspectors completed the risk management protocols on entry to the centre of a signing in process and hand hygiene.

An opening meeting was facilitated with the chief executive officer (CEO), national quality lead manager and assistant person in charge, which was followed by a walkabout the centre. The person in charge was on planned leave at the time of inspection.

St Joseph's Hospital Mt Desert was a single-storey building with basement, that accommodated laundry, storage, offices and staff facilities. The main entrance was wheelchair accessible and led to an expansive foyer with reception, seating area and main dining room; the main fire alarm system, registration certification, suggestion box and complaints procedure were located here. The activities room and church were located beyond the main foyer. The centre was set out in 4 wings namely Daffodil, Bluebell, Woodland and Lee View which radiated off the main foyer. Each wing was self-contained with day rooms, a dining area and comfortable seating areas along wide corridors. Corridors and seating areas had lovely photographs, paintings and art decorating the walls. As part of their end-of-life care facilities there were two Potel rooms for families; these comprised comfortable seating and kitchenette facilities.

Four secure well-maintained landscaped gardens located to the front and back had seating areas throughout, with scenic views of the River Lee Valley and surrounding woodlands. There were seating areas along corridors with views of either the enclosed gardens or the avenue leading into the centre; residents were observed enjoying these spaces with their visitors or sitting watching the birds and rabbits. The inspection was in the middle of storm Babet so residents chose to stay indoors and away from the inclement weather.

Bedrooms were seen to be spacious with good room for their bedside chair, locker, storage facilities for residents' belongings, and use of assistive equipment if required. All rooms were en suite with shower, toilet and wash-hand basin facilities. Many of the bedrooms were decorated in accordance with the resident's preference

with book shelves, photographs and other memorabilia. Some bedrooms and corridors were recently painted; the décor in other parts of the building was showing signs of wear and tear, nonetheless, painters were on site during the inspection.

Following from the last inspection, orientation signage was mounted on corridors and coloured murals decorated entrances to each wing. This provided good orientation for residents throughout the centre. Communal rooms had new signage to indicate their purpose, such as day rooms.

The residents' communication board was displayed outside the activities room; this had the minutes of the most recent residents' meetings displayed. The activities schedule for 2023 was displayed on each unit and a large coloured schedule was displayed outside the activities room for residents to see what was happening during the day and evening times; also displayed was information on the pastoral care programme. The schedule had activities over six days of the week, Monday to Saturday. Inspectors saw that residents gathered in the activities room or in the seating area on the corridor outside the activities room and have refreshments before mass at 11 o clock. Mass was celebrated Tuesdays to Saturdays and a service was facilitated on Mondays. Rosary was held in the chapel every afternoon after dinner. Several residents were seen to use the exercise bikes in the activities room on both days of inspection. Staff were observed helping residents to get seated, adjusted the pedals in accordance with the residents' requirements, and the residents were happy with the exercise programme. An exercise programme was facilitated in the activities room after mass which was attended by many residents. In the afternoon, the activities room was full as there was live music on both days. Staff were seen to encourage residents to do sing along and clap to songs, or individual residents sang or recited poetry; and said it was a practice run for the party at the weekend following the inspection.

Inspectors observed that approximately half of residents remained either in bed or in their bedrooms throughout both days of inspection. Some residents were seen to have the radio or television on in their bedrooms, others sat/lay in bed in silence.

Dinner and tea times were observed. Many residents were assisted with their meals in their bedrooms and in general, interaction was positive and the staff member sat facing the resident while providing assistance. Others had their meals in the smaller dining rooms on each unit. On one unit, there was very limited interaction by staff with residents; there was no background music playing to create a relaxed atmosphere, just mainly silence. In the main restaurant dining room, tables had not been adjusted to reflect the current HPSC guidance as the number of tables was very limited and most only had two chairs per table, a few had four seats. Aside from the three residents who dined there from Cedar Lodge, all other tables were not set for residents before they came for their meal. Cutlery and napkins were brought to the table with the food or after food was served. This was discussed on the first day of inspection, and on the second day, it was agreed that tables would be set at 12:15pm after staff had finished their morning break. While menu choice was available to residents, the menu displayed at the serving counter was the menu for staff rather than residents. The catering manager explained that staff go around

to each resident with the menu to discuss choices.

Meals were well presented and residents gave positive feedback about the quality and choice for their meals. The dining area on one unit was closed as it was being re-floored; one resident decided he would come to another unit to his friend to have his dinner with him, however, two different staff explained to the inspector that he could not be served for another 30 minutes in accordance with the serving times on his unit, and so the resident sat with his friend and watched him have his meal. Although the meal was eventually served, but by this time his friend had finished his meal.

Laundry was segregated at source and each unit had their designated laundry trolleys. There were separate trolleys for clean linen for comfort rounds. The ancillary facilities including housekeeping rooms, the laundry and sluice rooms generally supported effective infection prevention and control. Clean and dirty areas were kept separate and the workflow patterns of each area were clearly defined. These rooms were well-ventilated, clean and tidy with surfaces that facilitated easy cleaning. For example, housekeeping rooms on each unit had a janitorial sink and sufficient space for storage and preparation of trolleys and other cleaning equipment. Cleaning carts were equipped with locked compartments for storage of chemicals. Each unit had two sluice rooms equipped with hand hygiene facilities and a bedpan washer; bedpan washers examined did not provide for effective decontamination.

Overall, the general environment including residents' bedrooms, communal areas and toilets were clean. Equipment viewed was also generally clean with some exceptions. For example, two commode basins and two raised toilet seats in one sluice room were visibly unclean.

Conveniently located alcohol-based product dispensers along corridors and within resident bedrooms facilitated staff compliance with hand hygiene requirements. Clinical hand wash sinks were located in sluice rooms and treatment rooms. Inspectors were informed that sinks within residents' rooms were dual purpose, used by both residents and staff.

Emergency evacuation floor plans were displayed on each unit; they were orientated to reflect their relative position in the centre, had room numbers and a point of reference' You are Here'.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, the findings on this inspection demonstrated that while some improvement

was evidenced and the registered provider had put systems in place to address the shortfalls identified on the previous inspection regarding monitoring and oversight of the service, these initiatives would take time to embed into practice. Significant concerns detailed in the last inspection report regarding staffing were not addressed comprehensively; the addition of just one HCA on night duty to support the service remained inadequate cognisant of dependency levels of residents and the size and layout of the centre. Other staffing shortfalls were discussed under Regulation 15, Staffing. Other areas for improvement identified included infection control and restrictive practice assessment; these were repeat findings. Further review of the governance and management systems was necessary to be assured that the service provided was safe, appropriate, consistent and effectively monitored.

St Joseph's Hospital was operated by the Bon Secours Health System Limited. The designated centre formed part of the Bon Secours Care Village which also accommodated Cedar Lodge (comprising apartments for independent living). The governance structure comprised the board of management (BOM), the chief executive officer (CEO) and senior management team. The CEO was the person nominated to represent the registered provider. On site, the structure comprised the person in charge, assistant director of nursing (ADON), clinical nurse managers (CNMs x 5), care team, human resources (HR) and finance departments. CNMs were appointed to each unit and one CNM rotated on day duty each weekend to provide management oversight and support the service. There was no management cover on night duty: an on-call system was in operation for management cover.

The service had access to the Bon Secours health safety and well-being officer and the national quality manager, both of whom were on site on a regular basis. The consultant geriatrician was clinical director for the service and provided support and direction for residents and staff.

A schedule of audit for 2023 was in place and CNMs were given responsibility for clinical areas such as infection control, restrictive practice and falls, wound care and pressure ulcers, and medication management. Results of these audits were brought by the pertinent CNM to the clinical governance meetings for discussion and actioning. Again, this was a relatively new initiative that would require time to embed regarding development of action plans with time-lines to enable quality improvement. Audits were discussed with one CNM who showed good insight into their purpose, and highlighted deficits in care templates for example, which could not capture a holistic picture of residents; she had actioned this to enable staff record relevant information to develop personalised care plans relating to food and nutrition, wound management and skin integrity. An environmental audit was completed of the premises and planned maintenance works were scheduled to enable upgrading of the premises. While the scope of audit had expanded, this would take time to embed into practice to ensure the service was effectively monitored to drive improvement.

Clinical governance meetings were facilitated every two months and these were attended by the clinical lead, quality manager and in-house management team. Set aganda items included key performance indicators (KPIs), staffing, committees' updates and complaints for example. Matters were seen to be followed up on

subsequent meetings. Quality and safety meetings were convened every six weeks with set agenda of clinical and non clinical matters including fire safety. Heads of Department meetings were facilitated on a monthly basis and minutes from these meetings fed into the governance meetings to enable oversight of the service. The health safety and well-being officer was on site during the inspection to provide information regarding fire safety precautions.

Schedule 5 written policies and procedures were updated on inspection as follows:

- policy relating to admissions updated to reflect time-lines specified in the regulations
- safeguarding policy was updated to reflect a rights-based approach to protection of residents' finances
- complaints policy and procedure consolidated to reflect the 2022 legislation requirement
- regarding information relating to infection control, staff did not have access to current legislation and best practice guidance to enable better outcomes for residents.

Contracts of care had the requirements as specified in the regulations. The statement of purpose and floor plans were updated at the time of inspection to ensure regulatory compliance.

Regarding the premises, the provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists and colour coded cloths to reduce the chance of cross infection. Cleaning records viewed confirmed that all areas were cleaned each day. Inspectors observed there were sufficient numbers of clinical and housekeeping staff to meet the infection prevention and control needs of the centre. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. All staff had completed training in safe guarding, fire training and infection prevention and control. Nonetheless, further training was required to ensure staff had up-to-date information regarding antimicrobial stewardship, MDROs and the management of residents colonised with MDROs.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had applied to re-register St. Joseph's Hospital, Mt Desert. The application was made in a timely manner and fees were paid. The required information was submitted as part of the application in line with specified requirements as set out in the registration regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was full time in post and had the necessary experience and qualifications as required in the regulations. She was involved in the governance, operational management and administration of the service. Deputising arrangements in place ensured that the service was managed by a suitably qualified and experienced person in the absence of the person in charge.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that there was adequate staffing levels having regard for the assessed needs of residents, and the size and layout of the centre:

While one additional HCA was rostered on night duty to support units, this remained insufficient. On night duty, one nurse and one HCA were rostered on each unit. Cognisant that all units had maximum and high dependency residents who could require two staff for comfort rounds, and the nurse had responsibility for medication rounds along with attending to sick residents, accidents or incidents, leaving the comfort rounds to be completed by the HCA. Many of the issues raised in complaints logged related to significant delays in answering call bells, for example, one resident waited 45 minutes to be assisted as the nurse was tending to a sick resident and the HCA could not assist the resident on their own as they required two HCAs for assistance.

During the day, approximately half the residents remained either in bed or in their bedroom. Residents were scheduled to have a shower only once a fortnight, consequently, it could not be assured that there were adequate staff to enable residents have a high standard of care or that they were afforded choice regarding their personal care.

Following review of duty rosters and staff allocation rosters, there were inadequate staff rostered to facilitate activities for 103 residents as some days, there was just one staff rostered for meaningful activation for the service and no staff allocated to activities on the units.

Judgment: Not compliant

Regulation 16: Training and staff development

While staff had completed training related to infection control, further training was required to ensure staff were knowledgeable and competent in antimicrobial stewardship and in the management of residents colonised with MDROs. Details of specific issues identified were set out under Regulation 27.

The service had transitioned from one information technology platform to another, and while most staff were trained up in the new system, some staff required training or further training, as some staff were recording daily care for example on paper-based records and others on the computer. This resulted in duplication with both records being incomplete regarding care delivered, safety checks completed, or other interventions (such as monthly weights), to ensure a holistic approach to care deliver in line with the residents assessed needs, preferences and wishes.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was updated on inspection to ensure regulatory compliance as follows:

- address of next of kin of two residents
- gender of four residents
- a resident's temporary transfer was recorded as a discharge and this was corrected to reflect their transfer.

Judgment: Compliant

Regulation 21: Records

A sample of Schedule 2 Staff files were examined. These were updated on inspection to reflect the verification of references process.

Judgment: Compliant

Regulation 23: Governance and management

The inspector acknowledged the efforts made by the registered provider to strengthen the governance and management of the centre with quality improvement initiatives described heretofore. Nonetheless, inadequate staffing levels and deficits in the audit programme did not assure that the service was either adequately

resourced or effectively monitored.

Further oversight by the management team was required in relation to ensuring residents rights were met, aspects of care, the use of restraint and aspects of infection control as outlined under the specific regulations in the report.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The contracts of care were updated following the findings of the last inspection to reflect additional fees and exclusion of items covered by the Nursing Homes Support scheme.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose and floor plans were updated at the time of inspection to include the following:

- the person nominated to represent the registered provider
- qualifications of the person in charge
- complaints procedure to reflect the 2022 legislation,
- laundry service for personal clothing and bed linen
- floor plans to include facilities in each room, measurements of each room, purpose and function of all room, and basement floor plans.

Judgment: Compliant

Regulation 30: Volunteers

The centre had three volunteers to the service. Documentation including vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, as specified in the regulations were in place for volunteers. Job descriptions and supervision arrangements were detailed.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of her responsibilities regarding reporting incidents in line with regulatory requirements. Incidents were reported and followed up to ensure and enable best outcomes for residents.

Judgment: Compliant

Regulation 34: Complaints procedure

Improvement was noted in recording complaints. The complaints procedure was updated to reflect the change in legislation in 2022. The complaints records were examined and this showed many complaints were appropriately recorded and followed up by the person in charge to the satisfaction of the complainant.

Judgment: Compliant

Regulation 4: Written policies and procedures

While there were written policies as specified in Schedule 5 of the regulations, these were not comprehensively implemented into practice, as described throughout the report, for example, in Regulation 17 Food and Nutrition, Regulation 9, Residents' Rights and Regulation 29 Medication management for example.

Judgment: Substantially compliant

Quality and safety

The provider continued to respect the rights of residents to maintain meaningful relationships with people who were important to them and manage and protect residents from the ongoing risk of COVID-19 infection. Signage reminded visitors not to come to the centre if they were showing signs and symptoms of infection. There were no visiting restrictions in place on the days of the inspection and residents were observed to receive visitors throughout both days of inspection.

In relation to care planning, the technology system had changed earlier in the year, and while most staff had received training, others did not. This resulted in incomplete records, both in care planning documentation and daily records relating

to care delivered and restrictive practice monitoring, as well as transfer letters for times when residents' were temporarily transferred to other health care facilities such as acute care. End-of-life care plans were not routinely completed when a resident was well and able to make these decisions for themselves in the sample viewed by the inspector. While the restrictive practice assessment allowed risk to be quantified, it did not inform the decision-making process. This resulted in continuing high levels of bed rail restraint usage.

In general, the health care needs of residents were supported. The clinical director was a consultant geriatrician who provided additional support to residents and staff. Documentation demonstrated that residents had access to a range of health care professional with regular reviews by the physiotherapist, occupational therapist (OT), podiatry, tissue viability nurse (TVN), dietitian and the speech and language therapist (SALT). There were no delays in residents being reviewed following referral to specialist services. Of the sample of care documentation reviewed, wound care was managed in line with best practice. The service was not a pension agent for any resident.

The pharmacist was facilitated to undertake regular medication management audits and these were completed on a quarterly basis. Reports showed that each resident's medication prescription was reviewed and recommendations made to enable best outcomes for residents. However, these recommendations were not always acted upon to ensure best outcomes for residents.

Inspectors observed many examples of kind, discreet, person-centred and respectful interventions between staff and residents during the course of the inspection. However, there were some occasions where residents could not exercise choices and where care practices did not reflect a person-centred approach. For example, inspectors observed a list for showers which were scheduled on set days once a fortnight which did not suggest that residents could choose to shower when they wished. Furthermore, the use of household cleaning cloths when delivering and assisting with resident's personal care did not support dignity and respect. Inspectors were informed that more appropriate products had been sourced and would be trialled prior to implementation.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, the general environment was clean and well maintained. Waste, used laundry and linen were segregated in line with local guidelines, at point of care. However, inspectors observed inconsistent application of standard infection control precautions including equipment cleaning. Barriers to effective hand hygiene practice were also observed during the course of this inspection. Findings in this regard are further discussed under regulation 27.

Infection prevention and control audits tools covered a range of topics including waste management, environmental and equipment and sharps safety. However inspectors were informed that audits were not routinely tracked and trended to monitor progress.

The provider had access to diagnostic microbiology laboratory services and a review

of resident files found that clinical samples for culture and sensitivity were sent for laboratory analysis as required. Staff did not have access to electronic reports however copies of laboratory reports were printed and filed in their healthcare record.

An up to date record of residents with previously identified multi-drug resistant organism (MDRO) colonisation (surveillance) was not maintained. This meant that the provider was unable to monitor the trends in development of antimicrobial resistance within the centre. A review of acute hospital discharge letters and laboratory reports found that staff had failed to identify a significant number of residents that were colonised with MDROs including including Carbapenemase-Producing Enterobacterales (CPE), Vancomycin-resistant Enterococci (VRE) and Extended Spectrum Beta-Lactamase (ESBL). Furthermore, a review of care plans found that accurate information regarding MDRO colonisation was not recorded in resident care plans to effectively guide and direct the care of residents with a recent history of MDRO colonisation. Findings in this regard were presented under regulation 27.

The overall antimicrobial stewardship programme also needed to be further developed, strengthened and supported in order to progress. For example, there was an over reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection. Samples were routinely tested on admission and four monthly in the absence of signs and symptoms of urinary tract infection. This was contrary to national guidelines which advise that inappropriate use of dipstick testing can lead to unnecessary antibiotic prescribing which does not benefit the resident and may cause harm including antibiotic resistance.

Prevalence of antibiotic use for prophylaxis (prevention) of infection was also high, with approximately 8% of residents prescribed prophylactic antibiotics. This practice was contrary to national and best practice guidelines which advise that there was limited evidence of any additional benefit from such prophylaxis beyond 3-6 months but there was significant evidence of harm.

Local infection prevention and control guidelines which covered aspects of standard including hand hygiene, waste management, sharps safety, environmental and equipment hygiene were available. However, staff were unaware of the National Clinical Effectiveness Committee (NCEC) Infection Prevention and Control guidelines published in May 2023.

Regulation 11: Visits

Visitors were observed coming and going to the centre on both days of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in their bedrooms or in the communal spaces through out the centre. The centre's website was updated at the time of inspection to reflect the change in HPSC guidance regarding the open visiting policy

in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space in their bedrooms to store their clothes and display their possessions with double wardrobes, bedside locker, some had chest of drawers and drawers as part of their vanity display unit; some residents had bookshelves. Used linen was laundered by an external contractor and residents clothing was laundered on-site. Clothes were marked to ensure they were safely returned from the laundry.

Judgment: Compliant

Regulation 17: Premises

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs. The centre was clean, bright and welcoming throughout. There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to help maintain residents' safety. New orientation signage and use of colours encouraged and aided residents' independence and orientation throughout the centre. While there was visible wear and tear in the building, there was ongoing painting and decorating and maintenance to upgrade the physical environment.

Judgment: Compliant

Regulation 18: Food and nutrition

Action was necessary to ensure that residents meals were appropriately served:

- meals were not served properly in accordance with their policy and stated mission of their statement of purpose
- tables were not set with cutlery in line with normal dining serving.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Transfer letters were seen to be available in both hard and soft copies for times when residents' were temporarily transferred to other health care facilities such as acute care. The letters generated from computer records (soft copies) were comprehensive and included MDRO and HCAI histories, however, the hand written letters did not have this detail and the template did not allow for comprehensive information to be included, consequently, the receiving care facility did not have a complete overview of the resident and their medical history to inform individualised care, and possibly put the necessary precautions in place to safeguard both the resident and the receiving care service.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy was in place and had the specified risks as detailed in the regulations.

Judgment: Compliant

Regulation 27: Infection control

The provider did not comply with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services (2018). Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example:

- management and staff were unaware of which residents were colonised with MDROs. Lack of awareness meant that appropriate precautions may not have been in place to prevent the spread of the MDROs within the centre,
- a review of eight care plans found that information was not recorded in resident care plans to effectively guide and direct the care residents colonised with MDROs
- there was no evidence of ongoing targeted multidisciplinary antimicrobial stewardship quality improvement initiatives, training or guidelines. This impacted the overall quality of antibiotic use within the centre and may contribute to antimicrobial resistance, Clostridium difficile infection and other side effects.

Standard infection control precautions were not effectively and consistently

implemented by staff. For example:

- sinks within residents bedrooms were dual purpose used by both residents for personal hygiene and staff for hand hygiene. Inspectors were informed that that waste water used for residents personal hygiene was disposed of in sinks in resident's rooms. This may lead to environmental contamination and the spread of MDRO colonisation,
- staff informed inspectors that they manually decanted the contents of commodes/bedpans into toilets prior to being placed in the bedpan washers for decontamination. This increased the risk of environmental contamination and the spread of MDRO colonisation,
- detergent to assist with the removal of soiled human waste receptacles had not been connected in four bedpan washers. This may impact the effectiveness of decontamination
- urinary catheter bag was trailing on the floor.

Staff did not have up-to-date information to inform best practice as follows:

the National Infection Prevention and Control Guidelines and the antimicrobial stewardship guidelines were not available to staff advice and support was not sought from an antimicrobial pharmacist as outlined in the centre's medication management policy.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety certification was in place regarding routine and annual fire maintenance. Daily fire safety checks were comprehensively completed. Fire training was facilitated regularly and fire training was up to date for all staff.

Drill records showed that there continued to be improvement in response times. While simulated evacuations were not completed in the largest compartments (10, 11 and 12 bedded compartments), these were scheduled for November and December as part of the on-going safety precautions to be assured that staff could evacuate residents in a timely and safe manner.

An external fire safety risk assessment was commissioned and the findings and report were due to be submitted to the registered provider by November 2023. This would then be the template for the planned implementation of fire safety works.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The pharmacist was facilitated to meet their obligations to residents under current legislation. Appropriate records were maintained of medication related recommendations made by the pharmacist. The pharmacist completed quarterly medication audits and provided staff training and updates on medication changes.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of assessments and care plans were reviewed and while they contained some information to inform individualised care, they were not comprehensive. The service had transitioned from one information technology platform to another, and while most staff were trained up in the new system, some staff required training or further training as some staff continued to record daily care for example on paper-based records and others on the computer. This resulted in in-complete records regarding care delivered, safety checks completed, and other interventions (such as monthly weights), to ensure a holistic approach to care deliver in line with the residents assessed needs, preferences and wishes.

Of the sample of end-of-life care plans reviewed, these were not comprehensively completed. The only information in one resident's assessment was their religion; a second assessment seen had the resuscitation decision for the resident, however, all other information was generic and not resident-specific. Another resident's care documentation reviewed had no information in their assessments relating to their mobility, nutrition requirements and their spirituality.

Judgment: Substantially compliant

Regulation 6: Health care

Reports showed that each resident's medication was reviewed by the pharmacist and recommendations made to enable best outcomes for residents. However, these recommendations were not always acted upon to ensure best outcomes for residents, for example, discontinuing antibiotics in line with the antimicrobial stewardship guidance, or changing medications that were more suited to being crushed to maintain their effectiveness in line with drug licensing regulations.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Action was necessary to ensure that restrictive practices were implemented in line with national policy, as:

- The rationale for many of the assessments relating to bed-rail restraint stated that bed-rails were implemented 'in the resident's best interest'. Narrative in the bed-rail restraint risk assessment did not inform decision-making as some of the residents were agitated and confused and bed-rails could be contra-indicated in these circumstances. In the sample of care plans examined, least restrictive alternates were not considered for any resident. Consequently decisions made regarding restraint remained subjective and not based on assessed risk or evidence-based. This was a repeat finding.

Judgment: Not compliant

Regulation 9: Residents' rights

While it was reported that staff were assigned to activities on units when the activities co-ordinators were off duty, the duty roster and staff allocation roster did not have staff assigned to ensure activities would occur. In addition, some days there was just one activities co-ordinator scheduled on duty for 103 residents so it could not be assured that all residents had opportunities to participate in activities.

The activities schedule was set out for one week and this was the schedule for 2023, so it could not be assured that it was updated on a weekly basis for example, or that it was changed to suit the wishes and preferences of residents or the weather for example.

Institutional practices relating to mealtimes for example, or fortnightly shower schedules, or residents remaining in their bedrooms or in bed all day in silence, was not reflective of a rights-based approach to care delivery

The use of household cleaning cloths when delivering personal care to residents did not support dignity and respect.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Joseph's Hospital OSV-0000284

Inspection ID: MON-0039141

Date of inspection: 24/10/2023

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: • Person in Charge (PIC) will review rosters and increase staffing numbers where needed to ensure adequate staffing levels to meet residents' needs. Recruitment is underway for a second Assistant Director of Nursing (ADON). This additional role will allow for greater clinical governance. With immediate effect, staffing level on night duty will be increased. Each unit will have one staff nurse and two Healthcare Assistants (HCA) on night duty to ensure resident needs can be effectively met. Recruitment is in progress. Agency HCA will be utilised as an interim measure until all vacant roles are filled. • PIC will ensure residents will receive a high standard of care and that residents' choice is respected regarding personal care. PIC will ensure that all staff complete HSEland training on a human rights-based approach to care. Residents will continue to be encouraged to leave their rooms during the day, to ensure social aspects of care are met. Residents will be encouraged to attend activities/ attend dining room for meals/ mobilise throughout the facility with staff. • PIC and activity coordinators will review and expand the activity program to ensure all resident preferences and level of engagement are incorporated. PIC will ensure all residents are provided the opportunity for meaningful engagement and activity. Rosters will be reviewed in line with the new schedule of events, with a view to increasing activity staffing level to meet the needs of all residents and to provide activities 7 days per week. This will ensure meaningful activation for the service.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
• Infection Prevention and Control (IPC) lead has commenced training on antimicrobial stewardship and Multi-Drug Resistant Organisms (MDROs) with all clinical staff. A schedule of training is in place to ensure all clinical staff attend. IPC lead will continue to educate staff on the latest guidance for best practice.
• Documentation of care is now streamlined to the EpicCare system with paper-based records no longer in use. This will eliminate duplication and incomplete recording of resident care. PIC will audit clinical documentation on monthly basis going forward to ensure a holistic approach to care. A corrective and preventive action plan (CAPA) based on the audit findings will be developed.
CNMs on each unit have commenced additional training on the EpicCare system with all nurses and HCAs to ensure all staff are knowledgeable in its use. Training commenced on 14th November and is occurring twice weekly on all units.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• PIC will review rosters and increase staffing numbers where needed to ensure adequate staffing levels to meet the needs of the residents.
• Recruitment is in progress for a second Assistant Director of Nursing to provide further oversight of clinical care and enhance the management team.
• A review of current staffing levels is underway, and recruitment is in progress to increase night staff levels throughout the facility. Each unit will have one staff nurse and two HCAs on night duty to ensure resident needs can be effectively met.
• PIC will ensure staff complete HSEland training on a human rights-based approach to care.
CNM on each unit is actively reviewing restraint use with a view to reduce restrictive practice where possible and aiming for a restraint-free environment.
IPC lead is actively monitoring and spot-checking care to ensure best practice is adhered to in relation to infection prevention and control.
• PIC will ensure allocation of staff to activities is highlighted on the staff roster, where appropriate. This will ensure meaningful activation for the service.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies

and procedures:
• PIC ensures all staff read and understand schedule 5 policies. CNM on each unit will oversee care- through observation, discussion and spot-checks- to ensure policies are comprehensively implemented.
• In relation to food and nutrition: Dining room tables are now being set with cutlery prior to residents attending for their meals. This will continue on a daily basis and is monitored by the catering supervisor. PIC will ensure that all meals are served in accordance with policy. PIC ensures all policies in relation to food are adhered to and that a positive dining experience is promoted for residents.
• In relation to resident rights: PIC will ensure a rights-based approach to care delivery throughout the facility. Mealtime practices will be reviewed to ensure residents wishes and preferences are respected, particularly in relation to where and when meals are served.
PIC will ensure a person-centered approach to residents' personal care. A shower schedule will not be utilised in the facility, instead residents' wishes will be respected in relation to their personal care.
PIC will ensure residents are engaged in meaningful activity. Staff will encourage residents to attend activities, communal areas, and dining areas to allow for social needs to be met. Where a resident opts to remain in their room, staff will offer individualised activity to the resident.
A review of activity schedule and staffing will be carried out by the PIC to ensure that all residents have access to opportunities to participate in activities.
• In relation to Medication Management: Senior management will meet with GPs to discuss prompt review of any recommendations, to ensure best outcomes for residents. Meeting will occur before December 31st 2023.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• PIC will ensure that all meals are served in accordance with policy. PIC ensures all policies in relation to food are followed and that residents have a positive dining experience.
• Dining room tables are now being set with cutlery prior to residents attending for their meals. This will continue on a daily basis and is monitored by the catering supervisor.
• Menus are displayed on dining room tables each day and also displayed in larger print on the whiteboard. Background music is played in the restaurant throughout the day to provide an ambient atmosphere.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

• PIC will ensure transfer documentation is streamlined to the EpicCare system with paper-based records no longer in use. This will ensure that comprehensive information is included and that a complete overview of the resident is provided to the service receiving the resident, inclusive of MDRO and Healthcare Associated Infection (HCAI) history.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• PIC will ensure the surveillance of MDRO colonisation is routinely undertaken and recorded. A review of all residents' clinical notes is now complete. MDRO surveillance has commenced. An MDRO folder is in place documenting all residents with a history of MDRO or HCAI. This folder is maintained by the IPC lead and is available to all staff. Staff education on MDROs has commenced with the IPC lead. A schedule of training is in place to ensure all clinical staff attend. IPC lead will continue to educate staff on the latest guidance for best practice.

• Care plans have been updated to include MDRO status and transmission-based precautions. This will ensure that care plans effectively guide and direct the care of residents colonised with an MDRO.

• PIC will ensure antimicrobial stewardship to improve and measure the appropriate use of antimicrobials. Antimicrobial guidelines are made available for clinical staff. Residents who were prescribed prophylactic antibiotics for a period over 6 months have been discontinued. An antimicrobial data tool is utilised monthly, and this will partly inform a quarterly audit. A QIP will be developed post each audit to ensure best practice. The antimicrobial pharmacist in the Bon Secours Hospital Cork has been contacted to provide advice and support to the clinical staff in the facility. Staff have received education on ceasing the use of urine dip-testing and the practice is no longer in use in the facility.

• PIC will ensure best practice is followed in relation to disposal of wastewater post residents' personal hygiene. All staff are informed that wastewater is not to be disposed of in the handwashing sink in resident rooms.

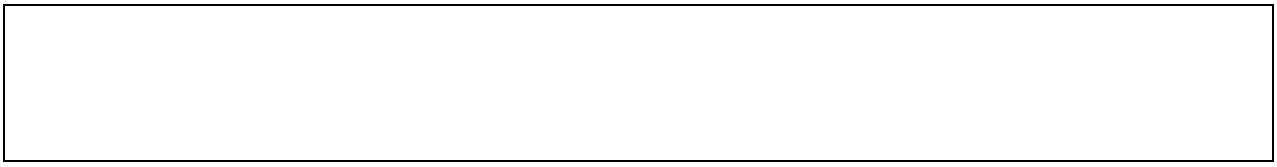
• All staff have been informed that it is not appropriate to decant contents of commodes/bedpans in toilets prior to being placed in bedpan washer for decontamination. Staff education on IPC risk of environmental contamination in relation to this practice has been provided by the IPC lead. IPC lead will monitor staff practices to ensure this is no longer occurring.

• Detergent has been connected to the new bedpan washers in the facility. This will be monitored by the housekeeping supervisor going forward. The older model bedpan washers do not have the facility to be connected to a detergent and instead have a free-pour option. Disinfectant/detergent is available in the sluice rooms to staff for use.

• IPC lead has provided refresher education to all clinical staff on catheter care, including the appropriate method to hang the catheter bag to ensure the bag and opening port are not touching the floor. • The National Infection Prevention and Control Guidelines and the antimicrobial stewardship guidelines are available to all staff in the clinical room of each unit.

Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: • PIC will ensure documentation of care is streamlined to the EpicCare system with paper-based records no longer in use. This will eliminate duplication and incomplete recording of resident care. • CNMs on each unit will carry out additional training on the EpicCare system with all nurses and HCAs to ensure staff are knowledgeable in its use. • PIC will provide education and guidance to staff nurses on effective care planning to ensure care plans are person-centered and comprehensive. End of Life care plans will be developed to ensure documentation of resident and family wishes at end of life. • PIC will audit clinical documentation on monthly basis and develop a corrective action plan based on the audit findings.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • Medication reviews are carried out three monthly (or more frequently if required) by the resident's attending GP. Pharmacy carries out medication usage reviews and makes recommendations to the clinical staff and GP. • Senior management will meet with GPs to discuss prompt review of any recommendations made to ensure best outcomes for residents. Meeting to be scheduled but will occur before December 31st 2023.	
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: • PIC and restrictive practice lead will review all restrictive practices used in the facility to ensure compliance with the national policy. St. Joseph's Hospital is committed to a restraint free environment and person centred approach to care. • A review of the risk assessment in use for restraint will be conducted by the PIC to ensure assessment is informing decision making, and is incorporating risk versus benefit, resident view, alternative approaches and is in line with best practice. • A review of current restrictive practices will be carried out to reassess any restraint and attempt to reduce restraint use. Restrictive Practice (RP) Lead will provide education to all staff regarding use of restrictive practice, associated risks, promoting a restraint-free environment and a human rights-based approach to care. A schedule has been developed for trial removal of current restraints. Removal is scheduled with one resident restraint being removed on trial on each unit at a time. Removal of restraints will follow a standard operating procedure to ensure resident safety, including increased frequency of safety checks. CNM on each unit will monitor progress of trial restraint removal and report at restrictive practice committee meetings.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • PIC and activity coordinators will review and expand the activity program to ensure all resident preferences and level of engagement are incorporated. PIC will ensure all residents are provided the opportunity for meaningful engagement and activity. Rosters will be reviewed in line with the new schedule of events, with a view to increasing activity staffing level to meet the needs of all residents and to provide activities 7 days per week. This will ensure meaningful activation for the service. • The activity schedule is now updated on a weekly basis and is posted on each unit for residents to view. • PIC will ensure a rights-based approach to care delivery throughout the facility. Mealtime practices will be reviewed to ensure residents wishes and preferences in relation to where and when meals are served are respected. PIC will ensure a person-centered approach to residents' personal care. A shower schedule will not be utilised in the facility, instead residents' wishes will be respected in relation to their personal care. PIC will ensure residents are engaged in meaningful activity. Staff will encourage residents to attend activities, communal areas, and dining areas to allow for social needs to be met. Where a resident opts to remain in their room, staff will offer individualised activity to the resident. • Appropriate cloths are now in use for the delivery of personal care to residents, ensuring dignity and respect.	



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 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	31/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2023
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/11/2023

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.	Substantially Compliant	Yellow	31/12/2023
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.	Substantially Compliant	Yellow	31/12/2023
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	30/11/2023
Regulation 27	The registered provider shall ensure that procedures,	Not Compliant	Orange	30/11/2023

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/11/2023
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.	Substantially Compliant	Yellow	30/11/2023
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Substantially Compliant	Yellow	31/12/2024

	the resident concerned and where appropriate that resident's family.			
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.	Substantially Compliant	Yellow	31/12/2023
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	31/12/2023
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and	Not Compliant	Orange	31/12/2023

	linguistic background and ability of each resident.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/01/2024
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	30/11/2023
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	30/11/2023