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

Issued by the Chief Inspector

Name of designated centre:	Kilminchy Lodge Nursing Home
Name of provider:	Kilminchy Lodge Nursing Home Limited
Address of centre:	Kilminchy, Portlaoise, Portlaoise, Laois
Type of inspection:	Unannounced
Date of inspection:	13 April 2026
Centre ID:	OSV-0000052
Fieldwork ID:	MON-0049260

About the designated centre

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

This is a single-storey purpose built centre. Kilminchy Lodge Nursing Home is staffed by qualified nursing and care staff at all times and caters for residents whose dependency levels range from low to maximum. It accommodates both female and male residents over the age of 18 years with a varied range of care needs. This centre can accommodate up to 74 residents. It has 68 single bedrooms, and three twin-bedrooms, all with en suite facilities. Privacy screening is provided in the shared bedrooms. There is a large living room where many of the daily activities take place. The main kitchen is adjacent to the large dining area which leads to a secure outdoor area. The centre is situated in residential area in a busy town and is serviced by nearby restaurants/pubs/libraries/ pharmacies/ GP surgeries etc.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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 13 April 2026	08:00hrs to 16:10hrs	Laurena Guinan	Lead
Monday 13 April 2026	08:00hrs to 16:10hrs	Aoife Byrne	Support

What residents told us and what inspectors observed

Inspectors found that this was a well-run centre where residents were supported by a team of staff who were kind and caring. From what the inspectors observed and from what residents told them, residents were happy with the care and support they received. Those residents who could not articulate for themselves appeared comfortable and content. The centre had a relaxed and friendly atmosphere.

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the compliance plan from the previous inspection, unsolicited information received, and statutory notifications submitted to the Chief Inspector since the last inspection in October 2025.

On arrival, the inspectors walked around the centre, then had an introductory meeting with the person in charge and the regional director. The centre was purpose-built and divided into three units, Dunamaise, Maryborough and Slieve Bloom. The three units were interconnected and shared communal areas such as a dining room, two sitting rooms, a snug, a visitors' lounge and a hairdressing salon. There was a high standard of cleanliness throughout the centre, and the corridors had hand rails and were free of obstruction so residents could move about with ease. The dining room had menus on display on the tables, and the activities schedule was on display in the main sitting room. There was access to a secure courtyard from the dining room and this was seen to be well-maintained. There was an appropriately equipped smoking area in the courtyard, however, the inspectors pressed the call-bell located here twice and it was not responded to. This was discussed with the person in charge who acknowledged that it could not be heard by staff who were not in direct vicinity of the dining room. This was a finding on a previous inspection. During the walkaround, the inspectors saw handover sheets and records of safety checks, both of which contained personal information on residents, easily accessible at two of the nurses' stations.

The inspectors saw a number of residents' bedrooms and many had been personalised with their own belongings. Residents told inspectors that their rooms were comfortable, and some residents chose to spend most of their day there. Other residents were seen taking part in group activities in the main sitting room. All residents said that there was a good choice of activities to choose from and one resident said that 'you wouldn't be bored here'. Staff were accompanying a group of residents on an outing to a local attraction on the morning of the inspection, and one resident said they often went out for the day with family members. A number of visitors were seen throughout the day and those spoken with said they could visit at any time.

Staff were seen to knock on bedroom doors before entering and they engaged with residents in a respectful manner. All residents spoken with said that staff were kind and considerate, and the inspectors observed call-bells being responded to promptly. Residents described staff as 'excellent' and 'always around for you'. They told inspectors that preferences for their routine were respected, with some choosing to rise early and others preferring to sleep later.

Lunchtime was observed to be a sociable and relaxed experience, with residents eating in the dining rooms or their bedrooms, aligned with their preferences. Plenty of drinks were also available for residents at mealtimes and throughout the day. Residents spoken with said they were satisfied with the food available. Positive interactions between staff and residents were noted at mealtimes and throughout the day. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner.

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 impact on the quality and safety of the service being delivered.

Capacity and capability

The centre was seen to be well-resourced, with a stable management structure, although gaps were seen in some of the oversight systems in place.

Kilminchy Lodge Nursing Home Limited is the registered provider of Kilminchy Lodge Nursing Home, and is part of the Emeis group.

There was a person in charge who worked full-time in the centre and who was supported in their role by two assistant directors of nursing and a regional director who was present on the day of inspection. Staff nurses, health care assistants, an activities coordinator, household, catering, administration and maintenance staff made up the remainder of the staff team in the centre.

The inspectors reviewed a sample of audits that indicated a good level of compliance in many areas such as wound care, the transfer of residents to acute facilities, and the management of responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Where areas for improvement were identified, an action plan was in place to address the concern and these were seen to be completed. However, gaps in care plans seen by the inspectors on the day of the inspection had not been identified in care plan audits.

There was a system of meetings in place to enable efficient communication in the centre. Issues raised at these meetings were seen to be addressed in a timely manner. For example, concerns regarding the storage of residents' clothes raised at

a governance meeting in January 2026 was communicated and discussed with staff, and improvements were documented in a meeting in February. There was an annual review for 2025 and this was seen to have been completed in consultation with residents and families. An action plan for 2026 was being compiled, and the person in charge reported that restrictive practices and end-of-life care were identified as areas for continued enhancement over the coming year. The provider made improvements with the end of life experience for residents in 2025, however continued review in this area prompted the person in charge to liaise with a palliative care outreach programme, and the facilitator of the programme was visiting residents in the centre on the day of the inspection. The compliance plan from the previous inspection had been fully implemented.

A nationwide protest had resulted in a number of road blockades close to the centre in the days prior to the inspection. The person in charge had completed a risk assessment with contingency measures to ensure the centre was adequately resourced during this time. The inspectors saw an ample supply of hygiene, household and personal protective equipment in the centre's storage shed, and the fuel generator had been filled and serviced. No disruption to the access to pharmacy or food supplies had been experienced.

A review of staff rosters showed a good number and skill-mix of staff, with adequate measures in place to cover absences. There was one nurse and two health care assistant vacancies. A new nurse was due to commence employment in the coming weeks and the provider was actively recruiting for the health care assistant roles.

There was a robust induction system in place and staff who had recently completed the induction period said that it was comprehensive. New and relief staff routinely worked with experienced staff, and staff spoken with said that they felt supported. There was a suite of training available to staff, and the inspectors were told that staff were given ample notice and accommodated to attend training. The training matrix showed a high compliance in training in all areas including fire training, management of challenging behaviour, safeguarding, restrictive practice and infection prevention and control.

Documentation requested for the inspection was made available and provided in a timely manner. However, there were gaps in some residents' care records as outlined under Regulation 21: Records.

There was a complaints procedure on display in the centre and this was in line with the regulations. The inspectors reviewed a sample of complaints and saw that they were handled in line with the procedure. Both the complaints officer and the review officer had completed training in managing complaints.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to ensure that residents' needs were met in a prompt manner.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that there was good access to training and appropriate measures of formal supervision in place such as induction forms and appraisals. Staff spoken with told the inspectors that they felt supported in their roles.

Judgment: Compliant

Regulation 23: Governance and management

The oversight systems in place did not always ensure that the service was effectively monitored. This was evidenced by:

- The call-bell in the smoking area could only be heard if staff were in close proximity to the dining room. The oversight systems in place to monitor call bells had not identified this issue.
- Residents' information was not always kept in a safe and secure manner. This was not identified by the oversight systems in place to ensure that residents' information was kept safe and secure.

These are repeat findings.

- Care plan audits had not identified the use of generic care plans, and discrepancies between assessments and care plans seen on the day of the inspection.
- The oversight systems in place to ensure prompt referral to allied health professionals, and the accurate recording of their recommendations, were not robust.
- Oversight systems of staff practices did not identify if care was carried out in line with assessments. For example, an elimination care plan and continence assessment indicated a resident was continent, however, the resident was seen using continence wear.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had an accessible and effective procedure for dealing with complaints which was in line with the regulations.

Judgment: Compliant

Regulation 21: Records

The registered provider had not ensured that records of residents' medical assessments and treatment provided by the medical practitioner as set out in Schedule 3 were kept in the resident's health care file. For example, on one occasion it was documented in the nursing notes that a resident had commenced treatment for an infection, however, there was no evidence from the medical practitioner to indicate they had reviewed the resident and recommended this treatment.

Not all records were stored securely, and therefore residents' personal information was easily accessible to unauthorised persons. For example:

- Clinical handover sheets were seen left on the counter at a nurses' station.
- Records of safety checks on residents were easily accessible at a nurses' station.

This is a repeat finding.

Judgment: Substantially compliant

Quality and safety

Overall, residents expressed satisfaction with the care provided, and with the responsiveness and kindness of staff. However, deficits in the oversight of care plans and health care were seen on the day of the inspection.

Care plans were formally reviewed at intervals not exceeding four months and included consultation with the residents, or where applicable, their family. Inspectors observed examples of very good person-centred care plans that clearly outlined residents' preferences, including the time they like to go to bed, and their likes and dislikes in respect of food. However, the use of repetition and generic statements, which were not person-centred, was seen in a number of care plans reviewed on the day of the inspection.

Restrictive practices in use in the centre included bedrails, sensor mats and tilt and space chairs. From a review of records, there was evidence that residents had a full

risk assessment completed prior to the use of restrictive practices, and all restraints were included in the risk register. This was in line with the national policy.

Residents had good access to appropriate medical and health care. A general practitioner (GP) attended the centre twice weekly and was readily available for out-of-hours cover. Residents had access to a range of health care professionals, and this was evidenced from a review of residents' care records. Documents showed regular chiropody visits, and refusal to see the chiropodist was also documented. The majority of residents and visitors who spoke with the inspectors were satisfied with the GP service and out-of-hours medical cover. However, not all residents received timely medical and health care as discussed under Regulation 6: Healthcare.

The inspectors saw both breakfast and lunch being served. Residents were given the choice to dine in the dining room or in their rooms, and those who dined in their rooms confirmed that their meals were delivered hot. There was ample staff to assist residents and they did so in a respectful manner. The atmosphere during meal times was calm, and staff were seen to offer residents a choice of drinks and condiments, and the option to wear clothing protectors. Residents said that the food was tasty and staff accommodated them if they wanted to order off-menu. The inspector saw a sample of menus, and there was a variety of meals on offer. The provider had conducted nutrition audits and residents had requested more stews and casseroles, and less sponge cakes. These were seen to have been incorporated into the menu plans. Residents described the food as 'excellent' and said there was 'more than enough'. The chefs had a record of residents who required modified diets, and those requiring specific nutritional requirements, and this was updated regularly in consultation with nursing staff. Residents' preferences, such as a smaller portion or no sauce, were documented in the days' food choices. All food was cooked in the main kitchen which was a suitable size, clean and organised. The kitchen also had a separate room for the storage of chemicals and cleaning equipment, and a separate toilet for kitchen staff.

Regulation 18: Food and nutrition

There were adequate quantities of freshly prepared food and drinks, and the dietary needs of residents were accommodated. There was an adequate number of staff to assist residents at meal times.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

There was evidence that when residents were transferred out of the centre to another service that all relevant information accompanied them to the other service. Transfer letters were maintained in the residents' files.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While all residents had care plans in place that were initiated within 48 hours of admission and reviewed at regular intervals, from a review of a sample of residents' records, not all care plans had been updated when revised. This was evidenced by the following:

- There was no comprehensive assessment to indicate the need for resident's rights-based care plan, medication management care plan, an infectious process care plan and restrictive practice care plan for a sample of five residents reviewed. These were all pre-populated and generic, and contained the same information.
- A continence assessment for two residents were reviewed but not updated to contain all the key information relating to the specific resident, such as the type and size of continence wear required and frequency of product changes.
- One residents' nutritional assessment and nutrition care plan had not been updated to contain the correct information and contained differing modified diets. One indicted the resident was level 6, soft diet, and the other indicated they were level 5, minced moist diet. Therefore, it was difficult to determine which information was relevant.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner, physiotherapy, dietitian, speech and language therapy, and tissue viability nurse (TVN). However, not all residents received timely medical and health care in line with their care plans as developed under Regulation 5. For example:

- A treatment recommended by the TVN was not available in the pharmacy for over a month, and there was no evidence that an alternative treatment option had been discussed with the TVN.

Not all referrals were completed in a timely manner to respond to residents' changing needs. For example:

- A treatment recommended by the TVN in February 2026 had not been referred to the GP for prescription. Inspectors confirmed this on the day of inspection through conversation with staff, who were unaware the resident had been recommended this treatment, and observed that the resident had not received the treatment at the time of the inspection.
- A resident who was admitted to the centre in March 2026 did not have a medication prescribed until 11 days after their admission. It was observed that the resident had not been reviewed by the GP in this time.
- A resident who was assessed as experiencing a delirium due to a change in condition had not been reviewed by the GP. The resident was subsequently assessed by the palliative care team, but the source of this referral was not evident.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

There was a low level of restraint in use in the centre. From a review of records, inspectors saw evidence that where restrictive practice such as bed rails were in use, there was a risk assessment in place, and evidence of alternatives trialled prior to its use.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Kilminchy Lodge Nursing Home OSV-0000052

Inspection ID: MON-0049260

Date of inspection: 13/04/2026

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:
By the 09th of May 2026 a weekly call bell audit will be implemented which will include sound level and battery level check. This will be conducted by the maintenance team. The team will confirm if the alarm when activated is audible. This will be reviewed and monitored weekly by the inhouse management team.
From 1st May 2026, residents' information will be stored securely in the facility provided. This will be monitored and actioned during the daily Managers Walk Around. The newly installed locked unit will store any resident information that requires to be viewed by staff, but when not viewed/ in use will be stored securely.
By the 30th of May 2026 all residents' care plans will be reviewed to ensure that each care plan is person centred and meeting the individual needs of the resident.
By the 13th of May 2026, the Director of Nursing will have scheduled training sessions on assessments and care plans to ensure care planning is resident specific, person centred and meets the current assessed needs and preferences of each resident. Quarterly Training in conjunction with quarterly audits will be used to identify gaps in care planning and resident files and will guide staff training.
This will be monitored by the inhouse management team and monthly by the Regional Director at Clinical governance meeting.
A Meeting with the General Practitioner and liaison with MDT services was conducted on the 16th of April 2026 to address any gaps in timely reporting and referral of and by MDT team members. 1. Timely reporting and follow up of recommended treatment, 2. Accurate and Appropriate referral of requested of MDT referral and treatment 3. Evidence of Care provision and onsite review.
Nurses Handover will reflect that all nurses have received communication on what changes, interventions, and treatment of care has been requested by the G.P. CNM oversight will ensure care is delivered in line with assessed needs.
Commencing the 09th of May 2026, the CNM will liaise with the assigned nurse at G.P in house clinical rounds to ensure oversight and triangulation of required information. This will be monitored by the in-house management team. This CNM oversight will ensure

care is delivered in line with assessed needs.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A Meeting with the General Practitioner and liaison with MDT services was conducted on the 16th of April 2026 to address any gaps in timely reporting and referral of and by MDT team members. 1. Timely reporting and follow up of recommended treatment, 2. Accurate and Appropriate referral of requested of MDT referral and treatment 3. Evidence of Care provision and onsite review. Nurses Handover will reflect that all nurses have received communication on what changes, interventions, and treatment of care has been requested by the G.P. CNM oversight will ensure care is delivered in line with assessed needs.
By the 13th of May 2026, the Director of Nursing will have scheduled training sessions on assessments and care plans to ensure care planning is resident specific, person centred and meets the current assessed needs and preferences of each resident.
Quarterly Training in conjunction with quarterly audits will be used to identify gaps in resident files and will guide staff training.
Commencing the 09th of May 2026, the CNM will liaise with the assigned nurse at G.P in house clinical rounds to ensure oversight and triangulation of required information. This will be monitored by the in-house management team. This CNM oversight will ensure care is delivered and documented in line with assessed needs.
From 1st May 2026, residents' information will be stored securely in the facility provided. This will be monitored and actioned during the daily Managers Walk Around. The newly installed locked unit will store any resident information that requires to be viewed by staff, but when not viewed/ in use will be stored securely.
This will be monitored daily by the inhouse management team and Monthly by the Regional Director at Clinical governance meeting. Ongoing.

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:
By the 30th of May 2026 all residents’ care plans will be reviewed to ensure that each care plan is person centred and meeting the individual needs of the resident.
By the 13th of May 2026, the Director of Nursing will have scheduled training sessions on

assessments and care plans to ensure care planning is resident specific, person centred and meets the current assessed needs and preferences of each resident. Quarterly Training in conjunction with quarterly audits will be used to identify gaps in care planning and resident files and will guide staff training.	
Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A Meeting with the General Practitioner and liaison with MDT services was conducted on the 16th of April 2026 to address any gaps in timely reporting and referral of and by MDT team members. 1. Timely reporting and follow up of recommended treatment, 2. Accurate and Appropriate referral of requested of MDT referral and treatment 3. Evidence of Care provision and onsite review. Nurses Handover will reflect that all nurses have received communication on what changes, interventions, and treatment of care has been requested by the G.P. CNM oversight will ensure care is delivered in line with assessed needs.
Nurses Handover will reflect that all nurses have received communication on what changes, interventions, and treatment of care has been requested by the G.P. CNM oversight will ensure care is delivered in line with assessed needs.
Commencing the 09th of May 2026, the CNM will liaise with the assigned nurse at G.P in house clinical rounds to ensure oversight and triangulation of required information. This will be monitored by the in-house management team. This CNM oversight will ensure care is delivered in line with assessed needs.

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 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/05/2026
Regulation 23(1)(d)	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	30/05/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in	Substantially Compliant	Yellow	30/05/2026

	accordance with paragraph (2).			
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	31/05/2026