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:	Clarehaven
Name of provider:	Health Service Executive
Address of centre:	St Canices Road, Finglas, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	24 August 2023
Centre ID:	OSV-0007745
Fieldwork ID:	MON-0041245

About the designated centre

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

Clarehaven Community Unit is located in Glasnevin. The centre was refurbished in 2019 and provides residential care for 47 older persons who are of medium, high and maximum dependency. The centre accommodates both male and female residents who are primarily over the age of 65. The centre consists of two single storey buildings which are divided into two units, Clarehaven and Seanchara. There is a variety of twin and single rooms, and communal areas include living rooms, visitor rooms and a hairdressers. Clarehaven Community Unit aims to provide a quality holistic service to older persons, delivered by skilled professionals that are person centred and recognise the rights and needs of each individual and their family.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

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 24 August 2023	09:20hrs to 16:30hrs	Karen McMahon	Lead

What residents told us and what inspectors observed

From the inspector's observations and from what the residents told them, it was clear that the residents living in the centre received a good standard of quality and personalised care. The overall feedback form the residents was that the centre was a lovely place to live with plenty of activities and friendly staff.

On the day of inspection the inspector was met by the person in charge and two clinical nurse managers. The centre is split over two buildings. One building is called the Clarehaven unit while the other unit is called the SeanChara unit. While touring the premises, the inspector observed that both units were clean and well-maintained.

Residents' bedrooms were observed to be bright, spacious and comfortable spaces. Many residents had personalised their rooms with photographs and personal possessions. There were eight double occupancy rooms which were well laid out and each resident had an ample amount of space. Privacy curtains ensured that residents living in these rooms had their privacy and dignity maintained at all times.

There were a selection of sitting rooms and dining rooms available for the residents to use, throughout both units. There was appropriate seating in these areas and some of the tables in the dining rooms had grooves in them to allow residents in wheelchairs to sit in close proximity to the table, at mealtimes. The sitting rooms were comfortable spaces for residents to participate in activities or to sit and watch T.V. The daily newspaper was available to residents to read. All the sitting rooms had fridges in them, with drinks and snacks available to the residents throughout the day.

The hallways were bright and the bedroom doors were painted in a variety of bright colours. This supported residents living with dementia find their bedroom and navigate the environment. Residents' artwork decorated the hallway walls. There was also fish tanks and some memorabilia items, including on old Singer sewing table. In one sitting room there was a large artwork piece which had been made by residents painting individual smaller canvases that when put together made a large painting.

There was a number of safe enclosed gardens and courtyards available to residents in the centre. These were accessible through communal areas. The inspector observed that the Clarehaven unit had a large enclosed outdoor space which was well-maintained with raised beds for residents to plant in, and mature trees and seating which allowed residents to enjoy the outdoors. SeanChara unit had multiple smaller outdoor areas. However, many of these were noted to need some attention. There were bare flowerbeds and the outside furniture needed repair. There were also multiple slip and trip hazards for residents in these spaces caused by a large amount of leaves on the ground, moss growing through gaps in the patio slabs and

uneven ground surfaces.

The inspector observed activities going on throughout the day of the inspection. One group of residents were making stuffed pumpkin decorations, from old unused clothes, for the upcoming autumnal season. This was being overseen by the activity co-ordinator on duty that day. Residents participating in this activity were clearly enjoying it. Another group of residents were observed coming in from a day trip to Phoenix park and were full of chat about how they thoroughly enjoyed getting out and about. There was a clear activity schedule in place in the centre with a varied choice of activities to meet the needs of all residents' residing in the centre. Mass took place in each unit once a week and was also streamed on TV from the local church each morning.

The inspector spoke with a number of residents on the day of inspection. All residents were complimentary about the services they receive. One resident said "if it wasn't good here then we'd be gone somewhere else." Residents all told the inspector about the kindness of staff and how helpful they were with their needs. Staff were observed by the inspector to be gentle and respectful in their interactions with residents.

Visiting was facilitated without restrictions throughout the centre. While no visitors were observed visiting during the inspection, residents reported that their family and friends could visit as they wish.

The next two section of the report present the findings of the 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 inspection found that the provider aimed to provide a high standard of care to the residents, however the inspector found insufficient oversight in respect of the management of restrictive behaviours and implementation of local policies.

There was a clear governance and management structure in place in the centre and the registered provider had arrangements to ensure that the centre was adequately resourced to deliver care in accordance with the centre's statement of purpose. However, gaps were identified in the oversight and management of the centre that required improvements.

This was a one day inspection to monitor the compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).

The centre is operated by the Health Service Executive (HSE), who is the registered provider. The management structure within the centre included an assistant director

of nursing, who was the person in charge. The person in charge was supported in their role by a number of clinical nurse managers and clinical staff including members of a multi-disciplinary team, nurses and health care assistants. Other staff also included activity co-ordinators, and household and catering staff.

There was a higher management structure within the remit of the registered provider that also provided support to the centre. This included a director of nursing who was on-site at least once a week. Regular management meetings took place with these members of senior management, the person in charge and other persons in charge from other centres, who shared the same registered provider. However, while staff meetings took place, there were no formal internal management meetings between the person in charge and clinical nurse managers within the centre. This resulted in a lack of oversight, follow through and effective monitoring of any changes made as a result of the outcomes of the senior management meetings.

There was a draft version of the annual review made available to the inspector on the day of inspection. This had not yet been made available to residents as it was still in draft format. While there was some reference to residents in the report, there was a clear lack of substantial and robust input from residents and their families. The report did not clearly demonstrate the levels of satisfaction of residents with all aspects of the services provided in the centre.

Written policies and procedures also needed some improvements, this is further discussed under Regulation 4; Written Policies and procedures.

The complaints policy had recently been updated to reflect the recent changes in the regulation. However, it still required some improvements. There was no clear documented procedure for informing residents soon after admission about the complaints procedure and did not detail how the complainant or the person who is the subject of the complaint should not be adversely affected by making the complaint.

Regulation 19: Directory of residents

The registered provider had established and maintained a Directory of Residents in the centre and was in line with the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

While there was management systems in place, the internal management systems needed improvements in the oversight to ensure the service provided is safe, appropriate and effectively monitored. For example, the following issues in the centre had not been identified and actioned:

- significant concerns regarding the use of restraints and the provider's failure to oversee staff practices and identify that they did not align to local policy.
- potential fall hazards, in outside spaces in one unit, and the need for maintenance works in these areas.

The annual review for 2022 had not yet been formally approved or made available to residents. It lacked evidence of appropriate consultation with residents and their families and did not reflect an overall view of the residents' level of satisfaction with the services provided, in the centre.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Improvements had been made to the contracts since the previous inspection. Contracts were now in line with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

While the complaints policy and procedure had been updated since the recent regulatory changes, some gaps were identified. For example;

- There was no written procedure in the policy to ensure that residents were informed of the complaints procedure as soon as is practicable after their admission to the centre.
- the policy did not outline or acknowledge how the complainant or the person who is the subject of the complaint is not adversely affected by reason of the complaint having been made.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Not all of policies were in line with the regulatory requirements, and some policies,

where available, were not implemented in practice. In addition, a number of policies had not been updated to reflect best evidence practice. For example;

- There were two generic documents representing the policy on "The creation of, access to, retention and destruction of records". One was a document published by the National Hospitals Health care records management steering committee published in April 2007 and the second was a document published by the Freedom of Information Liaison Group in October 1999. Neither of which had been reviewed or were in line with current up-to-date best practise and regulatory requirements.
- The policy on "Recruitment, selection and vetting of staff" was represented by a HR circular, circulated by the HSE in March 2018. This was not an appropriate representation of local policy and procedures and had also not been reviewed, since its publication.
- Some policies were not implemented in practice, for example the policy on restraint

Judgment: Not compliant

Quality and safety

Overall residents appeared happy living in the centre and their health, social care and spiritual needs were well catered for. Residents were well supported by staff and were able to choose how they spent their day. However, some improvements were required to ensure a safe and good quality service for residents, speciffically in respect of restrictive practices and residents' guide.

Residents with communication issues had access to specialist services including opthamology and audiology. Care plans clearly demonstrated appropriate means of communication for these residents. Staff were seen to be familiar with the needs of residents and were patient in their interactions with them.

Residents had safe access to medications, which were administered appropriately in accordance with guidelines as set out by the Nursing and Midwifery Board of Ireland. Residents who required transfer to hospital had all relevant documents sent with them. Any changes to care were reflected in the resident's care plan, on return to the centre. Care plans identified residents' beliefs and wishes for end-of-life care.

The inspector noted that there was a varied programme of group activities available for residents and observed that many staff engaged actively in providing meaningful activity and occupation for residents throughout the day of inspection. Information boards for residents were located in various areas around both units. These boards detailed information on upcoming activities, planned social occasions, the complaints procedure and advocacy services. Photos of a recent visit from a travelling pet farm were located near the information boards for both residents and visitors to see.

Staff had relevant training in responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). However, the inspector's review of residents care plans showed that significant action was required to ensure the use of restraint was being used appropriately and in line with the registered provider's own policy. This is further discussed under Regulation 7; Managing behaviour that is challenging.

A residents guide was available which described key areas of the service but improvements were required. The information around the complaints policy needed to be reviewed to reflect recent regulatory requirements and the information on advocacy services needed better provision and detail.

Regulation 10: Communication difficulties

Residents were facilitated to communicate freely in the centre. Where specialist requirements were required residents had access to appropriate services and care plans adequately reflected the needs of the resident.

Judgment: Compliant

Regulation 13: End of life

Residents, at end of life, had access to medical and palliative supports, as well as appropriate religious and spiritual services. Care plans documented individual wishes and spiritual beliefs.

Judgment: Compliant

Regulation 20: Information for residents

The information for residents did not detail the procedure around the external complaints processes such as the Ombudsman. Additional information regarding independent advocacy services was required. Advocacy services were briefly referenced under the resident's committee section of the information booklet but it did not provide appropriate detail on the role and function of advocacy services.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

An appropriate transfer document was used for the safe transfer of residents to hospital. Care plans were updated to reflect any changes in care on return from hospital treatment.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There was an appropriate pharmacy service offered to residents and a safe system of medication administration in place.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a high level of restraint use within the centre. A review of care planning arrangements and the registered provider's policy on restrictive practice, found that restraint was being used in breech of the center's own and national policy. For example;

- The policy clearly outlined that the use of restraint required the consent of a resident or an appropriate designated person if the resident lacked capacity to consent. However, there was no documented consent in any of the care-plans reviewed on the day of inspection.
- The centre's policy clearly stated that restraint "is not permitted for exit seeking behaviour". However, in one resident's care plan the reasons for use of restraint were documented as being required due to a "high risk of absconsion" as well as displaying responsive behaviour towards staff. Furthermore, it was stated how this resident did not consent to wearing a wander alarm so instead staff had placed it in the residents' mobility aid without the resident's knowledge.
- The policy stated that bedrails can be used at the request of the resident in specific circumstances only. However, the inspector found examples where residents who did not meet the criteria had bedrails in use. This posed a health and safety risk.

Furthermore, the care plans reviewed demonstrated a lack of individualised care

measures to respond to residents who may display responsive behaviour. The care plans also evidenced a lack of knowledge by staff on how to deal with such responsive behaviours.
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 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant

Compliance Plan for Clarehaven OSV-0007745

Inspection ID: MON-0041245

Date of inspection: 24/08/2023

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1) An internal nursing management meeting between the Person In Charge (PIC) and unit Clinical Nurse Managers will commence on 29/09/23 and be held on a six weekly basis. This will facilitate the communication and oversight of service matters within the unit on a formal basis. The agenda will include the implementation of policy. This will meeting will be minuted.

2) A daily walkround of the unit by the PIC, clinical nurse manager or nurse in charge commenced on 03/09/23. This includes a review of restrictive practices to ensure practice is in line with policy. Findings and actions arising will be shared with staff and documented in the daily unit handover sheet.

3) The unit will implement a quarterly quality and safety walk around. This will include senior management and a Quality Patient Safety representative. To commence on 10/11/23.

4) The leaves were removed from the outdoor areas on 25/09/23. Removal of moss will be completed by 31/10/23. A meeting has been scheduled for 28/09/23 with the unit Gardener to agree on a maintenance schedule.

5) Work to address the uneven paving in the outdoor garden areas will commence on 09/10/2023. In the interim period, to minimise risks of falls, residents are encouraged to use the other courtyard. The estimated completion date for the works is 31/12/2023. This is to allow for weather conditions which may impact on progress.

6) The garden furniture was removed on 25/08/23.

7) The Annual Review Report 2022 was approved by senior management on the 28/08/2023 and has been made available to residents. The PIC will ensure that the Annual Review report 2023 will be completed by 31/03/24.

8) The Residents Survey and Residents Committee agenda will be reviewed to ensure they comprehensively capture the view of residents. This will be used to inform service planning and the Annual Review Report 2023. This will be completed by 02/10/2023.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1) The Admissions Policy and Complaints Policy have been updated to include all information as outlined in the regulations. This will be completed by 29/09/23.

2) The Residents Information Guide, which is provided to residents on admission, has been updated to include the complaints procedure. This will be completed by 29/09/23.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
1) The outdated policy covering 'the creation of, access to, retention of and destruction of records' has been removed and replaced with the up to date version. The outdated policy covering 'recruitment selection and vetting of staff 'has been removed and replaced with the up to date versions.

2) Monitoring, review and updating of policies will be coordinated through the quarterly policy committee meeting for Dublin North City and County Community Nursing Units (DNCC CNUS). This committee reports to the overarching Quality and Patient Safety Committee for DNCC CNUS.

3) Staff were informed of the findings of this report on 24/08/2023. They were reminded of the policy and of the requirement to implement policy in full. Additional steps taken to promote implementation including education and an update to documentation, will be outlined under Regulation 7.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
1) The Residents Information Guide has been updated to include detail on the role and function of Advocacy Services and the procedure for external complaints processes including the Ombudsman. This will be completed by 29/09/23.

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:
1) The daily nursing management walkround will encompass a review of documentation to ensure compliance with policy and to ensure that restrictive practices are used appropriately. Findings, learnings and actions will be discussed and monitored at the internal nursing management meeting.

2) The Register of Restrictive practice is maintained by a Clinical Nurse Manager and reviewed monthly by the Person In Charge. The register is a standing item on the quarterly Restraint Free Environment Committee. Any actions from this committee will be monitored at the internal nursing management meeting. All occasions where restraint is used is reported to HIQA on a quarterly basis in line with regulations.

3) The Restraint Free Intervention Assessment and Multidisciplinary Prescription for Restrictive Intervention Form has been reviewed and updated to include a section on consent to ensure that this is documented. The CNMs are working with each resident and their families where there has been an MDT prescription for restrictive intervention to ensure consent is obtained and documented appropriately. This will be completed by 15/10/23.

4) Individualized care plans for responsive behaviours are in place. Psychosocial interventions available include Complimentary Therapy by CNS (i.e. reflexology, aromatherapy, contracture management), Diversional therapies, Cognitive Stimulation Therapy group and meaningful activities. An audit of care plans will be conducted by the Practice Development Nurse, ADON or CNMs to ensure appropriate implementation of the policy on the use of restraints. To be completed by 31/10/23.

5) All residents' care plans are reviewed in full by staff nurses, every three months or as required to ensure they accurately reflect the wishes and care needs of residents.

6) A monthly nursing quality care metrics has been completed to monitor and improve

residents' care.

7) A full care plan documentation audit will be completed annually by the Practice Development Nurse. Commenced on 21/09/23.

8) A Managing Responsive Behaviours refresher course is available to all staff. In addition, on 25/10/23 staff will participate in a Dementia Virtual Simulation Bus training initiative.

9) National Dementia training which includes discussion on the reduction of restrictive practices, human rights and responsive behaviours is provided twice yearly for all staff. All new staff will attend. Current staff are supported to attend as required.

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 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent advocacy services.	Substantially Compliant	Yellow	29/09/2023
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	29/09/2023
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 23(e)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/03/2024

	review referred to in subparagraph (d) is prepared in consultation with residents and their families.			
Regulation 23(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the Chief Inspector.	Substantially Compliant	Yellow	28/08/2023
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	29/09/2023
Regulation 34(4)(b)	The registered provider shall ensure that a resident (b) is not adversely affected by reason of the complaint having been made by them or by any other person, whether or not that person comes within the definition of complainant or	Substantially Compliant	Yellow	29/09/2023

	not.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	25/09/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	25/09/2023
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	15/10/2023
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	Not Compliant	Orange	15/10/2023

	the website of the Department of Health from time to time.			