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:	Mill Lane Manor Private Nursing Home
Name of provider:	The Brindley Manor Federation of Nursing Homes Limited
Address of centre:	Sallins Road, Naas, Kildare
Type of inspection:	Unannounced
Date of inspection:	04 December 2025
Centre ID:	OSV-0000066
Fieldwork ID:	MON-0048915

About the designated centre

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

Mill Lane Manor Private Nursing Home is a designated centre providing health and social care to men and women over the age of 18 years. Care is provided in purpose-built, two-storey premises located in a residential area in Naas Co. Kildare. The building consists of 52 single-occupancy bedrooms and nine twin-occupancy rooms. All bedrooms have full en-suite facilities. A passenger lift is available between the ground and the first floor. Communal areas include two lounges and an oratory, and there is a designated hairdressing salon. There are two internal courtyards along with grounds to the front of the building. Parking is available at the front, side and rear of the centre. The centre provides a service to individuals with a range of needs, including long-term care, short-term care, acquired brain injury and dementia. A short-term respite and convalescence service also operate in the centre.

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
Thursday 4 December 2025	08:30hrs to 16:15hrs	Sinead Lynch	Lead

What residents told us and what inspectors observed

The inspector met with many residents and visitors during the inspection to gain insight into the lived experience in the centre. The feedback was overwhelmingly positive. Residents praised the staff for their kindness and attention, while one visitor detailed how their relative was a recent admission and they found the staff and management to be 'exceptional' and 'responsive'.

Notwithstanding the positive feedback from residents and relatives, there were some concerns identified with care planning and assessment and also staff training. In particular, some residents' care plans did not guide care, which is discussed further under Regulation 5: Individual assessment and Care plan. In addition, a small number of staff had not completed training in relation to manual handling and managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This is detailed further under Regulation 16: Training and staff development.

There had been some improvements to the premises since the last inspection in July 2025 but further work in relation to the carpets was still required as many areas of the carpets were worn or stained. The registered provider had an action plan in place to ensure all flooring was repaired or replaced throughout 2026.

When asked about their food, all residents who spoke with the inspector said that the food was very good. They said that there was always a choice of meals, and it was always hot and tasted good. They confirmed that food and snacks were available at all times, including out-of hours.

Residents informed the inspector that they were very happy and content with the cleaning and laundry service in the centre. Residents said their clothes are returned promptly and neatly, and that their bedroom is cleaned daily.

Residents' bedrooms were observed to have adequate storage space with some residents requiring more storage than others. There were call-bell facilities available to residents and staff were observed responding to these call-bells promptly.

Many residents gathered in the reception area throughout the day where they met with relatives or attended activities and this area was seen to be a hub for activities and social engagement. Residents appeared to enjoy the activities and one resident said 'if I am not happy I will say it, but at the moment this is a good place to live'.

There were many notice boards displayed around the centre, these provided information on advocacy services, how to raise a complaint and detailed what

safeguarding is. There was a colourful poster informing residents and relatives about the upcoming Christmas party which residents said they were excited to attend.

There were many storage rooms around the centre. The inspector observed sufficient supplies available to meet the needs of the residents. These included wipes, toiletries and continence wear. Staff spoken with informed the inspector that there is no problem in obtaining resources or any items required.

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 inspector found that residents in the centre benefited from a well-managed and resourced service that was responsive to their wishes and suggestions for improvement. There were robust governance and management arrangements in place, which ensured a high level of regulatory compliance across many regulations inspected against. However, further strengthening of residents' care planning and assessment arrangements and some improvements in respect of staff training were required.

While the majority of staff had completed mandatory and relevant training to support them in fulfilling their roles effectively, a review of records showed a number of gaps, as further detailed under Regulation 16: Training and staff development. There had been some turnover of staff since the last inspection with 33 new staff commencing in their role while 23 staff had left. Staff were provided with a comprehensive induction and new staff were very aware of their responsibilities in providing care to their residents.

This was an unannounced risk inspection carried out to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulations 2013 to 2025. The registered provider of Mill Lane Manor is The Brindley Manor Federation of Nursing Homes Limited which is part of the larger Emeis group. The inspector followed up on the compliance plan from the last inspection in July 2025 and found that the provider was working within the agreed time-frame in relation to the renovations of the premises. The management of records had significantly improved, and there was a more robust system in place where all documents were stored safely while being easily accessible. Documentation utilised when residents were being transferred to another facility now contained all the required information to ensure the transfer was comprehensive and detailed.

The person in charge worked full-time in the centre and they were supported by an assistant director of nursing. There was further support from a regional director who

was present in the centre on the day of inspection. There was a team of nurses, healthcare staff and housekeeping there to support the management team.

An audit schedule was in place for 2025 and a range of tools were being used to monitor and audit the quality of care delivered to the residents in areas such as incidents, assessments and care plans, falls, and medication management. These audits had identified issues in relation to the care planning and assessment process which the inspector highlighted on the day, However at the time of this inspection, not all areas for improvement had been actioned.

Regulation 15: Staffing

The inspector reviewed a sample of staff duty rotas and in conjunction with observation of practice and communication with residents and visitors, found that the number and skill mix of staff was sufficient to meet the needs of the residents, having regard to the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff had not completed mandatory training in all areas that may affect care delivery. For example:

- One staff member had not completed their fire training.
- Two staff had not completed manual handling training.
- Four staff had not completed responsive behaviour training.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents was in a computerised format. It was updated to include the name, address and telephone number of the resident's general practitioner (GP), details of all transfers to and from the centre, as well as details in respect of residents who had died, including the date, time and cause of death.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider's oversight of the management systems in place needed strengthening to ensure the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The management systems for ensuring all staff had completed the mandatory training was not in place. This is further detailed under Regulation 16: Training and staff development.
- Although a variety of monitoring systems were in place, quality improvement plans were not consistently developed to address known deficits in care planning arrangements as identified in the care planning audits. This is further detailed under Regulation 5: Individual assessment and care plan.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Each resident had a contract for the provision of service. These contracts included the type of bedroom they would be accommodated in, the fees to be charged and information pertaining to services available in the centre.

Judgment: Compliant

Quality and safety

Overall, the inspector was assured that residents were supported and encouraged to have a good quality of life in the centre and that their healthcare needs were well met.

The inspector found that there were sufficient staffing levels and an appropriate skill-mix to meet the care needs of the residents living in the centre. However, while care planning documentation was available for each resident in the centre, there were significant gaps in the care planning and assessments records, which meant that key information was not available to support a comprehensive review of residents' care. This will be discussed further under Regulation 5: Individual assessment and care planning.

The provider had been implementing improvements in the centre with regards to premises and fire precautions since the last inspection and was on track to meet the completion dates for targets set out in the last compliance plan.

There were measures in place to protect residents from being harmed or suffering abuse, and to promote residents' safety and respond to incidents reported. There were posters displayed around the centre detailing what abuse is and how to recognise it and who to report it to. The inspector saw evidence that all staff had completed safeguarding training and had garda vetting in place prior to commencing employment in the centre.

In relation to residents rights' there had been significant improvements since the last inspection. Residents were observed to be provided with choice in how they carry out their day or where they go. Residents were observed having their meal in the main dining room, while a few residents requested to have their meals in the reception area or in their bedrooms. Residents had access to activities and their wishes to attend or decline were respected.

There was a comprehensive risk management policy in place. The person in charge updated the risk register regularly and all risks identified on the day were clearly documented with a timely action plan in place and an accountable person named.

Regulation 26: Risk management

There was a risk management policy in place that met the legislative requirements. The risk register included actual risks, such as the risk associated with holding doors open with furniture and the need to replace the magnetic systems on these doors. Appropriate monitoring arrangements were in place until the replacement of the magnetic systems was effected.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessments and care plans found that they were not in line with the requirements of the regulations and did not guide care delivery. For example;

- Care plans for residents at risk of absconsion were not reflective of current practice. For example the care plan for one resident at risk of absconsion specified 15 minute checks were required to ensure resident's safety, however, such checks were no longer in place. Staff were unsure of the current arrangements. This may put the resident at risk as some staff

believed these checks were still in place while other staff said they were no longer required.

- Post-fall assessments and care plans were not in line with local policy and best practice. For example, one resident who had a fall, had their neurological observations taken three times at 15 minute intervals, however, no further checks were completed for the next eight hours. Should a medical episode occur this may not be timely identified.
- Validated assessment tools were not appropriately used to identify and act on clinical deterioration. For example, one resident who sustained a head injury following an unwitnessed fall had neurological assessments completed in line with policy. However, in one instance, records showed that staff failed to take timely action when the neurological score deteriorated.

Judgment: Not compliant

Regulation 8: Protection

All reasonable measures were taken to ensure residents were protected from abuse. All staff had completed the mandatory training in safeguarding vulnerable adults and displayed good knowledge of what constitutes abuse in their conversation with the inspector. There were safe systems in place to safeguard residents' money. The provider acted as a pension-agent for four residents. Financial transactions were transparent and a separate account had been created for residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were upheld in the centre and all interactions observed during the day of inspection were person-centred and courteous.

Residents had access to a wide range meaningful and engaging activities. The activity schedules were on display and residents were involved in person-centred activities throughout the day.

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	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Quality and safety	
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mill Lane Manor Private Nursing Home OSV-0000066

Inspection ID: MON-0048915

Date of inspection: 04/12/2025

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:
The PIC will ensure that all staff complete mandatory training in line with regulatory requirements. By 4th February 2026, a review of all training records will be undertaken to identify outstanding training to be completed.

A training matrix is maintained and will be reviewed on a weekly basis from 1st February 2026 by the PIC and monthly by the RD/PIC at the homes Clinical Governance meeting.

The matrix is also reviewed by PIC /RD and the training department on a monthly basis to ensure ongoing compliance- Ongoing.

The manual handling training statistics are at 100% currently with ongoing training scheduled for 06/03/2026.

Fire training statistics are at 98% currently and training has been scheduled for the 04th of February 2026.

Responsive behavior training statistics are at 92% currently and the training is scheduled for the 4th of February 2026.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
From 1st January 2026, the PIC will strengthen governance and management arrangements to ensure effective oversight of care delivery through regular audits, ongoing staff supervision, and routine management walkabouts to monitor care practices and identify areas for improvement.
All residents' assessments and care plans are currently being reviewed and updated to ensure they accurately reflect individual risks, controls, and care practices, with completion scheduled by 31st March 2026. Staff will receive refresher guidance on the use of validated assessment tools and appropriate escalation processes by 31st January 2026.
Staff nurses are scheduled to attend a person-centred care planning education session on 29th January 2026.
From 1st February 2026, oversight will be provided by the PIC and the Regional Director through monthly clinical governance meetings. Training compliance will be maintained through monthly audits, ongoing governance discussions, and regular meetings with the training department.
From 1st February 2026, progress will be monitored through regular monthly and quarterly, or as required, management and clinical governance meetings to ensure sustained improvement. Where gaps in practice continue to be identified, staff will be supported through one-to-one coaching, targeted retraining, and mentoring.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
All residents' assessments and care plans are being reviewed and updated to accurately reflect current risks, controls and care practices due to be completed by the 31st of March 2026.

Care plans for absconsion risk will clearly outline current supervision arrangements. Ongoing due for completion by 31st of March 2026.

Post-fall assessments and neurological observations will be completed in line with policy and best practice. Staff will receive refresher guidance by 31st of January 2026 on the use of validated assessment tools and escalation procedures.

Ongoing care plan audits are commenced to ensure compliance. Staff nurses are scheduled for a person-centred care plan education session on the 29th of January.

Care plan meetings are scheduled with residents and families as per policy and are currently ongoing.

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	06/03/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2026
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	Not Compliant	Orange	31/03/2026

	admission to the designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/03/2026