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:	Millbrae Lodge Nursing Home
Name of provider:	Millbrae Lodge Nursing Home Limited
Address of centre:	Newport, Tipperary
Type of inspection:	Unannounced
Date of inspection:	11 June 2025
Centre ID:	OSV-0000419
Fieldwork ID:	MON-0047225

About the designated centre

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

Millbrae Lodge is a purpose-built two-storey nursing home that provides 24-hour nursing care. It can accommodate up to 81 residents both male and female over the age of 18 years. It is located in a rural area close to the village of Newport. It provides short and long-term care primarily to older persons. Accommodation is provided in three units on both floors. There is a lift provided between floors. The first floor mostly caters for residents with low-to-moderate care needs including residents requiring respite and convalescence care. The ground floor caters for people requiring a higher level of care due to their physical and or mental condition. There is a separate secure special care unit that accommodates 15 residents who need a smaller, more secure unit due to their cognitive impairment. There is a variety of communal day spaces provided on all floors including dining rooms, day rooms, oratory, smoking rooms and activities room. Residents also have access to two secure enclosed garden areas. The centre can accommodate residents who require naso-gastric feeding and with tracheotomy tubes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	76

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
Wednesday 11 June 2025	09:15hrs to 17:00hrs	John Greaney	Lead
Thursday 12 June 2025	07:30hrs to 16:30hrs	John Greaney	Lead
Wednesday 11 June 2025	09:15hrs to 17:00hrs	Leanne Crowe	Support
Thursday 12 June 2025	08:30hrs to 16:30hrs	Leanne Crowe	Support

What residents told us and what inspectors observed

This inspection took place over two days, during which inspectors spent time in the centre observing the care provided and talking to residents, visitors and staff to get a sense of what life was like for residents living in Millbrae Lodge Nursing Home. Inspectors met with and spoke with a large number of residents and also availed of opportunities to chat with visitors over the course of the two days.

On arrival at the centre, inspectors were met by the assistant director of nursing (ADON) as the person in charge was on planned leave. Following an introductory meeting with the ADON, inspectors walked through the centre and met with some residents and staff.

Millbrae Lodge Nursing Home is a modern purpose-built facility that is registered to accommodate 81 residents in 59 single bedrooms and 11 twin bedrooms, all of which have en-suite facilities. There were 76 residents living in the centre on the days of the inspection. It is a two storey building with bedroom accommodation and communal space on both floors. Bedroom accommodation in the main section of the ground floor comprises 30 single and four twin rooms. There is also a dementia specific wing on the ground floor, called the Special Care Unit, that has eleven single and two twin rooms. Bedroom accommodation on the first floor comprises 18 single and five twin rooms.

Overall, the premises was warm, comfortable and mostly well-maintained. There were some signs of general wear and tear observed including, chipped paint work and splashes on walls from alcohol dispensers. Areas of the premises occupied by residents, such as bedrooms and communal day rooms, were observed to be clean. Inspectors viewed a number of bedrooms and saw that they were warm, homely spaces, and personalised with photographs and souvenirs reflecting residents' lives and interests.

Staff were observed to be providing personal care to residents throughout the morning. While staff were providing personal care, bedroom doors were closed to protect residents' privacy and staff were seen to knock prior to entering the rooms. Inspectors did, however, observe two bedrooms in which the doors were open and the residents in these rooms had removed their duvets/blankets. These residents had either removed their night attire or it had risen up, leaving them partially exposed. Nursing and care staff were busy providing personal care to other residents at this time. The ADON was made aware and immediately addressed this by covering up the residents. Additionally, inspectors observed instances of care being provided to residents in a manner that was not person-centred, such as staff standing over some residents while assisting them to eat, and the use of non person-centred terminology to describe residents and their care needs. These actions compromised the privacy and dignity of these residents.

Residents were observed to be neatly dressed, in accordance with their preferences. The main communal areas on both the ground and first floors are open-plan dining and sitting rooms and this is where most residents spent their day. Residents in the Special Care Unit have their own sitting and dining space, which is also open-plan.

There is a large secure outdoor space on the ground floor with multiple access points from the main corridors and freely accessible to residents. Residents living on the first floor were free to access the outdoor space on the ground floor, either independently or with the support of staff. Residents in the Special Care Unit have their own secure outdoor space that is readily accessible from the sitting room.

Overall, both residents and visitors gave positive feedback on the kindness of staff and stated that they were generally content living in the centre. While residents were complimentary regarding the staff that cared for them, a number of residents who spoke with inspectors felt that there were insufficient staff on duty to meet the needs of residents. This was echoed by some staff and visitors and was supported by the observations of inspectors. For example, some of the positive comments from residents included "I'm so comfortable here, I don't want to go home" and "I really love it here, the staff are so kind and the food is top quality". One visitor commented that "all staff are very nice and they phone me straight away if there are any changes". Other residents, however, stated that they felt there were not enough staff, with one commenting that "they seem to be under pressure". Another resident stated "staff try their best but sometimes they don't have enough time to take care of everyone". Staff commented that previously a number of residents had their morning personal care provided by night staff. This practice had ceased and now some residents do not have their personal care completed until approximately 11.30am as the workload has increased for day staff. Inspectors did observe, particularly in the Special Care Unit, that staff struggled to meet the needs of all residents due to their high level of needs related to their cognitive impairment. In response, staffing levels were enhanced during the inspection, with the addition of a healthcare assistant to core staffing levels. Management committed to inspectors that this enhanced staffing resource would remain in place.

Residents who spoke with the inspectors provided mixed feedback in relation to the programme of activities that was available to them. While many said that they enjoyed the range of activities provided, others felt that they were not in line with their individual interests and capabilities. Inspectors spent time observing residents in the various communal areas to get a sense of their lived experience. Inspectors observed staff interacting with residents in a respectful and caring manner. Most group activities appeared to take place on the ground floor and activities were predominantly facilitated by an activity coordinator. The activity coordinator was not scheduled to work on the day of the inspection but arrived to the centre later in the morning. It was evident that given the design and layout of the centre which was spread over two floors and three separate units, it was not possible for one person to facilitate activities for all residents in the centre. Inspectors observed residents spending significant periods of time with minimal stimulation at various times of the day. Engagement with the residents was predominantly task-centred for the purpose of meeting their care needs, with little time available to meet their social care needs.

Inspectors observed the lunchtime dining experience. Residents were offered a choice of food. Meals appeared wholesome and appetising. Many residents spoken with confirmed they enjoyed the food on offer. Staff were knowledgeable regarding the different diets each resident was to receive in line with their care plan. Inspectors observed residents with a mobility impairment being assisted by staff to and from wheelchairs. Appropriate assistive equipment was available and used by staff on most occasions. Following a witnessed fall, staff were observed supporting a resident to their seat by lifting them under their arms. This was not in accordance with the manual handling guidance in place for the resident. The staff who provided assistance to this resident did not complete a full physical assessment prior to the transfer, however, the resident did have a physical assessment after being assisted back to the chair. Staff were observed interacting with the resident and providing verbal assurance throughout. Another resident suffered an unwitnessed fall on the first day of the inspection. Neither resident sustained injuries from the falls.

An inspector arrived early on the second day of the inspection to meet with night staff and to confirm that residents' preferences in relation to the provision of personal care and breakfast were being met. There was a calm atmosphere in the centre and there were no residents in the communal rooms. The inspector observed day staff arriving for duty and there was a formal handover of care from night to day staff. The handover was comprehensive, detailing the care needs of residents and any issues that had arisen over night. Night staff confirmed to the inspectors that previously a number of residents had personal care provided by night staff before day staff arrived, to ease work pressures on day staff rather than it being the expressed wishes of residents to have care provided at that time. This practice had stopped a number of months prior to this inspection, when senior management became aware of the practice.

Some staff spoken with stated that although there was a shortage of fitted sheets previously but there were always plenty of top sheets. A new supply of fitted sheets had been made available in the months prior to this inspection that considerably improved the stock levels, but occasionally there were still shortages. On the day of the inspection, inspectors checked the linen trolley and there was adequate supply of fitted sheets. The provider was made aware of the occasional shortage and committed to increasing the stock further. Staff confirmed that there was no shortage of personal protective equipment (PPE) and this was validated by inspectors on checking the supply in the PPE store room. The chef confirmed that there was never any problem with the supply of food.

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 impacted the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection conducted over two days by two inspectors of social services. The inspection was conducted to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations) 2013 (as amended). The inspectors also followed up on the compliance plan submitted by the registered provider following the previous inspection in November 2024. The findings of this inspection is that significant action is required by the provider in relation to management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Specifically, action is required in relation to oversight arrangements for the delivery of care, staffing and the submission of notifications.

Millbrae Lodge Nursing Home is a privately owned nursing home. The registered provider is Millbrae Lodge Nursing Home Limited, a company comprising four directors. This inspection was carried out following the airing of an RTE Investigates programme in June showing concerning practices in respect of the provision of care to vulnerable residents in two other designated centres in the Emeis group. Although this centre did not feature in the programme, the centre is one of the 25 nursing homes that are part of the Emeis Group. There are centralised support structures across the organisation to support the centre in the areas of human resources, training, finance and quality. The senior management team include a Chief Executive Officer, a Chief Operating Officer, a Regional Director, Associate Regional Director and the person in charge.

While there were management systems, such as weekly key performance indicators (KPI) reports, weekly clinical governance meetings, an electronic auditing system and arrangements to analyse and manage adverse incidents and on-going risks in the centre, these systems were not adequately robust to identify areas of poor practice. For example, the provider had been made aware of poor practices in the centre over a period of time resulting in incidents not being recorded, appropriately investigated and inadequate mitigation measures being put in place to prevent recurrence. This also resulted in the failure to notify the Chief Inspector in line with legal requirements. The provider had responded to this information and had taken measures to strengthen management systems by improving oversight, particularly in relation to night duty. There was an enhanced focus on ensuring that all incidents and complaints were recorded and actions taken to address any issues identified. This was confirmed by inspectors through a review of complaint and incident records. Notwithstanding these improvements in management systems, further action continued to be required. The management structure was not in accordance with that outlined in the centre's Statement of Purpose and there continued to be deficits in the oversight of clinical aspects of care. Further review of resources was also required, in respect of the provision of meaningful activities to the residents. . While there were briefly two staff employed in the role of activity coordinator, this had recently reduced to one and management were seeking to employ a second person. These issues are discussed in more detail under Regulation 23: Governance and management of this report.

Records were predominantly stored electronically but some were paper-based. Records were generally stored securely and easily retrievable. Inspectors reviewed a sample of staff files. These contained all of the information and documentation

required by Schedule 2 of the regulations, including evidence of An Garda Síochána vetting disclosures and nursing registration with the Nursing and Midwifery Board of Ireland (NMBI). Inspectors found one instance when accurate up-to-date records were not maintained relating to the care and welfare of a resident and this is outlined further under Regulation 23 of this report.

Inspectors reviewed unsolicited information received by the Chief Inspector since the last inspection. Some of this information was partially substantiated, specifically in respect of reportable incidents and record keeping.

A number of months prior to this inspection, management had received information that a member of staff may not have submitted accurate information as part of the recruitment process. An investigation was commenced but the staff member left prior to the completion of the investigation. A review of recruitment practices on this inspection found that there were now adequate systems in place for the recruitment, selection and induction of staff. References and qualifications were verified prior to commencing employment. New staff underwent a programme of induction to ensure they were familiar the operation of the centre. Enhanced supervision arrangements were put in place when it was identified that the performance of staff was not at the desired level. There was an ongoing comprehensive programme of training in place, to ensure staff had the appropriate knowledge and skills to perform their respective roles. However, findings of this inspection were that enhanced supervision by the management team was required, to ensure that residents' care was effectively monitored. This is further detailed under Regulation 23 of this report.

Discussions with staff and the observations of inspectors indicated that staff were familiar with residents' needs. Interactions by staff with residents were generally respectful. Staffing levels were kept under review by management, for example, an additional staff member had been rostered on night duty when it was identified that additional supervision was required at night. The provider also decided to roster an additional staff member in Ivy unit following two falls on the first day of the inspection. However, issues referenced earlier in this report in relation to the length of time that personal care takes in the mornings and issues in relation to residents' dignity being compromised, indicate that a further review of staffing is required. This was also the feedback from residents and staff. This is discussed further under Regulation 15 of this report.

There were policy and procedures in place for the management of complaints. There was an enhanced focus by management on recording complaints and staff were encouraged to record all complaints. This led to an increase in the number of complaints in the complaints log. Complaints records included details of the investigation, actions taken and the satisfaction or otherwise of the complainant.

Registration Regulation 4: Application for registration or renewal of registration

An application to renew registration of the designated centre in accordance with the requirements set out in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 had been made by the registered provider. All of the required information had been submitted six months in advance of the registration expiry and therefore had protection in accordance with Section 48(3) of the Health Act 2007.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge is an assistant director of nursing (ADON) and was on planned leave on the days of the inspection. The ADON had been appointed on an interim basis during the extended absence of the director of nursing (DON). The person in charge is an experienced registered nurse with the required post-registration management qualifications and experience in management and nursing older persons.

Judgment: Compliant

Regulation 15: Staffing

A review was required of staffing levels, particularly in the morning. A number of staff reported that they found it difficult to provide personal care to residents in a timely manner. This was supported by feedback from residents and the observations of inspectors. Previously a number of residents had personal care provided by night staff, a practice that had not been requested by the residents concerned. When senior management became aware of this, the practice had ceased and this placed pressure on day staff due to the increase in workload for morning staff without an increase in staffing levels.

Based on the observations of inspectors and discussions with staff, the provision of activities was predominantly reliant on activity staff. There were insufficient staff facilitating activities to meet the social care needs of residents given the size and layout of the centre. While there were briefly two staff employed in the role of activity coordinator, this had recently reduced to one and management were seeking to employ a second person.

Judgment: Not compliant

Regulation 16: Training and staff development

While staff were facilitated to attend training and there was a high level of attendance at mandatory training some staff were overdue attendance at refresher training. For example:

- 19.5% of staff were overdue attendance at fire safety training
- 18% of staff were overdue attendance at training on responding to and managing behaviour that is challenging
- 7% of staff were overdue attendance at training on detection and prevention of and responses to abuse.

While records indicated that all staff had up-to-date training in manual handling, it was not always evident that this training was being implemented in practice. For example, inspectors observed two staff assisting a resident to their chair following a fall by lifting them under their arms. This was not in accordance with the manual handling guidance in place for the resident. Additionally, staff did not take adequate time to assess the resident for injuries.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider had ensured that the records set out in Schedules 2, 3 and 4 were kept in the designated centre in a safe and accessible format.

Gaps in records relating to the unaccompanied absence of a resident is addressed under Regulation 23 of this report.

Judgment: Compliant

Regulation 23: Governance and management

Significant action was required in relation to governance and management to ensure adequate oversight of care delivery and to monitor the quality and safety of care delivered to residents. For example:

- the governance structure outlined in the Statement of Purpose specified one person in charge (PIC), two ADONs and two clinical nurse managers (CNMs). As the PIC was on long-term absence, one of the ADONs was appointed to the role of PIC on an interim basis. On the day of the inspection, the interim PIC was on planned leave and the second ADON was deputising. As a result, there was a significant gap in senior nursing management to provide oversight of care delivery

- following information received by the provider in relation to unreported incidents occurring within the centre an investigation was commenced. While the investigation was not yet concluded at the time of this inspection, inspectors were not satisfied that the investigation was adequately comprehensive and addressed potential deficits in the performance of all staff members involved in the incidents
- the provider had recently taken steps to ensure that all incidents were recorded, however, there continued to be gaps in risk management. For example:
    - while injuries of unknown origin were recorded in the incident log, these were not properly investigated or recognised by staff as potential indicators of abuse. Additionally, while management conducted audits of accidents and incidents, this deficit was not captured through the audit process
    - an incident which could have resulted in a resident falling from a balcony on the first floor was not recorded and mitigation measures were not put in place. Interim mitigation measures were put in place on the second day of the inspection
    - a full review was required of staffing levels to ensure that residents could receive care in a timely manner. Management had responded to information in relation to the provision of morning care and breakfasts to some residents by night staff. This practice had ceased following unannounced night visits by management, however, the impact of this redistribution of care activities from night to day staff was not considered. Day staff reported to inspectors that this increased their workload and as a result some residents did not receive morning care until shortly prior to lunch. Inspectors also observed that staff struggled to meet the needs of residents in the dementia unit due to their high care needs
- enhanced supervision of staff was required as the inspectors observed a number of incidents whereby staff practice was inappropriate or did not support the privacy and dignity of residents
- while records required to be kept in respect of each resident were generally well-maintained, the daily nursing notes for one resident did not reflect that the resident had left the centre unaccompanied.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications required to be submitted to the Chief Inspector were not always submitted within the relevant time frame. For example:

- a resident had left the centre unaccompanied, however, the notification was submitted almost two years after the event

- notifications were not submitted in a timely manner when allegations had been made to the provider of possible misconduct by members of staff.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place which met the requirements of the regulations. A review of the records found that complaints and concerns were managed and responded to in line with the requirements of the regulations

Judgment: Compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

A notification had been submitted detailing the arrangements in place for the management of the centre in the absence of the person in charge.

Judgment: Compliant

Quality and safety

Overall, the inspectors observed that the interactions between residents and staff were kind and respectful throughout the inspection. However, the allocation and supervision of staff impacted on the clinical and social care provided to residents. Consequently, care was not always person-centred and delivered in line with residents' assessed needs and care plans. In addition, the quality and safety of the care provided to residents was impacted by inadequate oversight and implementation of the management systems and policies in place to safeguard and protect residents.

Residents' clinical care records were maintained on an electronic record system. On admission to the centre, residents' health and social care needs were assessed using a range of validated assessment tools, which informed the development of care plans. While these were reviewed every four months, or as changes occurred, they did not always reflect the care needs of some residents. These issues are discussed in more detail under Regulation 5: Individual assessment and care plan of the report.

There were systems in place to support residents that exhibited responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment). A restraint-free environment was promoted in the centre. The provider had arrangements in place to monitor the use of restrictive practices. Restrictive practices were informed by an appropriate risk assessment and were only implemented when alternative measures were determined to be unsuitable.

Inspectors observed residents participate in activities that were predominantly facilitated by an activity coordinator. Over the course of the inspection, residents were seen to participate in board games, art, and a music session facilitated by an external musician. A large number of residents were observed to be attending Mass remotely via a live feed from a local church. Notwithstanding these observations, the registered provider had not provided sufficient opportunities for residents to participate in activities, in accordance to their interest and capabilities. At the time of the inspection, one staff member was responsible for the provision of activities across both floors of the centre. On the first day of the inspection, the activity co-ordinator was not scheduled to be on duty but arrived to the centre later in the morning. The inspectors observed that in the absence of the activity co-ordinator, activities to promote residents' social engagement did not occur consistently. For example, a number of periods were observed during the day where residents were congregating in dayroom areas with little social interaction from staff. It was also evident that during the periods when the activity co-ordinator was facilitating an activity on one floor of the centre, residents on the remaining floor were not always provided with opportunities for engagement in activities.

There was a safeguarding policy in place that provided guidance and support to staff on the appropriate actions and measures to take to protect residents, should a safeguarding concern arise. However, inspectors found that appropriate action had not been taken to investigate a number of incidents that occurred within the centre, in line with the centre's own policy. Although 93% of staff were up-to-date with mandatory training in safeguarding vulnerable adults, inspectors found that some staff demonstrated incomplete knowledge of safeguarding procedures such as the recognition of bruising as a potential sign of abuse, and therefore staff did not consistently implement the centre's policy.

The provider supported residents to manage their pension and social welfare payments. Arrangements were in place to ensure residents' finances were managed in line with best practice guidelines.

Regulation 17: Premises

The design and layout of the centre was suitable for the number and needs of the residents accommodated there and met residents' individual and collective needs. The centre was found to be spacious and residents' bedroom accommodation was personalised in accordance with their preferences.

Judgment: Compliant

Regulation 20: Information for residents

An information guide for residents had been developed and was accessible to residents. It contained the information required by the regulations, including a summary of the services and facilities available to residents.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care plans did not always accurately reflect the individual needs of the residents, such as in relation to the personal care needs of residents or behavioural support needs. For example:

- A care plan for a resident assessed as being at high risk of leaving the centre unaccompanied, did not refer to the mitigating measures that the management team had put in place to reduce this risk, such as the carrying out of 15 minute monitoring checks
- A resident who required specific interventions in relation to their personal hygiene needs did not have this detail recorded in their care plans.

Care plans in place to support residents that required increased supervision were not consistently implemented. For example, one resident's care plan directed that 15 minute monitoring checks were completed to ensure their safety. A review of this documentation found that some checks were not consistently completed.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required or requested.

Residents could be referral to allied health services, such as speech and language therapy and tissue viability nursing, as needed.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Restrictive practices, such as bed rails, were managed in the centre through ongoing initiatives to promote a restraint-free environment. Restrictive practices were implemented following an appropriate risk assessment, and in consultation with the multidisciplinary team and the resident.

Arrangements were in place to support residents who experienced responsive behaviours.

Judgment: Compliant

Regulation 8: Protection

A review of the incident log identified a number of incidents of bruising had been recorded since management had enhanced the focus on recording all incidents. While these were appropriately recorded in the incident log, the review of these incidents was from a clinical perspective rather than also recognising that these may be signs of possible abuse and considering them from a safeguarding perspective.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had not ensured that residents were provided with sufficient opportunities to participate in activities in accordance with their interests and capacities. Inspectors observed residents spend long periods of time with limited stimulation other that the television, to which many did not show any interest. This is a repeated finding from the previous inspection.

Inspectors also observed that some residents' privacy was compromised due to them removing their clothes and being visible from the corridor. Additional oversight was required by staff to support these residents maintain their privacy and dignity.

Judgment: Not 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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Millbrae Lodge Nursing Home OSV-0000419

Inspection ID: MON-0047225

Date of inspection: 12/06/2025

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of staffing levels as well as staff allocation was completed in line with a review of resident dependencies to ensure sufficient staff are available in a timely manner to assist residents with personal care (at a time of their choosing) and to support residents to engage in meaningful social activities. Completed 15th June 2025 From the 20th August 2025 the PIC will complete documented management walkabouts to oversee that the provision of personal care is delivered in a timely manner. From 1st August 2025, the PIC will monitor and audit all activities provided to ensure that all residents are supported to complete both group and one to one activities in line with their wishes and preferences. There are two activity staff employed since the 1st August 2025.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: By the 30th September 2025, additional sessions of refresher training will be delivered to ensure all staff training is up to date. By the 31st August 2025, a focused programme of supervision, observation and trainng will be completed to ensure that staff are using appropriate manual handling practices in accordance with resident needs, agreed policies and best practice. From the 20th August 2025 the PIC will complete documented management walkabouts to review practices and ensure all agreed actions are implemented.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Recruitment is ongoing to fill the post of the ADON. It is planned to have this post filled by the 30th September 2025. This will enhance the current senior management oversight of care delivery.

The initial investigation was reviewed to ensure it comprehensively investigated the issues raised and to identify any additional actions required to address findings and to mitigate the risk of reoccurrence. This investigation is now closed.

A new investigation arising from matters highlighted in the original investigation has commenced and it is planned to have this completed by 31st October 2025.

Training and performance management support for relevant staff and managers is currently in place to address improvements required in risk management. This will be completed by 31st October 2025

By the 30th September 2025, training in conducting audits will be delivered to ensure deficits in practice are identified and addressed appropriately.

The use of the balcony was risk assessed and remedial actions were put in place. New magnetic key pad locks will be in place to limit access to the area. This will be completed by 8th October 2025.

By the 31st August 2025, all residents will be re-assessed and their care plans updated to ensure staff are guided to deliver care and assistance to residents at a time and in the manner of their chossing and in line with their assessed needs.

A review of staffing levels as well as staff allocation was completed in line with a review of resident dependencies to ensure sufficient staff are available to meet the needs of residents. This will be monitored and documented by the PIC through the daily walkabouts. Completed 15th June 2025
From the 1st August 2025, the regional team will review all complaints, risk assessments and incidents as well as obtaining staff and resident feedback to ensure that staffing to ensure that call care needs are meet in a timely manner.

The supervision of staff has been reviewed and changes implemented to ensure appropriate and timely care delivery and to ensure privacy and dignity for all residents. The CNM is now place on each floor to provide guidance and supervision for all staff. Completed 15th June 2025

A supervision and training plan was implemented in the nursing home since January 2025 to ensure that all daily nursing notes reflect the care delivered to residents including new risks identified and actions/updates to address risks. This is monitored weekly by the PIC and reviewed monthly as part of the clinicial governance meetings to ensure actions remain appropriate- complete and ongoing

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
By the 31st August 2025, refresher training will be provided to the DON and ADONs in respect of their regulatory responsibilities and the importance of recognizing incidents requiring notification in a timely manner.

From the 1st August 2025 all of the above will be reviewed by the regional team at clinical governance to ensure good compliance and improved standards of care.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
By the 31st August 2025 all residents will be re-assessed and their care plan updated to ensure they guide staff and reflect the individual needs and preferences of the residents specifically the safety and supervision arrangements in place to reduce risks identified and the specific interventions on relation to their personal hygiene needs.

From the 1st August 2025 the PIC will completed weekly reviews of all safety checks to ensure they are completed appropriately to maintain resident safety and fulfill requirement to have accurate and timely records of care delivered.

From the 1st September 2025, on a monthly basis, the regional director will review a sample of care plans, cross reference with resident assessments and triangulate with staff to provide robust oversight and assurance that care plans are in line with resident needs and guide staff appropriately.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
By the 30th September 2025 all nurse managers will have received training on identifying bruising as a risk of abuse. This will also include training on the steps requires in terms of investigation and reporting incidents

From the 1st August 2025, a weekly review of all incidents of bruising identified will be completed by the PIC to ensure due consideration is given, during investigation of the incidents, to the risk of abuse and to safeguard all residents.

From the 1st August 2025, a monthly analysis of all incidents of bruising identified will be completed by the regional team including a review of skin integrity records and care plan to ensure the investigation is comprehensive and actions identified are sufficient to safeguard residents.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A review of staffing levels as well as staff allocation was completed in line with a review of resident dependencies to ensure sufficient staff are available in a timely manner to assist residents with personal care (at a time of their choosing) and to support residents to engage in meaningful social activities. Completed 15th June 2025

By the 30th September 2025, all staff will have received training on the importance of ensuring a culture of high-quality person centred and rights-based care.

By the 31st August 2025, all residents will be re-assessed and their care plan updated to ensure the care plan guides staff and reflects the individual needs and preferences including specific interventions in relation to ensuring individuals’ privacy and dignity

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	20/08/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	31/10/2025

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	31/08/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	01/09/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	01/09/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(2)(b)	The registered provider shall	Not Compliant	Orange	30/09/2025

	provide for residents opportunities to participate in activities in accordance with their interests and capacities.			