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:	Maryfield Nursing Home
Name of provider:	The Frances Taylor Foundation Chapelizod CLG
Address of centre:	Old Lucan Road, Chapelizod, Dublin 20
Type of inspection:	Unannounced
Date of inspection:	04 March 2025
Centre ID:	OSV-0000064
Fieldwork ID:	MON-0045003

About the designated centre

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

Maryfield Nursing Home aims to provide full time nursing care in a supportive and stimulating environment for residents over the age of 18. It is a purpose built nursing home with 69 single ensuite bedrooms, for both male and female residents. General nursing care, dementia care, palliative and end of life care are all available in the nursing home. It is situated in Chapelizod with many amenities nearby. These include restaurants, public houses, shops and public parks.There are facilities for recreation onsite; including activity rooms, a library and pleasant grounds which include secure internal courtyards. There are activities taking place in the centre that link with the community, for example a choir and a knitting group. There is also daily roman catholic mass.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	68

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
Tuesday 4 March 2025	08:20hrs to 17:30hrs	Niamh Moore	Lead
Tuesday 4 March 2025	08:20hrs to 17:30hrs	Sarah Armstrong	Support

What residents told us and what inspectors observed

From the observations of inspectors and from speaking with residents and their families, it was evident that residents were generally happy living in the centre and were supported by kind and dedicated staff. Residents told inspectors "the staff are so kind and obliging" and "we can't find anything to complaint about". Visitors spoken with were very complimentary of the quality of care that their family members received with comments such as "it is nice to leave and feel my loved one is well looked after".

Maryfield Nursing Home is located in Chapelizod, Dublin 20. The centre provided accommodation for a maximum of 69 residents and is laid out across three floors with access to each floor by lift and stairs. The building was bright, warm, nicely decorated and clean. The design and layout of the home promoted free movement for residents, corridors were wide with assisted handrails throughout. Residents' bedrooms and facilities were divided into four units, which were referred to as St. Patricks, St. Brigid's, St. Anne's and St. Kevin's. One of these units was dementia friendly and was decorated with familiar Dublin landscapes such as a Clery's department store sign.

Residents had access to a number of communal day spaces and a dining room on each respective unit. There were additional communal spaces available for residents outside the individual units such as a chapel, a celebration room, an activity room, café and family room. There was sufficient private and communal space for residents to relax in. There was plenty of accessible outside space for residents to use around the centre including two secure courtyards.

All bedrooms were single occupancy and had ensuite facilities. Many residents had personalised their rooms with photographs and personal possessions to provide a homely environment. Residents told inspectors that they were happy with their bedrooms, including the views out their windows.

Residents were complimentary of the care they received, comments included that their preferences were respected and prioritised. One resident also said they are never left waiting for staff to respond to their needs. While there were unanimous compliments given regarding the care and staff, two people spoken with said that there had been a lot of changes in management over the last two years which have been difficult.

On the day of the inspection, mass took place in the morning. Inspectors were told that a priest attended the centre daily to celebrate mass. Inspectors were also told that the residents were due to enjoy pancakes that evening to celebrate 'Pancake Tuesday'. In addition, activity staff were observed organising and confirming an outing for some residents which was due to occur the day following the inspection.

Inspectors observed the lunch-time dining experience in three of the units.

Residents could choose to dine in one of the dining rooms or in their bedrooms. Residents were offered a choice of main courses such as fish or bacon. Meals appeared wholesome and appetising. Inspectors observed that staff checked the temperature of the meals prior to serving. There was a sufficient number of staff available to assist at mealtimes and this assistance was provided in a calm, respectful and appropriate manner. Many residents spoken with confirmed they enjoyed the food on offer.

Residents reported that they felt safe and secure in the centre and that they were supported by staff to live a good life, numerous compliments were provided on the care residents received from staff. Residents stated that if they had any concerns or complaints they would speak with staff.

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

Overall, the registered provider aimed to provide a good service. Residents clinical care needs were well met and residents reported to be happy with the care provided. However, this inspection found that improvements were required to the governance and managements systems in place to ensure effective oversight of records, auditing, mandatory training and complaints procedures.

The Frances Taylor Foundation Chapelizod CLG is the registered provider for Maryfield Nursing Home. There are nine company directors, with one of these directors present during this inspection. Senior nurse managers facilitated this inspection. A new person in charge was recruited and was scheduled to begin in the coming weeks after the inspection.

Inspectors reviewed records such as, the hard copy directory of residents and found this was not kept fully up-to-date. The registered provider had a schedule of written policies and procedures in place which were available to staff on the electronic system, however, inspectors saw examples where the provider's policies were not being adopted into practice, which is further detailed under Regulation 4: Written Policies and Procedures, Regulation 34: Complaints Procedures and Regulation 29: Medicines and Pharmaceutical Services.

Inspectors reviewed the training matrix for the designated centre and saw a suite of training was available to staff in areas such as responsive behaviour, restrictive practices and fire safety. However, significant gaps were seen in attendance at training on safeguarding and infection control, manual handling, and for staff nurse roles, medication management. Overall, inspectors saw evidence of some good systems for the supervision of staff such as induction forms completed for new staff, probation reviews and annual appraisals. However, a review of some supervision

records, further highlighted that the oversight of mandatory and appropriate training required review. For example, two supervision records identified that staff required to attend refresher training and this had not yet occurred. This is further discussed under Regulation 16: Training and Staff Development.

There were sufficient resources available to ensure effective delivery of care, and there were various oversight systems in place through meetings, weekly key performance indicators were tracked on clinical care of residents and there was regular auditing of clinical and non-clinical areas. However, further oversight was required to ensure that areas for improvement identified within these systems were responded to timely.

The complaints procedure was displayed in a prominent position within the centre. There was a complaints policy which outlined the complaints management processes for the centre. For example, the complaints officer was the assistant director of nursing and the review officer was the person in charge. While the complaints log was made available to the inspectors to review, there was evidence that the complaints policy had not been fully adhered to, which is discussed under Regulation 34: Complaints Procedures.

Regulation 16: Training and staff development

There were gaps in staff attending mandatory and appropriate training relevant to their roles, as per local policy and regulatory requirements. For example:

- 17 percent of staff required training in safeguarding
- 14 percent of staff required training in infection control
- 50 percent of nursing staff required training in medication management
- 19 percent of staff required training in manual handling

Judgment: Substantially compliant

Regulation 19: Directory of residents

While there was a directory of residents available, action was required to ensure it contained all information outlined in Schedule 3 of the regulations. For example;

- The sex of each resident was not recorded.
- The name and address of any authority, organisation or other body which arranged the resident's admission was not recorded for any resident.
- The address of the resident's next of kin was not recorded in a sample of three records reviewed.
- The telephone number of the resident's next of kin was not recorded in a sample of two records reviewed.

- Where the resident was transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident was transferred was not recorded for one record reviewed.
- The cause of death was not recorded for one record reviewed.
- The time of death was not recorded for eight records reviewed.

Judgment: Substantially compliant

Regulation 23: Governance and management

Some of the management systems in place to ensure that the service was safe and effectively monitored were not fully effective. This was evidenced by:

- There was insufficient oversight of training within the centre meaning that staff had not been provided with access to appropriate training.
- Auditing systems were not fully reliable in monitoring performance to ensure care provided was safe. For example, one audit did not identify that the doors to the sluice rooms were not locked to prevent residents entering, which posed a safety concern.
- Actions from audits relating to medicines had not been implemented which posed a health and safety risk to residents. For example:
    - A medication audit completed in February 2025 identified that the keys to two medication fridges were not available, some open medicines did not have a date of opening stickers on them and some residents' requiring crushed medicines did not have this written in their care plans. These findings were also observed during the inspection.
    - Two medication audits completed by the pharmacist in March 2024 and October 2024 identified that the temperature in the treatment rooms exceeded 25 degrees, and that medicine trolleys were not fixed securely to the wall when not in use, both of these findings were observed by inspectors on the day of the inspection.

While an annual review for 2024 was available and outlined actions to be taken in 2025, further review was required to ensure that the centre's performance was measured against the national standards. In addition, there was no evidence that the annual review was prepared in consultation with residents and or their families.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors saw that there were three open complaints, two of which dated to 2023. One record did not contain evidence that this complaint was investigated and

concluded, as soon as possible and in any case no later than 30 working days after receipt of the complaint.

The inspectors reviewed a sample of three closed complaints and found that they were all investigated in line with the centres complaints policy, however all three, including one which was made in writing did not have evidence that the following were provided to the complainant:

- a written response informing the complainant whether or not their complaint had been upheld,
- the reasons for the decision and any improvements recommended and
- details of the review process.

The complaints and review officers had not received suitable training to deal with complaints in accordance with the registered provider's own policy and the regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had policies and procedures in place which were seen to have been reviewed within the last three years. However, as discussed within this report inspectors were not assured that all of these policies were adopted by management and staff within the designated centre. Specifically the policies on training and medicines management. For example:

- The Medication Management Policy and Procedure effective from January 2025 detailed that where a resident self-administers medication there will be;
    - an individual risk assessment carried out,
    - lockable storage in the residents bedroom for medicines with a key kept by the resident and a spare one with the main drug keys.
    - In addition, it states that a resident records the medication taken in his or her own self-administration reminder chart. Following a review of records and discussion with residents and staff, this was not being implemented in practice.

Judgment: Substantially compliant

Quality and safety

Residents in Maryfield Nursing Home were supported by a team of staff that knew them well. The centre itself was well-maintained, comfortable and appropriate to

residents' needs. While inspectors found that some improvements had been made since the previous inspection, further oversight and action was required to achieve full compliance with the regulations, particularly relating to medicines management.

Overall, there were good standards of evidence based healthcare provided in this centre. Records showed that residents saw their general practitioner regularly, and where specialist medical input was required, referrals were made in a timely manner.

From inspectors' observations during this inspection, staff were seen to communicate respectfully and effectively with residents including those with communication difficulties.

The building was clean and bright. The registered provider had support with maintenance to ensure the premises was kept in a good state of repair internally and externally. There was adequate communal and private space available other than residents' bedrooms.

The inspectors followed up on the compliance plan from the inspection of April 2023 in relation to medicines, and found that there were some improvements made. For example;

- the inspectors saw that checks of controlled medication were recorded by two nurses at the change of every shift,
- staff nurses were administering prescribed nutritional supplements,
- and there was an electronic medicine record system in place.
- In addition, medication administration was observed and of the sample seen, the practice was in line with professional guidelines.

However, inspectors saw evidence where the registered provider's medication policy had not been adopted in practice.This is further discussed under Regulation 29: Medicines and pharmaceutical services.

Regulation 10: Communication difficulties

Assessments had been completed of the communication needs of residents and where residents had specialist communication requirements, these were recorded in their care plan.

Judgment: Compliant

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of residents, it

was of sound construction and in a good state of repair.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medication management processes such as the storing of medicines required review by the registered provider and person in charge to ensure they were safe and evidence-based. For example:

- Temperatures in two drugs store rooms required review to ensure they were suitable for the storage of medications. On the day of inspection they were observed to be above 25 degrees and records reviewed had documented ranges between 27-28 degrees.
- The storage of medicines required further review to ensure practices were in line with the registered provider's policy. For example:
    - A medicine which was due to be stored in the controlled drug safe was seen to be stored in one medication trolley.
    - A Schedule 2 drug was stored in the controlled drug safe, however this was not recorded on the register. This created a risk that there was no oversight of this controlled drug.
    - There were gaps in the temperature records for a fridge in one treatment room on the day of the inspection.

Judgment: Not compliant

Regulation 6: Health care

A GP attended the centre twice a week and as required. Timely referrals to allied health professionals such as palliative care, dietitians and community services to include chiropody were completed.

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 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for Maryfield Nursing Home OSV-0000064

Inspection ID: MON-0045003

Date of inspection: 04/03/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training records have been reviewed post inspection. Safeguarding, Infection Control for all staff and Medication Management trainings for all staff nurses are now 100% completed. Manual Handling training is scheduled for 23rd April 2025 with the aim of completion to all staff that requires re-training and for new staff. PIC will be meeting with the HR Department on a monthly basis to review training requirements to ensure relevant trainings are met in a timely manner.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: Directory of residents have been reviewed, and all missing information have now been completed and recorded. A checklist for all admissions and re-admissions is in place. The Clinical Nurse Managers will have an oversight of this checklist to ensure residents' information and transfer details are recorded accurately. This is also added to the Assessment and Care Plan audit tool to capture missing information and update accordingly. An End-of-Life checklist is also in use. PIC is completing a floor training for all Nurses on the use of these checklists through the electronic record system. Clinical Nurse Managers will have an oversight on the End-of-Life checklist when a resident passes away.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A floor discussion/meeting with all staff has been completed on 06/04/2025 to emphasize the risks involved in leaving the sluice rooms unlocked for the safety of all the residents. Checks are incorporated into DON/ADON/CNM's daily walk arounds.

Medication management training is scheduled for 10th April 2025 as refresher training for all staff nurses to ensure medication management policy is followed and adhered to.

A review of 2 clinical rooms in St. Anne's and St. Bridgid's by building contractor was completed on 24th March 2025 and a plan is in place to install Air Conditioning Unit to maintain desirable temperature for the proper storage of the medication for completion by end of April 2025.

The installation of the chain locks for all medication trolleys was completed on 28th March 2025.

A folder for Annual Review for 2024 has been in place with the minutes of residents' meetings and copies of activities that took place in 2024. This will be reviewed to ensure Mayfield's performance was measured against the national standards.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Existing complaints have now been closed.

The Person in Charge will oversee all logged complaints to ensure correct procedure is followed as per complaints policy. Any findings and learnings will be recorded and disseminated to all staff through floor discussions or at staff meetings to prevent same complaints happening going forward.

Complaints training is organized for the Provider, Senior clinical managers and senior nurses on 7th May 2025.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
An individual risk assessment for resident self-administering medications was completed on the day of the inspection. This is added to the Medication management audit tool to ensure it's in place and updated accordingly.

Lockable storage is now in place in the bedroom of the resident's self-administering medications. A key is kept by the resident and another key is on the main drug keys of the unit.

Medication management policy is updated to reflect the correct procedure in recording of resident's self-administration of their medications. All staff nurses have been informed of the policy change and are to sign that the policy is read and understood.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A building contractor had completed a review of clinical rooms in St. Anne's and St. Brigid's. A plan for installation of air conditioning units is scheduled for completion by end of April 2025 to ensure the desired temperature is maintained for the storage of medications.

Medication Management training is scheduled for 10/04/2025 for all staff nurses as a refresher course to ensure correct adherence to the medication management policy. Medication management audit tool is updated to capture correct storage of Schedule 2 drug.

Clinical nurse managers will oversee temperature records daily during their rounds to ensure nurses are following the correct procedure. Any discrepancies will be discussed with the nurses on duty.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/04/2025
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/04/2025
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care	Substantially Compliant	Yellow	30/04/2025

	delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.			
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	30/04/2025
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	30/04/2025
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	31/05/2025
Regulation 34(2)(g)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/05/2025

	complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	31/05/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/04/2025