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:	Maynooth Lodge Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Rathcoffey Road, Crinstown, Maynooth, Kildare
Type of inspection:	Unannounced
Date of inspection:	25 May 2026
Centre ID:	OSV-0004593
Fieldwork ID:	MON-0050281

About the designated centre

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

Maynooth Lodge Nursing Home is single storey purpose built nursing home that is spacious and laid out in three parts one of which is a separate unit referred to as the dementia friendly area. Residents can be accommodated in this secure unit that had a combined area divided by a corridor as the residents' day and dining room. The centre is registered to accommodate 85 residents. All bedrooms (81 single and two twin bedrooms) have full en-suite facilities. The main dining room adjoined the kitchen where meals were prepared and cooked. There was ample communal space throughout which included day spaces and sitting rooms, a smoking room, an equipped hair salon, an oratory, laundry, staff and visitor facilities. Residents and visitors had access to a variety of secure well maintained outdoor garden courtyards with raised beds, paved patios and seating areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	84

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 25 May 2026	06:45hrs to 14:30hrs	Sinead Lynch	Lead
Monday 25 May 2026	06:45hrs to 14:30hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors spoke with many residents to gain insight into their experience of living in Maynooth Lodge. Most residents spoken with were complimentary in their feedback and expressed satisfaction about the standard of care provided.

Inspectors arrived unannounced at 6.45am in the morning and observed the handover process (sharing of relevant information between the night-time staff and the day staff), which detailed information about the residents' condition and any changes that had occurred throughout the last few days. Inspectors spoke with night staff who reported they had enough staff to meet the needs of the residents. Both during the early morning and throughout the day call bells were answered promptly and staff attended to residents on their request.

The inspectors observed residents mobilising around the centre, some independently and others under the supervision of staff. Manual handling practices observed were reflective of best practice. Communal areas, including sitting and dining rooms, were seen to be well-used by residents. Resident bedrooms were found to be neat and tidy. The inspectors observed that many residents had pictures and photographs in their rooms and other personal items which gave their rooms a homely atmosphere. The provider was proactive in maintaining and improving facilities and physical infrastructure through ongoing maintenance and renovations as observed in the recently redecorated areas.

Residents had access to numerous communal day spaces and dining rooms. There were additional communal spaces available for residents outside the individual units, including an oratory, hairdressers and ample areas for seating. Outdoor spaces were also safe and well maintained and furnished with seating and tables.

From speaking with residents and what the inspectors observed, residents appeared content living in Maynooth Lodge Nursing Home. Residents informed the inspectors that they were 'well looked after' and that 'staff were good and kind'. Residents were very positive about the food offered to them and the choice made available.

The inspectors observed the breakfast and lunchtime meal experience. There was a delay in the service of breakfast in one corridor which lead to one resident asking the inspector why they had not received their breakfast. This was addressed immediately by staff, however the process required further review to ensure residents received a hot breakfast in a timely manner. Residents told the inspectors that the 'food was excellent' with a number of residents enjoying breakfast in bed.

There was a relaxed and calm atmosphere at lunch. Residents with high care needs were observed being assisted with their meal. Residents could view the food at the serving area prior to choosing the food on offer. Their food was served as per their

choice and was then taken to the table after they were seated. Staff were aware of any required modifications. Each resident was offered a clothes protector if they wished and a variety of drinks and condiments were offered with their lunch. Snacks were available outside of regular mealtime.

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

Overall, this inspection found that the registered provider and management team were committed to provide a safe quality service and had good oversight systems in place to ensure good regulatory compliance. The management team had implemented improvements since the last inspection in relation to end-of-life care plans. These were found to be more individualised with details in place to ensure staff could direct care.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended).

The registered provider of Maynooth Lodge nursing home is The Brindley Manor Federation of Nursing Homes Ireland which is part of the Emeis group and has a number of designated centres within Ireland.

There was a clearly defined management structure in place. The person in charge was very aware of their role to ensure high standard of care were delivered to residents and their role as a leader to other staff members. The person in charge was supported by two assistant directors of nursing who worked opposite each other to ensure there was senior clinical supervision in place over a seven-day period. There were also two clinical nurse managers in addition to a team of staff nurses, healthcare assistants, housekeeping, activities staff, catering and maintenance staff.

There were regular management team meetings which included reviews of any accidents or incidents, complaints or premises issues identified. Minutes of these meetings were provided to the inspectors. There was an annual review of the centre and a quality improvement plan in place. The residents' opinions and their views were taken into account when developing this annual review.

There were regular audits completed in the centre that had identified areas for improvement and learning. There were appropriate action plans in place with time frames to ensure all actions were completed in a timely fashion.

Staff training records were maintained to assist with monitoring and tracking completion of mandatory and other training completed by staff. A review of training records indicated that all staff were up to date with mandatory training.

Records of complaints were available for review and the inspectors also reviewed five complaints that had been received since the last inspection. Complaints were listened to and investigated. However, the complainants were not informed in writing of the outcome of their complaint or any improvements identified following the investigation. As a result those who made complaints were not informed of the appeals process. This is not in line with the local complaints procedure or the regulatory requirements.

Notifiable incidents were submitted to the Chief Inspector in line with regulatory requirements and an incident and accident log was maintained in the centre.

Regulation 15: Staffing

On the day of the inspection there were adequate staffing levels available to meet the needs of the current residents, taking into consideration the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

There was a training programme in place for staff and records confirmed that staff were facilitated to attend training in fire safety, manual handling procedures and safeguarding residents from abuse.

Judgment: Compliant

Regulation 21: Records

The registered provider had in place all records set out in Schedule 3 of the regulations. These were stored safely and were accessible and made available for inspection.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place that identified the lines of authority and accountability. There were management systems in place to monitor the effectiveness and suitability of care being delivered to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had notified the Chief Inspector of Social Services of any allegations or confirmed abuse within the required time frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was not followed in relation to five complaints that had been received. For example:

- The complaints were not always acknowledged in writing.
- There was no written response informing the complainants whether or not their complaint was upheld, the reasons for that decision, any improvements recommended and details of the review process.
- The information in relation to the review office was not provided to the complainants.

Judgment: Substantially compliant

Quality and safety

Overall, residents were in receipt of a good standard of care from dedicated and kind staff who promoted each resident's individual human rights. Residents were safeguarded from abuse and were respected as individuals.

The feedback from residents informed the inspectors that safeguarding measures were in place and followed by staff.

Residents had computerised care plans in place. Where there was a safeguarding concern or risk, there was a comprehensive care plan developed to direct care. Each resident was assessed prior to admission and on admission their safeguarding risk was reassessed. However, the inspector found there were some opportunities for improvements in relation to some safeguarding care plans as further outlined under Regulation 5: Individual assessment and care plan.

Residents were encouraged to live their lives as they wished and a 'positive risk-taking' approach was utilised. Residents were provided with the right and ability to decide what they wanted to do and how they lived their lives.

Where residents presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), there was a specific care plan in place to guide staff in how best to support the resident. The monitoring of these behaviours was well documented and from this, triggers were identified and measures put in place in mitigate the risk of reoccurrence.

Residents were provided with access to a wide range of activities. Residents were given the choice to attend if they wished, while other residents preferred the one-to-one time with staff. Residents' wishes were very well respected in relation to their choice of activities and how they spend their days. Residents had access to the centre's complaints procedure, advocacy services and they attended regular residents meetings.

The person in charged had notified the Chief Inspector of incidents of alleged and confirmed abuse. The inspectors reviewed the investigations and action plans in place. These were found to be comprehensive and at all times ensured residents were safeguarded and protected. Where learning was identified this was shared with all staff when appropriate.

Regulation 12: Personal possessions

There was adequate storage in the residents' rooms for their clothing and personal belongings including a lockable unit for safekeeping.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While overall care plans reviewed were person centered, some gaps were identified in the safeguarding care plans and care plans on how to manage behaviours that are challenging, as follows:

- Some care plans were not detailed enough to reflect the care being provided. For example, two residents who were receiving one-to-one care during the day and fifteen minute checks at night, did not have this reflected in their care plan. Their care plans stated they were receiving one-to-one care.
- Records were not available to reflect the level of supervision in place for one resident. For example, fifteen minute checks at night were recorded for one resident only; the second resident had hourly checks recorded, this was not reflective of their care plan.
- The residents' care plans were not always updated after recommendations being made for a change in their level of supervision.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents were receiving a good standard of healthcare. They had access to their general practitioner (GP) and to multidisciplinary healthcare professionals as required.

Judgment: Compliant

Regulation 8: Protection

The provider had an up-to-date Safeguarding Policy and measures in place to protect residents from abuse. Appropriate pension-agent arrangements were in place to safeguard residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

The provider and the person in charge were striving to promote a rights-based service for all residents. Residents were encouraged to partake in activities of their choice and staff took a positive risk-taking approach that upheld residents' rights. Residents were invited to attend regular residents' meetings. There was a good attendance at each of these meetings as evidenced in the attendance records and the minutes reviewed by the inspector.
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 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Maynooth Lodge Nursing Home OSV-0004593

Inspection ID: MON-0050281

Date of inspection: 25/05/2026

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Complaints Policy will be reviewed and amended to ensure the process is clearly outlined in line with regulatory requirements. The revised policy will clearly outline the process, timelines, and responsibilities for handling complaints at all stages and this will be completed by 30th September 2026	
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: All safeguarding and responsive behaviour care plans have been reviewed to ensure the level of supervision provided is accurately documented- complete Care plans of residents with one-to-one support and specific nighttime supervisions have been updated to outline the arrangements in place including duration, frequency and rationale- complete A review of the supervision records has been completed to ensure supervision is recorded accurately according to the care plan of the residents- complete. From 1st July 2026, the management team will monitor compliance through monthly care plan audits and supervision record reviews. All staff nurses will be provided with care plan training on person centered care,	

documentation standards and management of residents on enhanced supervision by 30th September 2026.

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 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	30/09/2026
Regulation 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	30/09/2026
Regulation 5(1)	The registered provider shall, in so far as is	Substantially Compliant	Yellow	30/09/2026

	reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			