Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Beaufort Campus Units Area 2 - St. John of God Kerry Services
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	24 November 2020
Centre ID:	OSV-0002905
Fieldwork ID:	MON-0028859

About the designated centre

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

The service was based on a large campus in proximity to a rural village. The service provided residential care for up to 39 residents who had moderate or severe intellectual disability. Some residents had a dual diagnosis and significant medical conditions. Residents were male and female and four of the residents availed of shared care and respite. Many of the residents had lived in the designated centre since they were young children. Accommodation was in 10 separate houses or units / apartments. Three residents had individual apartments. Between two and eight residents resided in each house. All accommodation was at ground floor level. The campus grounds were generally well maintained. The service was nurse led and the staff team comprised of nurses and care assistants. The designated centre was closed to future external admissions.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Tuesday 24 November 2020	09:30hrs to 18:30hrs	Michael O'Sullivan	Lead
Tuesday 24 November 2020	09:30hrs to 18:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

Of the 37 residents that lived in the designated centre, many residents communicated without words. In light of the recent COVID-19 outbreak on the campus, the inspectors limited their interactions with the five residents in one unit who had been diagnosed COVID positive. Full personal protective equipment (PPE) was used in all units visited where residents welfare and fire works completed required observation and confirmation. To reduce the risk to vulnerable residents, inspectors observed six other residents from outside of their homes. Telephone contact was made with residents families who spoke to the inspectors.

Inspectors arrived at the designated centre unannounced, to pursue some lines of enquiry. The registered provider was asked to alert all families who had a resident living on the campus, of the inspectors presence. The registered provider put in place a dedicated phone line so that families could make direct contact with the inspectors. The registered provider contacted families by email. Four families in total made contact. The majority of families spoke of the high standard of care that staff provided to residents. Families were happy with the supports in place. Some families acknowledged that they consented to the spending of residents monies on the provision of external therapies to their family member. No family was aware of the amount of money spent on external therapies. Families were complimentary of the efforts that staff made to provide a meaningful day and to also maintain family contact through direct visiting, transporting residents home and the use of information technology and mobile phones to aid communication. Some families were in receipt of daily updates in the form of photographs or videos which they very much appreciated. Some families stated that external activities were very dependent on staff resources but hoped that the employment of community activation staff would address this shortcoming.

Many families expressed concerns in relation to the current pandemic and the outbreak of COVID-19 within the campus and how it would or did impact on their family member. Concerns were also made in relation to the registered provider's communications regarding the possibility of handing the services to the Health Services Executive.

Capacity and capability

This was a follow up inspection to determine the level of compliance in relation to the registered provider's compliance plan response to the inspection of November 2019. Significant improvements were noted by the inspectors. It was evident that effective leadership and the delegation of actions across a number of managers had resulted in the registered provider addressing areas of previous non-compliance. A

substantial amount of actions committed to in the registered provider's previous compliance plan had been achieved. Resources to recruit additional staff and to address outstanding fire and safety works had been received and applied. Fire and safety works were on schedule to be completed by the end of the current year. Staff competencies and experience were subject to an ongoing staff review that provided for staff relocation to best suit the assessed needs of residents.

The provider in line with Regulation 23 Governance and Management had conducted an annual review of the quality and safety of services provided to residents. The provider had also carried out an unannounced visit to the centre at least every six months with plans put in place to address any concerns that had identified actions with time lines. The provider had also carried out internal audits in relation to fire and safety, adherence to the registered providers policies pertaining to managing residents finances and a personal outcome audit. Some of these audits were used by the provider to enhance the quality of service provided to residents. Local management had been requested to provide a detailed audit of all residents' monies spent over a defined 12 month period. It was evident from financial records requested from the registered provider, that a significant amount of residents' personal funds were spent on a range of external therapies. These therapies were reflexology, massage, gong and music.

The annual cumulative cost of external therapies availed of by residents was €20,723.25 with six residents having spent between €780 to €1225 in a 12 month period on reflexology. If there was a clinical indication for massage therapy, the overall cost to some residents was reduced by a waiver. This waiver was only applied to massage therapy. It was evident that some residents were spending a significant amount of their disposable income on external therapies. Inspectors were not assured that there were effective management systems in place to ensure that the service was appropriate to residents' needs with the significant amounts of residents' personal funds that were required for external therapies. Supports were not in place in relation to residents' payment for external therapies and were not subject to annual review. It was not evident that each resident had access to and retained control over their finances in this regard. It was not apparent if support was provided to residents to manage their financial affairs and the purchasing of such therapies. Nor was it evident whether the residents consented to such decisions. The cost of some of these therapies did not correlate with what was in the provider's statement of purpose and local management stated that this would be amended.

It was noted that the weekly activity schedule incorporated external therapies as part of the programme of activities. In some cases the number of paid external therapies on the weekly activity sheet exceeded what was provided for in the residents' financial passport. The provider's policy on resident finances did not include reference to external therapies and the cost to residents.

Inspectors were not assured that there were effective management systems in place to ensure that the service was appropriate to residents' needs with the significant amounts of residents' personal funds that were required for external therapies that accounted for resident activities. Supports were not in place in relation to residents'

payment for external therapies and were not subject to annual review or accounted for in the registered providers policy on residents' finances.

A staff recruitment process had been undertaken and there were additional staff recruited. Additionally, three new staff were appointed in September 2020 to plan and support activities for residents. These staff were not included in the general provision of care to residents so that their function of supporting activities was protected. An ongoing staff review on site involved the distribution of staff based on the assessed needs of residents. The inspectors reviewed the planned and actual staff rotas for the centre and these were in line with the numbers and skills mix necessary for the assessed needs of residents. It was also noted that the provider had carried out a staffing review of current resources taking into account the profile of the current residents and their changing needs. The provider had identified variances in relation to whole time equivalents that may be required to support enhanced care for residents and this piece of work was ongoing at the time of inspection.

The registered provider had records that evidenced all staff had undertaken fire and safety training that was in date. Additional training in relation to fire and safety awareness had also been undertaken. All staff had received training in relation to safeguarding vulnerable adults. The provider had in place training for managing and preventing behaviours that challenge as well as multi-element behavioural support. This training was specific to the assessed needs of residents and the home they lived in. Additionally, staff had undertaken training in relation to infection control, hand hygiene and the use of PPE.

Not all notifications had been made to the Chief Inspector, within the required three day period. One notification had not been made in the absence of the person in charge. All other reported incidents to the Health Information and Quality Authority (HIQA) were consistent with the registered provider's records on the national incident management system (NIMS).

Regulation 15: Staffing

The registered provider ensured that the numbers, qualifications and skill mix of staff were appropriate to the number and assessed needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had made significant improvements to the management

systems in place and additional resources had been secured to employ additional staff and address areas of regulatory non-compliance particularly in relation to fire and safety. However, the management systems in place did not ensure services were appropriate to residents' assessed needs. Residents' support needs to assist them to make an informed decision on the use of personal funds to pay for external therapies were not subject to annual review.

Judgment: Not compliant

Regulation 31: Notification of incidents

The registered provider did not ensure that all notifications were submitted to the Chief Inspector within 3 days of occurrence.

Judgment: Not compliant

Quality and safety

The inspectors noted that there had been an overall improvement in the quality and safety of services since the last inspection. The focus of service delivery was more aligned with the needs of and the support of residents. Staff allocations were based on the assessed needs of residents and prior to the COVID-19 pandemic had focused on increasing residents' access to the wider community. Residents were observed attending day services on the campus as well as being individually supported by staff to attend to exercise activities. Planned building and renovation works to address issues of fire and safety compliance were progressing to conclusion within the current year.

The premises provided additional space to residents as a result of reduced resident numbers. Most residents had a single occupancy bedroom and there were only two twin bedrooms for residents sharing. Bedroom spaces had been enhanced and there were additional efforts to personalise residents' bedroom spaces. Additional privacy access measures had been installed on bedroom doors, that afforded residents greater autonomy and security of possessions. Some premises had undergone extensive redecoration and two units had an additional sunroom completed. Residents appeared to enjoy these new spaces which gave them an additional vantage point of the campus. Some electrical switches had been upgraded to increase residents safety as well as encourage residents' use. Areas for receiving visitors were clearly identified and protected as visiting spaces. Some steel roller shutters had been removed and replaced with glazing which allowed residents to see into kitchens and food preparation as it was undertaken.

On the previous inspection, significant fire and safety issues had been highlighted to the registered provider. In response, the registered provider had secured funding to address such areas. On the day of inspection, the registered provider had a schedule of completed and proposed fire works. This schedule indicated that the registered provider would have all works completed by the end of 2020. It was evident that all fire drill times reflected the safe evacuation of residents. Each resident had a clear and current personal emergency evacuation plan. Each house had a weekly fire checklist that staff adhered to. Staff practices were observed to be of a good standard - fire exits were clear, oxygen was properly and safely secured and doors were not wedged open. The fire alarm system, the emergency lighting system and all fire extinguishers had been serviced in the current year. All staff had undertaken mandatory fire and safety training as well as local induction and fire and safety awareness training.

Since the previous inspection the registered provider had undertaken a significant review of its risk register and risk assessment process. The risk register for the designated centre was very comprehensive and allowed drill down to the individual risk assessments for each individual resident which were current and reflected the COVID-19 pandemic. On the day of inspection, it was evident that staff had undertaken training in relation to the proper use of PPE. Staff had also undertaken educational modules in relation to proper hand washing and breaking the chain of infection. Stocks of PPE were held centrally on the campus and it was observed that significant stocks were in place. Hand sanitizer stations were located throughout all houses with staff and residents observed to use these effectively. All visitors to a house were required to sign in and have their temperature recorded by a member of staff. Staff allocations were monitored to ensure that there was limited crossover and contact between the staff in each house.

A significant outbreak of COVID-19 had recently occurred on the campus. The registered provider had notified to HIQA a break in infection control procedures on campus. It was evident that the registered provider had taken this breach extremely seriously and this outbreak had little impact on the residents of this designated centre. Staff were subsequently retrained in relation to infection control policies, had back to work interviews and all crossover of staff between units was closely monitored and kept to an essential minimum. A clinical nurse manager was nominated as a lead worker representative and this person conducted weekly COVID-19 meetings with staff and attended monthly meetings in relation to quality and safety. Current public health guidelines were seen to be adhered to. The safe administration of medicines training for staff was occurring for the purpose of reducing staff crossover.

The activity records of all residents reviewed had reflected a significant improvement in the level of community based activities, prior to the start of the COVID-19 pandemic. The majority of community activities had opened up prior to the inspection, only to be restricted again in line with current national public health guidelines. The registered provider had recruited three additional social and recreational staff whose role was to support community activities for the residents and to work with other staff in the centre to promote community engagement. The impact of this engagement had yet to be seen as the staff were involved in planning

the roll out of activities before public health guidelines delayed increased community access. It was evident from family feedback that it was difficult for residents to plan for activities based outside the campus as staff resources were frequently cited as the reason preventing such activities occurring which impacted on residents accessing recreational activities and interests of choice.

The inspectors reviewed the individual care plans and notes relating to four residents. The records maintained were to a good standard. All individual goals had been the subject of review. It was clear that all residents had been in receipt of regular health assessments and their health needs were reviewed by staff working within their homes as well as allied health professionals. These professional inputs were specific to the assessed physical and medical needs of the residents in question. Reviews were clearly documented and the response of staff to attend to residents was immediate. Where representatives were unable to contribute to the residents' planning meetings, letters from the person in charge were sent to ensure family participation by seeking further involvement or any suggestions. All residents had a social story within their records explaining the works been undertaken to improve the environment they were living in. Residents had current safeguarding plans in place that were subject to ongoing review.

The health records and hospital passports of residents were reviewed on the day of inspection. All records were maintained to a high standard. Supports in place to support residents in outside hospitals were in line with current public health guidelines and there was evidence that the provider consulted clinicians in outside hospital to clarify a level of support required based on residents' needs and clinical direction. The level of supports agreed were consistent with the registered provider's protocol for supporting residents transferred to other hospitals.

Regulation 13: General welfare and development

The registered provider had increased facilities for residents to access community based activities prior to the commencement of the pandemic, the impact of additional recruited posts had yet to take place.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the number and assessed needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems in place in the designated centre for the assessment, management and ongoing review of risk in the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider ensured that all residents of this designated centre were protected from the risk of healthcare acquired infections especially COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider was taking steps to ensure effective fire safety management systems were in place, however the planned schedule of works to ensure the building fabric and building services complied with regulatory fire precautions were not yet complete.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that each resident had a current care plan that reflected effectiveness and changes in circumstance and assessed needs.

Judgment: Compliant

Regulation 6: Health care

The registered provider had in place appropriate healthcare for all residents based

on the residents' assessed needs.

Judgment: Compliant

Regulation 8: Protection

The registered provider ensured that residents were protected from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' personal living spaces had greatly improved, however, residents freedom to exercise choice and control over their daily lives remained limited to campus based activities.

Judgment: Substantially 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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beaufort Campus Units Area 2 - St. John of God Kerry Services OSV-0002905

Inspection ID: MON-0028859

Date of inspection: 24/11/2020

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23(1)(a)(c) :
Community based activities and actions will be implemented and restricted in line with the relevant public health guidelines relating to COVID 19 and the national restriction level in place at any given time.

• Therapies will be sourced in the community in the first instance as part of residents' activities once national COVID 19 restrictions allow. A review of each resident's participation in therapies will take place and identify if this activity can be pursued in the community.
Completion Date: 30/04/2021

• As per findings of the finance review carried out in October regarding residents' expenditure on external therapists, the registered provider will arrange for each family / representative to be notified of the findings of this review including an account of what the individual has spent on such therapies.
Completion Date: 31/01/2021

• Prior to the recommencement of any campus based therapies a Financial Will and Preference document will be completed in consultation with the resident and their circle of support outlining the proposed annual cost of therapies.
Completion Date:30/06/2021

• Financial Will and Preference document will be completed in consultation with the resident and their circle of support outlining the proposed annual cost of therapies identified as part of the residents personal planning meeting. This will be implemented in

line with the schedule of the residents Annual Planning meeting.
Completion Date : 30/12/2021

• As part of the annual audit schedule the PIC will ensure an audit is completed of the residents' financial passports.
Completion Date : 28/02/2021

• A review of the Local Finance Procedure to be completed to include reference to external therapies and reflect the option of residents accessing same.
Completion Date : 30/04/2021

• The Statement of Purpose has been updated to clarify costs of therapies to residents.
Completed : 11/12/2020

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Two additional CNM2 staff members from Designated Centre 2 have been added as administrators to the HIQA Portal to support the timely submission of notifications. These administrators have been advised by the PIC of the need to submit 3 day notifications as required by the regulator.
Completed: 30/12/2020

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Regulation 13(1), 13(2)(a), 13(2)(b):

• Social and Recreational support staff are in place and will resume individual community based activities in line with current National Public Health guidelines. A log of activities to monitor the implementation of the programme will be furnished to PIC monthly and jointly reviewed in consultation with team.
Completion Date: 30/05/2021

• Current campus based activities will be identified as part of the resident's individual planning process to determine if they are in line with resident's needs. Alternative

community based options will be identified to provide residents with increased opportunities for community activity in line with current National Public Health guidelines. Completion Date: 30/09/2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28(2)(b)(i), 28(3)(a) • A planned schedule of works to ensure the building fabric and building services comply with regulatory Fire precautions is in place. There is one item of work outstanding due to the delayed delivery of products; this will now be completed by 26/02/2021. Completion Date: 26/02/2021

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Regulation 9(2)(a), 9(2)(b) • Current campus based activities will be identified as part of the resident's individual planning process to determine if they are in line with resident's needs. Alternative community based options will be identified to provide residents with increased opportunities for community activity in line with current National Public Health guidelines. Completion Date 30/09/2021 • The PIC will review the community based activity with the CNM2 Manager per location on a quarterly basis as part of the PIC/CNM2 meeting to identify current implementation levels, progress and challenges in the location. Actions identified to improve implementation will be included and monitored in the unit plan. Completion Date 15/03/2021

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 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Substantially Compliant	Yellow	30/09/2021
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/09/2021
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in	Substantially Compliant	Yellow	30/09/2021

	accordance with their interests, capacities and developmental needs.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/12/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/12/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	26/02/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	26/02/2021
Regulation 31(1)(f)	The person in charge shall give	Not Compliant	Orange	30/12/2021

	the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	30/09/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/09/2021