Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dunlavin Nursing Home
Name of provider:	Dunlavin Nursing Home Limited
Address of centre:	Dunlavin Lower, Dunlavin, Wicklow
Type of inspection:	Unannounced
Date of inspection:	15 June 2026
Centre ID:	OSV-0005381
Fieldwork ID:	MON-0048963

About the designated centre

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

Dunlavin Nursing Home is located within walking distance from Dunlavin town. The centre is a 64 bed purpose-built facility. Residents' accommodation is arranged into three units. Stream unit is secured and provides accommodation for 18 residents who have dementia. Railway unit has accommodation for 25 residents and Market House unit has accommodation for 21 residents. All units in the centre accommodate male and female residents over 18 years of age. All residents reside in single bedrooms with full en suite facilities and there is one twin bedroom with full en suite facilities. Each unit has a day-room and a dining room. Other sitting rooms and seating areas are located in Railway and Market House units. A seating area is available by the nurses' station in Stream unit. All units have access to secure landscaped gardens. The centre caters for residents with long term care, convalescence and palliative care needs. The service provides 24 hour nursing care for residents, with low, medium, high and maximum dependency needs.

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 15 June 2026	08:10hrs to 15:50hrs	Aoife Byrne	Lead

What residents told us and what inspectors observed

Based on the observations of the inspector and discussions with residents and staff, Dunlavin Nursing Home was a nice place to live. Resident's rights and dignity were supported and promoted by kind and competent staff. The inspector spoke with residents and visitors who were very complimentary in their feedback and expressed satisfaction with the care, staff and the activities programme.

Dunlavin Nursing Home is a purpose built, one storey premises located on the outskirts of Dunlavin, Co. Wicklow. The centre is registered to provide care for a maximum of 64 residents. The accommodation consists of three units referred to as "Stream", "Market" and "Railway". The centre was nicely decorated in a homely way with residents art work on display throughout. Resident's bedrooms were personalised with their individual possessions such as furniture from home, plants and photos.

On arrival the inspector spent time walking through the centre, which provided an opportunity to introduce themselves to residents and staff. Some residents were observed to be up and about in the communal areas chatting with each other, while others were observed sleeping in their beds or waiting on breakfast in bed. The inspector observed that most bedrooms had the door and window open which meant residents who were still in bed were visible to people walking by. The inspector was told by staff that this was to improve circulation in the building throughout the day and night, due to the building being uncomfortably warm.

During the walk around the inspector observed a number of notice boards for residents, staff and visitors, which provided information on the providers complaints process and advocacy services. There was a display in the reception area to inform visitors and residents that the centre participates in the Caru programme for nursing homes. This programme is to ensure staff are supported in the delivery of palliative, end of life and bereavement care.

Overall, the premises was mostly well-maintained. The inspector observed that the corridors and bedroom doors had been painted since the last inspection in August 2025. There was an ongoing programme of refurbishment works to improve the premises that was seen on the day of the inspection. However, the inspector found that the ambient temperature was not suitable for residents in all parts of the designated centre. The electronic thermostat monitor in some parts of the centre in the early morning showed readings as high as 29 degrees Celsius. This was also observed on the last inspection.

Residents' spoken with said they were very happy with the activities programme in the centre. The weekly activities programme was displayed throughout the centre on notice boards. The morning activity included a serenity prayer with choir time. Following this, the residents had a sing song, with one resident singing "Que Sera,

Sera" and encouraging others to join in with the song. The inspector observed staff and residents having good humoured banter during this time. In the afternoon a large number of residents took part in chair exercises. In conversation with the activity staff, a fashion show and tropical themed party was planned for the summer and they informed the inspector that the residents decide on what activities they want to occur in the centre.

The inspector also observed lunch being served to the residents, and the food looked hot and nutritious. There was a choice of bacon and cabbage or steak and mushroom pie for lunch. However, there was only one option of level 5 minced moist diet, minced beef, available to residents on the day of the inspection and staff informed the inspector that there is normally only one option available. For those residents who required assistance, there were plenty of staff available to provide assistance and staff were observed sitting beside residents and assisting in a kind, and unrushed manner. Residents' feedback about the quality and quantity of food provided was mixed, with residents saying "the food is not great at times" and "the food could be better". Residents meetings echoed the comments from the residents spoken with on the day of the inspection, where concerns were raised in relation to "portion sizes", "texture of food" and "breakfast cold at times".

The inspector spoke with a number of residents on the day of the inspection. Residents spoke highly of the staff who supported them. One resident told the inspector "the staff are lovely" while another said "I get on with all the staff, they are great". Residents were aware of the procedure in place for making complaints and those who spoke with the inspectors said they felt comfortable to communicate any concerns to a member of staff. Residents also told inspectors that they felt safe living in the centre.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). This inspection also followed up on the compliance plan from the last inspection in August 2025 and reviewed solicited information. The inspector found that the provider had progressed with the majority of actions set out in their compliance plan following the last inspection, and this inspection found improvements in regulatory compliance. Notwithstanding this, there were gaps identified in meeting requirements of regulations to include Regulation 21: Records and Regulation 23: Governance and Management.

Dunlavin Nursing Home is operated by Dunlavin Nursing Home Limited and is the registered provider of this designated centre, which is part of the wider Silverstream Healthcare group who operates a number of other designated centres nationally. Since the last inspection, there has been changes to management with the assistant director of nursing (ADON) stepping up as the person in charge for the majority of 2026, while the provider was recruiting a new person in charge. The inspector found the person in charge responsive and knowledgeable on inspection. The person in charge worked full time in the centre and was supported in their management role by two clinical nurse managers. This was a recent change where they had recruited a second clinical nurse manager for the centre to strengthen the management structure.

The registered provider had monitoring systems in place to oversee the service such as meetings, and auditing. There were inconsistencies with staff and committee meetings. This meant that actions were not always followed up, or addressed at the follow up meeting. Furthermore, audits were occurring monthly and these included falls, pressure ulcers, care plans and dining experience. However, the inspector found areas that required improvement which had not been identified by the provider's own internal auditing systems.

The registered provider had completed an annual review of the quality and safety of care delivered to residents in 2025. There was evidence of consultation with residents, and an action plan put in place to respond to areas for improvement identified for 2026.

There was an ongoing schedule of training in the centre and the person in charge had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. Training on managing behaviour that is challenging was taking place in the centre on the day of the inspection.

Records maintained in the centre were in paper and electronic format. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available for each member of staff. There was a record of current registration details for all staff nurses with the Nursing and Midwifery Board of Ireland. However, the inspector saw that some staff files were not in line with Schedule 2, this is discussed further under Regulation 21: records.

The centre had a complaints policy that was in line with the regulations. The inspector reviewed a sample of both verbal and written complaints and saw that they had all been dealt with appropriately. Residents were aware of the policy in place for managing complaints and told inspectors that they felt safe and supported to raise any concerns with the staff team.

Regulation 16: Training and staff development

Staff had access to appropriate training for their roles. Mandatory training was provided in key areas such as adult safeguarding, moving and handling and fire safety. Refresher training was available to ensure staff maintained their training requirements. Staff were appropriately supervised in their roles and were confident to carry out their assigned duties.

Judgment: Compliant

Regulation 21: Records

A sample of staff files were reviewed. There were examples where the requirements of Schedule 2 of the regulations were not met. For example:

Two out of four staff files reviewed found that there was a gap in employment history for which an explanation had not been recorded.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had a valid contract of insurance.

Judgment: Compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was consistent and effectively monitored were not sufficiently robust. This was evidenced by the following:

- Insufficient oversight of the implementation of the compliance plan from the previous inspection. The provider had committed to reviewing all care plans and assessments to ensure they were updated and accurate to enable staff to deliver care appropriately.
- Auditing systems were not fully reliable in identifying and responding to areas for improvement. For example;

1. The audits carried out on the dining experience for residents did not identify the concerns raised by residents and the findings of this inspection. An audit

in quarter one and quarter two of 2026 outlined the centre received 100 percent compliance in this area.

2. Care planning audits had not identified that safeguarding care plans were generic, and not individualised to residents' assessed needs to provide effective guidance to staff on how to effectively safeguard the residents. This did not assure the inspectors that the provider understood the importance of effective communication and safeguarding plans for the residents who require them. This is a repeat finding.

- Inconsistent meeting schedules led to actions not being completed. For example, Infection Prevention and Control, Restrictive Practice and Safeguarding Committee meetings that occurred in February 2025 had not been followed up until March 2026.
- There was poor oversight of the ventilation within the centre to ensure that the designated centre was at a comfortable temperature. This is a repeat finding.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints were seen to be handled in line with the centre's complaints policy. A copy of the complaints procedure was displayed in prominent positions throughout the centre and included details of the complaints officer and what to do in the event complainants were not happy with the outcome of the complaint.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the residents living in Dunlavin Nursing Home were receiving a good quality of life. Residents' health, social care, and spiritual needs were met to a good standard. Some areas required further review and attention to improve compliance with the regulations, these included care planning, information for residents and the premises.

The inspector reviewed a sample of residents' records in each unit. Validated risk assessments were regularly completed to assess clinical risks such as; the risk of malnutrition, falls and pressure ulcers. Inspectors observed examples of very good person centred-care plans such as end of life care plans that clearly outlined residents' assessed needs and included their preferences relating to their cultural and spiritual needs. However, as discussed earlier in this report the care delivered

was not always reflected in care plans as outlined under Regulation 5: Individual assessments and care plans.

Overall the centre was suitably decorated and laid out to meet the individual and collective needs of the residents. The majority of all three units were recently painted and this included corridors and outside of residents bedroom doors. Some areas of the centre were found to require further maintenance, and a programme of refurbishment was ongoing in the centre. The areas that required maintenance will be discussed further under Regulation 17: Premises.

A residents' guide was available in the centre. However the guide was not updated with the most recent registration details, and correct details for the PIC and other management team. The guide contained information on the service and facilities available. It also advised how to access inspection reports. However, it did not contain all information as set out by the regulations.

The inspector found that residents were free to exercise choice about how they spent their day. There was a schedule of activities in place and residents could choose whether or not to attend these. Residents had access to television, radios, newspapers, telephones and internet connection. However, it was found on the day of the inspection that not all residents were afforded choice in relation to the dining experience. This is discussed further under Regulation 9: Residents rights.

Regulation 13: End of life

Residents received end-of-life care based on their assessed needs and their own preferences. Individualised end- of -life care plans were person- centred to address the physical, emotional, social and spiritual needs of the resident. Family and friends were incorporated into their end-of-life care plan with the consent of the resident.

Judgment: Compliant

Regulation 17: Premises

A review of the premises found that the provider had completed the majority of actions set out in the compliance plan submitted following the previous inspection. However some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations as follows;

- Resident's bedrooms had some wear and tear such as chipped paintwork, and damaged doors from the inside of the bedrooms.
- Some wear and tear to architraves throughout the corridors
- The courtyard was not well maintained for residents use, with weeds seen which made the area look unkempt and not a nice place to spend time in.

However, it is acknowledged that new artificial grass was installed as per the previous compliance plan, but this was not appropriate, and the provider has arranged for new artificial grass to be installed in the coming weeks. This was evidenced by emails.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents of the centre and this was made available to each resident. However, the guide did not include the terms and conditions relating to residence in the centre, and the complaints procedure is not in line with the policy.

Judgment: Substantially 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 28: Fire precautions

A review of fire precautions in the centre found that the provider had completed the actions set out in the compliance plan submitted following the previous inspection. Fire doors were realigned and adjusted and there was evidence of works completed. A new schedule was in place following a new fire audit completed.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Following a review of a sample of comprehensive assessments and care plans, not all care plans reflected the current assessed needs of residents, and were not

consistently person-centred, with insufficient detail to support staff in providing appropriate care. For example:

- Each resident had a combined safeguarding, human rights and behavioural support care plan in place. Therefore it was difficult to determine what information was relevant to the resident's current needs. These did not reflect the individual supports or care required or identify the safeguarding risks. This is a repeat finding.
- A mobility care plan for a resident who required a full hoist and wheelchair had information in relation to the use of a zimmer frame and hip protectors which was no longer relevant to the resident. Therefore, it was difficult to determine what information was relevant to the resident's current needs.
- A skin integrity care plan referenced a wound from 2025, that required assessment every three days and outlined the specific dressings required. However, on further review there was no wound assessment completed to inform the reason for the care plan.
- A safeguarding care plan had a chronology of historical information from August 2023 and information in regard to managing behaviours that challenge rather than safeguarding measures.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were not facilitated to fully exercise choice about their dining experience, as evidenced by:

- The inspector was informed by both staff and residents that residents recommended to be on a minced moist modified diet was not given a choice at meals, similar to residents on a regular diet.

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 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 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dunlavin Nursing Home OSV-0005381

Inspection ID: MON-0048963

Date of inspection: 15/06/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Person in Charge, supported by Human Resources Team, will complete a full audit of all staff files against the requirements of Schedule 2 using a standardised checklist. The two files identified during the inspection have been reviewed and, a written, signed and dated explanation for each gap in employment history has been documented. Any further gaps identified during the audit will be addressed in the same manner. The recruitment and staff file checklist will be revised so that a file cannot be signed off as complete until the full employment history has been verified and any gaps have been satisfactorily explained. The Administrator will complete a monthly audit of staff files to ensure gaps are addressed and compliance maintained.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The RPR Team has implemented a quarterly Clinical, Risk and Quality Improvement Plan Report covering inspection findings, previous compliance plan actions, internal audit findings and quality improvement plans. The person in charge will update and review the centre's action tracker monthly. The	

RPR Team will review progress through the quarterly report until all actions are completed, verified and closed, and emerging or recurring trends have been analysed.

When completing dining experience audits, the person in charge will include direct observation, resident feedback, food temperature, portion sizes and confirmation that residents receiving texture-modified diets are offered an appropriate choice.
A resident satisfaction survey was completed in June 2026. The results demonstrated a high level of satisfaction. Areas identified for improvement have been added to the centre's quality improvement plan and will be monitored to completion.

Care plan audits will assess whether care plans are current, individualised, linked to residents' assessed needs and provide clear guidance to staff. Repeat audits will verify that corrective actions have been completed and sustained.

A formal annual schedule has been established for Infection Prevention and Control, Restrictive Practice and Safeguarding Committee meetings. Each committee will meet at least quarterly.
Outstanding actions will be reviewed monthly by the person in charge, at the next relevant committee meeting and through the RPR quarterly report.

The Facilities Manager has completed a review of ventilation and thermal comfort throughout the centre, and additional equipment has been installed to improve air circulation and temperature control.
Temperatures will be monitored daily across all units during periods of warm weather. To ensure the effectiveness of the measures implemented.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The Person in Charge and Facilities Manager have completed a full environmental review and updated the centre's maintenance action plan.

Repairs to chipped paintwork, damaged internal bedroom doors and worn architraves have commenced and will be completed in line with the maintenance action plan.
The courtyard will be weeded and cleaned. The unsuitable artificial grass has since been replaced with a suitable surface (higher quality artificial grass) to ensure the area is safe, accessible and pleasant for residents to use.

The Facilities Manager will monitor completion of the works through monthly site visits and reviews with the person in charge. Any outstanding actions will be recorded and tracked to completion.
Residents' feedback on the courtyard and communal environment will be obtained through residents' meetings and considered as part of the ongoing premises

improvement programme.

The registered provider has completed significant improvement works within the centre and remains committed to maintaining the premises to a high standard.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:

The residents' guide has been revised to include the current registration details, the correct details of the person in charge and management team, and the terms and conditions relating to residence in the centre.
The guide also includes information on how residents can access inspection reports and the current complaints procedure.
Updated copies have been provided to residents/their representatives and made available within the centre.

The guide will be reviewed every 3 years and whenever there is a change to the service and management arrangements.

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:

Further improvements are required to ensure that all assessments and care plans consistently reflect residents' current needs. The person in charge and clinical nurse managers will complete a review of every resident's comprehensive assessment and care plan, prioritising safeguarding, mobility, skin integrity, wound care and behavioural support.

Generic safeguarding, human rights and behavioural support care plans will be replaced with individualised care plans where an assessed need or identified risk exists.
Each care plan will clearly identify the resident's current needs and risks, personal preferences, specific supports required and relevant escalation arrangements.
Historical information that no longer informs current care will be removed. Mobility care

plans will reflect each resident's current equipment, mobility status and required level of assistance.
Skin integrity and wound care plans will be supported by a current assessment and wound record. Care plans relating to resolved wounds or risks will be reviewed and discontinued where no longer required.

Registered nurses will receive focused training on assessment-led, person-centred care planning. Clinical supervision and audit findings will be used to ensure that the learning is embedded into practice.

Clinical Nurse Managers will complete weekly sample audits during the review period. The PIC/ADON will then complete monthly audits to verify that care plans remain current, individualised and reflective of residents' assessed needs. Any gaps identified will be corrected promptly and communicated to the relevant nurses to support improvements in practice.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The Person in Charge and Catering Chef will revise the menu arrangements so that residents prescribed on modified diet receive a meaningful choice at mealtimes.

At least two suitable options will be planned for main meals. These will be equivalent, as far as practicable, to the choices available on the regular menu and prepared in line with each resident's assessed needs and the required texture standard.
Staff will present the available choices verbally or visually and will support residents who require assistance to express a preference.

Dining experience audits will specifically review choice for texture-modified diets, food presentation, temperature, portion size and resident feedback.

Feedback will be reviewed through residents' meetings and management meetings, with actions recorded and followed through to completion.

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/10/2026
Regulation 20(2)(d)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	28/07/2026
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	28/07/2026
Regulation 21(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/09/2026

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	28/07/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/09/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	14/08/2026