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:	Miltown Lodge
Name of provider:	S O S Kilkenny Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	27 April 2021
Centre ID:	OSV-0006413
Fieldwork ID:	MON-0031025

About the designated centre

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

This centre is a large single storied house set in it's own grounds in close proximity to Kilkenny city. The centre has capacity for four residents. It has a large open plan kitchen diner with two living rooms, each resident has their own bedroom and one is en-suite. There is ample parking to the front of the house and a large paved courtyard for residents to enjoy is to the side of the house. This centre is open 24 hours a day for seven days a week year round. Residents in this centre are supported by a staff team comprising a nurse, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 27 April 2021	09:30hrs to 15:45hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This inspection was completed during the COVID-19 pandemic and as such the inspector adhered to national guidance and best practice throughout. Review of relevant documentation took place in the providers offices separate to the centre and the inspector later met both residents and spent time in the centre itself.

This centre is a large bungalow set in it's own grounds in the suburbs of Kilkenny city, with ample parking to the front and the majority of the gardens hard landscaped with some smaller areas set to grass. The centre has been laid out with wide corridors and circulation spaces and the communal areas are spacious and open plan. The centre is clean, warm and contains many personal touches making it homely and reflective of the residents who live there. Each resident has their own bedroom and bathroom and one resident took pride in showing the inspector where they kept their clothes and belongings that were important to them.

Only two residents currently live in this centre and the inspector met with them both during the day. One resident had been out with staff for a drive and on return, indicated they wished to change into a different jumper, they were observed to be respectfully supported in doing this and then independently took the discarded jumper to their laundry hamper. Another resident was resting in the living room and watching television. Later both residents were together in the kitchen looking at information on a laptop. One of the residents in the centre has a dog that is an important part of life in the house and the resident brings them for walks and enjoys playing with them. The dog also provides support and companionship when residents are relaxing.

Residents had access to transport to facilitate their access to the community however the restrictions in place associated with COVID-19 were having an impact on the residents. One resident told the inspector that they were fed up with the COVID-19 lockdown and got bored when they stayed in the house for long periods. They reported that the staff team had supported them to do some courses online and that they were enjoying them. The staff were observed to be respectful and friendly with the residents contributing to the warm atmosphere in the house. Where a resident required dietary modification the staff were seen to prepare food and drink and to bring no attention to differences in presentation, thus normalising the process.

While there were some areas for improvement found on this inspection they were not seen to impact on the positive experiences of the residents on a day to day basis. While previous inspections had noted significant concerns relating to resident compatibility the provider had made changes to address these and further development of this centre is planned to ensure positive quality of life for residents is maintained.

Overall, this inspection found that residents were afforded a person centred service

that met their assessed needs however, improvements were required to ensure that the service was safe and appropriately monitored. The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

While residents appeared content in their home, improvements were required by the provider to ensure monitoring and oversight arrangements were strengthened. The centre had a clearly defined management structure in place consisting of a person in charge, who worked on a full-time basis in the organisation and was supported in their role by a full-time and experienced person participating in management who held the role of assistant director of services. The person in charge is supported by a team leader in this centre.

Since the previous inspection there have been two changes in the role of person in charge and the current individual has just taken over this role. While they were new to the role in this centre the inspector saw that they were spending time getting to know the residents and their specific support needs.

The centre was found to be adequately resourced to provide for a good quality service to the residents who lived there. Staff were provided for the most part with relevant training to assist them in supporting residents. However, some staff had not completed specific training that was required for the provision of safe care to residents in line with their needs.

Systems to ensure the centre was monitored and audited as required by the regulations required improvement.There was no annual review of the quality and safety of care available in the centre. In addition six-monthly auditing reports were not being completed as required. Some audits of the service were occurring but they were not comprehensive and did not identified all issues that were found on the inspection in areas such as medication or behaviour that challenges.

Regulation 14: Persons in charge

There was a new person in charge in the centre who had just taken on the role in addition to that of person in charge of two other centres. While the person in charge was experienced and had the qualifications and skills necessary to manage the centre the inspector had concerns regarding the size of their remit. The provider had however, ensured a team leader was in place to support the person in charge and had committed to continuous review of the role.

Judgment: Compliant

Regulation 15: Staffing

There was a consistent staff team in place that was appropriate to the assessed needs of the residents. The staff team comprised social care workers, a nurse and care staff, a dedicated relief staff member was also allocated to the centre.

The inspector reviewed a number of staffing rotas and found they accurately reflected the staffing presence in the centre. The residents were supported at all times both day and night.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed training records for the centre and found that a number of staff were due refreshers of mandatory training, and some staff were due training in areas such as, fire warden and manual handling. Resident specific training was required in this centre to ensure safe care was provided to residents including dysphagia (eating, drinking and swallowing management) and Diabetes and glucagon training and the inspector was concerned that a number of staff had not received these.

Judgment: Not compliant

Regulation 23: Governance and management

As stated already there had been a recent change in the management team for this centre. Lines of authority and accountability were clear however and staff spoken to knew who to speak with should there be a concern. A team leader was also present in the centre to provide support to the person in charge in completion of audits and systems of oversight.

Oversight and review by the provider required improvement however, there had been no annual reviews of the quality and safety of care and support provided in the centre since the centre had been registered. In addition while a six monthly unannounced report had been completed in June 2020 none had been completed since then as required by the regulations.

Staff meetings were not being held on a regular basis with the last minutes available

for review dated in September of 2020. Some audits of the service were occurring but they were not comprehensive and did not identified all issues that were found on the inspection in areas such as medication or behaviour that challenges. It was also of concern that personal data that pertained to others was found in one residents file that had not been removed by management. This was completed on the day of inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose is a key governance document which describes the service to be provided. The provider had ensured that a statement of purpose was in place and had been subjected to regular review. This was reviewed and found to contain most information as required by Schedule 1, the document was immediately reviewed by the provider and a revised version submitted to the inspector. The inspector was satisfied that it reflected the day-to-day operation of the centre and accurately described the model of care and support provided.

Judgment: Compliant

Regulation 31: Notification of incidents

While the provider and person in charge were aware of their remit to notify the Chief Inspector of any adverse incident occurring in the centre as required by the regulations this had not consistently happened. A number of three day notifications had been submitted late and while the reason for this was identified as an internal system failure it had occurred on at least five occasions. In addition review of the incident records showed that not all minor injuries had been returned as required to the chief inspector on a quarterly basis.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector reviewed the complaints records in the centre and noted that all complaints had been dealt with in line with the providers policy and the satisfaction of the residents of the outcome had been recorded. Residents told the inspector that they knew how to make and complaint if they were not happy and explained they had been supported to write letters or make complaints external to the centre when

requested. A resident told the inspector they had complained about the length of time it had taken to make arrangements for them to move to another centre and explained that their complaint had been addressed with a meeting with the CEO and positive assurances given that the resident was happy with.

Judgment: Compliant

Regulation 21: Records

There were errors found in documents relating to the management of residents medication and care plans. A medication management plan for one resident had not been updated to reflect current speech and language therapy guidance regarding safe swallowing practices. A diabetes care plan which had been updated in March 2021 did not refer to the up-to-date daily and as required (prn) medication protocols.

Judgment: Not compliant

Quality and safety

The quality and safety of care provided to the residents was being monitored. However, this was not consistently identifying areas for improvement. While residents' complex healthcare needs were being comprehensively provided for, errors in documentation meant that risks were present that were not consistently addressed.

Residents were supported to enjoy best possible mental health and, where required, had access to psychiatry and behavioural support. Residents had a positive behavioural support plan in place although these had not been reviewed in line with the time frames identified in the plans. Some restrictive practices were in place that had not been identified as such and were not therefore assessed and reviewed in line with the providers policy. Staff had received training and where this required refresher training it was scheduled, this meant that they had the skills required to support residents in a professional and calm manner if or when required.

The registered provider and person in charge had ensured that control measures were in place to protect against and minimise the risk of infection of Covid-19 to residents and staff working in the centre.

There were policies and procedures in relation to medicines management and suitable practices in relation to ordering, receipt, storage, and disposal of medicines. However, on reviewing a number of medication care plans, prescriptions and administration records the inspector found that discrepancies in relation to the

administration of as required medicines and the details in medication care plans had not been recognised or reported.

Regulation 12: Personal possessions

The inspector found that improvements had been made since the last inspection regarding the management of residents personal possessions. Where previously resident's personal belongings had been in storage they were seen to be present in their home on this inspection. Records of personal possessions were in place and there was evidence these were updated.

Where a resident was supported by a family member to manage their finances this posed difficulties and potential risks. The resident did not have full access to their own money at all times and had no bank card or any sight of their accounts. Staff and management supporting the resident did not have oversight of the residents spending, as an example they had no copies of bank statements, and therefore could not complete audits in line with the service policy. This had been identified by the provider and while there was evidence of engagement with family, on the day of inspection the resident remains without access to or control of their finances.

Judgment: Substantially compliant

Regulation 17: Premises

This centre presents as a warm and inviting home for the residents who live there. One bedroom currently not occupied is being used as a quiet space for one resident and the residents both have their own bedrooms which are decorated in line with their preferences. The fourth bedroom has however, become an office and staff room, this was discussed with the person participating in management of the centre as this centre is registered for four residents and only three bedrooms are currently available.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had ensured there was a policy in place with respect to health and safety and risk management to guide staff. The person in charge had identified and assessed both general centre based and individual specific risks. There was evidence

of learning from review of incidents with new risks identified and assessed.

However, some risks had not been reviewed as required such as the falls risk assessment for one resident in the centre or the risks associated with infection control which had last been reviewed in December 2019. In addition, some individual risks were not identified, these included a risk of financial abuse.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider, person in charge and the staff team had taken steps in relation to infection prevention and control in preparation for a possible outbreak of COVID-19.

The person in charge ensured regular cleaning of the premises, sufficient personal protective equipment was available at all times and staff had adequate access to hand-washing facilities and or hand sanitising gels. Mechanisms were in place to monitor staff and residents for any signs of infection.

Provider audits were in place to monitor infection prevention and control systems in the centre and actions that were identified were being completed as required. Residents had been provided with a number of clear and easy read guidance documents and there was evidence that residents were involved in decision making with respect to testing and receipt of vaccinations.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements to detect, contain and extinguish fires in the centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Fire drills were held regularly in line with the providers policy and there was evidence that actions arose from review of these. Residents' personal evacuation plans were reviewed regularly and the centre evacuation plan had also been reviewed as required.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were policies and procedures in place relating to the ordering, receipt,

prescribing, storage and disposal of medicines. The inspector found a number of documentary errors on the day of inspection, which related to the administration of medication however, the residents had current and accurate kardex/prescriptions and records of administration were in place. These documentary errors are reflected in the judgement against regulation 21.

Residents had up-to-date self medication assessments completed and the staff team were familiar with the residents assessed medication needs. The protocols for 'as required' medication present in a residents file were not the most up to date, however, the current protocols were present in a daily working file. Medication audits were in place and where errors were identified there was evidence of learning from these and updated actions completed.

Judgment: Compliant

Regulation 6: Health care

Systems were in place to ensure the healthcare needs of the residents were provided for and access to GP services and other health and social care professionals, as required, formed part of the service provided. Residents' changing needs were recognised and appropriate assessments and supports put in place.

Detailed records were kept in line with the providers practices relating to attendance at all medical appointments. Residents had up-to-date hospital care plans and following recent planned admissions there was evidence that these plans are reviewed and live documents.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider promoted a positive approach to the management of behaviours that challenge and supported residents to experience positive mental health. The inspector found however, that the behaviour support plans for both residents had been due review in 2020 and these had not been completed. Both residents had updated mental health care plans and there was evidence of ongoing reviews by consultant psychiatry.

The inspector found there were a number of restrictive practices in use in this centre, these were recorded on a centre restrictive practice register and there was evidence they were reviewed and had been sent to the providers human rights committee for consideration and review when required. It was observed that consideration had been given to a number of practices to ensure the least restrictive

option was in use. However not all restrictive practices had been recognised and recorded, for example, one resident had limited access to the kitchen at times as a result of behaviours of concern.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to keep residents safe in this centre. Since the last inspection compatibility issues that were identified had been addressed, and the inspector noted that safeguarding plans were reviewed and closed in line with policy and there were no current safeguarding plans in place.

Where residents required support with personal care there were intimate care plans in place that provided specific and up-to-date information to staff.

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 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Miltown Lodge OSV-0006413

Inspection ID: MON-0031025

Date of inspection: 27/04/2021

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The manager has receives a updated training record for all staff from the training department and books staff on training as required. Staff also have access to their own training records and required to check this to ensure they are compliant in their training requirements. All staff have been given a date for quality conversations, this will identify gaps in learning/training and look for areas for development. Team meetings have been reintroduced, these will continue on a monthly basis and will have a learning/development theme as part of the standing agenda.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Manager will be carrying out monthly checks and oversight to ensure governance/oversight. A management weekly/monthly checklist will be implemented to evidence oversight/governance; this will be sent to ROM. Quality assurance has a schedule in place to ensure that 6 monthly and annual internal	

provider audits and carried out and completed.

There will be monthly team leader meetings to ensure all governance/oversight is identified, agreed and followed up for completion

Team meetings have been reintroduced and will take place on a monthly basis.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
New manager has oversight of all internal notifications that may require a HIQA notification and will be submit if required.

Manager has already submitted the last quarterly notification for Milton Lodge; this requirement will continue moving forward.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Manager has met with the nurse who works in the centre and discussed expectations and requirement to ensure all medical records are accurate and up to date. The team leader will initially ensure this is being done as required.

All Key workers have had a meeting with the manager, and are clear about ensuring all records/care plans are up to date and accurate.

A monthly check will be carried out by the manager/team leader, to ensure all of the above is being implemented.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

The process to get a bank account set up in underway, the family will continue to manage the residents account, however the service will be able to access bank statements and support the resident to have oversight of their finances and have a bank card available to them.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The 4th bedroom that is currently being used as the staff office can be converted back to a bedroom if this is required.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All risk assessments have been reviewed and updated as required. The manager/team leader will meet with key workers on a monthly basis to review risks and will direct any updates to current risk assessment to be completed, or identify any new risk assessments to be completed. The restrictive practice committee will recommence on the 17th June 2021 and all restriction will be reviewed in line with the policy.	

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Manager will carry out monthly checks of residents file to ensure all behavior support plans are current and up to date. There will also be a regular key worker meeting to ensure that all gaps in documentation is identified with agreed timescales to complete any work that needs to be completed.	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/08/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/08/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/12/2021

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the designated centre.	Not Compliant	Orange	30/06/2021
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	30/06/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/07/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Not Compliant	Orange	30/07/2021

	carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/07/2021
Regulation 31(1)(f)	The person in charge shall give 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.	Not Compliant	Orange	01/06/2021

Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	01/06/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	30/06/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/06/2021