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:	Moorehall Lodge Ardee
Name of provider:	Moorehall Living Limited
Address of centre:	Hale Street, Ardee, Louth
Type of inspection:	Unannounced
Date of inspection:	18 August 2026
Centre ID:	OSV-0000147
Fieldwork ID:	MON-0050836

About the designated centre

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

The designated centre provides twenty-four hour support and nursing care to 125 male and female older persons, with low, medium, high and maximum dependency levels. The range of needs include: Older persons care, Dementia Specific Care, Physical Care, Physical and Intellectual Disability, Young Chronic Care and Acquired Brain Injury. Respite, convalescent, short and long term care is provided. The centre has 113 single rooms and 6 twin rooms. It is made up of two buildings linked by an external linked corridor. The designated centre is a purpose-built two storey building and is situated in a retirement village which forms part of the local community. It is divided into five households; Anam Chara, Suaimhneas, Aoibhneas, Le Cheile and Misneach. Each household has its own front door, kitchen, open plan sitting and dining room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	114

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 18 August 2026	09:15hrs to 17:35hrs	Aislinn Kenny	Lead
Tuesday 18 August 2026	09:15hrs to 17:35hrs	Maureen Kennedy	Support

What residents told us and what inspectors observed

This was an unannounced monitoring inspection conducted by two inspectors of social services with a focus on adult safeguarding and reviewing the measures the registered provider had in place to safeguard residents from all forms of abuse.

The inspectors spoke in depth with 16 residents who were complimentary in their feedback and expressed satisfaction about the standard of care provided. Residents reported that they were 'well looked after' and that the staff always ensured that 'you had the call-bell' before leaving the room. Friends and families were observed to visit residents throughout the day of inspection. The inspectors spoke with five visitors who, overall, all told the inspectors that the 'staff were very good'.

The centre is comprised of two buildings, there are three households in the original building and two households in the second newer building. Each household has its own entrance opening into a large communal area with a kitchenette. A homemaker is present in each household providing supervision of residents during mealtimes and throughout the day. This provided a homely atmosphere and the inspectors observed kind and friendly interactions between staff and residents in these areas in all households.

The inspectors found that the premises was laid out to meet the needs of the residents. Residents' bedrooms were found to be clean and organised and many were decorated in a manner that reflected the residents' preference including photographs and ornaments. Residents who spoke with the inspectors were happy with the size, layout and décor of their rooms, one resident told the inspectors that their 'room was kept spotless by the staff'. There were various doors opening out to the enclosed courtyard spaces which were nicely decorated with shrubs and plants. One of these courtyards contained an old car and seating areas which were well-used by residents, according to the staff.

The inspectors walked around the centre and observed the morning routine for the residents and interactions between staff and residents. Staff were observed knocking on residents' doors before entering and were seen checking in with residents on a regular basis. Staff were observed to engage in good hand hygiene practices throughout the day.

Residents' rights and choice were promoted and respected within the centre. Activities were provided in accordance with the needs and preference of the residents. One resident told the inspectors that they enjoyed the 'bingo and knitting', while many residents were observed reading the available newspapers. An exercise class took place on the day of the inspection and was observed to be enjoyed by many of the residents taking part. There was access to advocacy with contact details displayed in the centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection with a focus on adult safeguarding and reviewing the measures the provider had in place to safeguard residents from all forms of abuse. This inspection found that there were good management systems in place to protect residents and that there was effective oversight of these systems. Some improvement was required to ensure residents' care plans were accurate and up-to-date to consistently guide care. Providing unrestricted access to the oratory also required review by the provider, as discussed further in the report.

The registered provider of Moorehall Lodge Ardee is Moorehall Living Limited and is part of the wider Virtue Group who own and run a number of centres nationally. A company director provided senior managment support to the centre and was present on the day of the inspection. The person in charge was responsible for the local day-to-day operations in the centre and was supported in the role by an assistant director of nursing (ADON), clinical nurse managers and a team of staff nurses, healthcare assistants, activities, catering, housekeeping, administrative and maintenance staff. It was evident that the centre's management and staff focused on providing a quality service to residents and promoting their well-being.

There was a schedule of regular team meetings in place including management and staff meetings. Minutes of these meetings were provided to the inspectors. The management team had developed audits that identified where improvements were required. They used these audits to implement improvement plans and drive quality care. Analysis of incidents and falls was taking place on a regular basis. However, while care planning audits had been carried out, they had failed to identify that there continued to be gaps in the nursing documentation, as observed during the inspection, and as further detailed under Regulation 5: Individual assessment and care planning.

On the day of the inspection, there were adequate staffing resources to ensure the effective delivery of care and to meet residents' individual needs. The staff were visible within the nursing home tending to residents' needs in a respectful manner. Staff had the required skills, competencies and experience to fulfil their roles and responsibilities. Staff had access to appropriate training and while the majority of staff had attended the required mandatory training to enable them to care for residents safely, there was one staff member who had no documented evidence of having completed any safeguarding training. Inspectors brought this to the attention of the provider on the day and were informed that this would be addressed and

scheduled straight away. There was good supervision of staff on the day of the inspection.

Regulation 15: Staffing

The centre was appropriately resourced with adequate staffing numbers across all disciplines to meet the needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role, and staff demonstrated an appropriate awareness of their training and their role and responsibility in recognising and responding to allegations of abuse.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the systems in place for the oversight and monitoring of care and services provided for residents, further action was required by the registered provider to achieve regulatory compliance as follows:

- While regular auditing on various aspects of the service was completed, the audit process was not sufficiently robust to identify all areas for improvement. For example, care planning audits conducted had not picked up on the gaps in documentation observed on this inspection as identified under Regulation 5: Individual assessment and care plan. This is a repeat finding.
- The inspectors found that one staff member had not completed any of the required safeguarding training either online or in person. The provider assured the inspectors that this oversight was being addressed promptly.
- Enhanced oversight of the use of the premises was needed to ensure that all areas were being used at all times in line with the conditions of the registrations. For example, the provider had organised staff training in the oratory, an area registered for use by residents.

Judgment: Substantially compliant

Quality and safety

The purpose of this inspection, focused on adult safeguarding, was to review the quality of the service being provided to residents and ensure they were receiving a high-quality, safe service that protected them from all forms of abuse. This inspection found that overall, the provider was proactive in their approach to safeguarding residents and appropriate measures were taken to protect residents from harm. Residents' rights and autonomy were promoted and there was a person-centred approach to residents' care. Some improvement was required concerning individual assessment and care planning to ensure information relevant to safeguard residents, where concerns had been previously raised, was timely documented in residents' care plans.

Care planning documentation was available for each resident in the centre. An assessment of each resident's health and social care needs was completed on admission. Inspectors reviewed a sample of care plans and found some gaps in the updating of care records, which meant that key information was not available to support a comprehensive overview of residents' care.

Residents with dementia and those with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were being effectively supported by staff. The provider had ensured that any restrictive practices in use in the centre had been documented in the centre's restraint register, which was reviewed on a regular basis. Residents with communication difficulties were supported to communicate freely by staff who were aware of their specific support needs in this area.

The inspectors found that all reasonable measures were taken to protect residents from abuse. There was a policy in place which covered all types of abuse and the inspectors saw that staff had received mandatory training in relation to detection, prevention and responses to abuse. There was a rigorous recruitment procedure in place. From a sample of staff files reviewed all staff had An Garda Siochana (police) vetting prior to starting work in the centre. For some staff, Garda vetting was being renewed at the time of the inspection and reminders had been sent out to staff in relation to this.

While the premises was well-maintained and appropriately laid out to meet the needs of the residents, the inspectors found that on the day of the inspection the oratory was not fully accessible for residents in the morning, as there was staff training taking place. Later in the afternoon a staff member was observed having their break in this area, which meant that these spaces, registered specifically for the use of residents, were not always available to the residents. An area of paving on the external grounds also required attention to ensure the safety of residents, staff and visitors this is further discussed under Regulation 17: Premises.

Regulation 10: Communication difficulties

The inspectors found that residents with communication difficulties had their communication needs assessed and documented in their care plan. Staff were knowledgeable about each residents specialist communication requirements.

Judgment: Compliant

Regulation 17: Premises

On the day of the inspection an area of the centre was not being used in line with its registered purpose for example:

- An oratory, which was a large area registered for use by residents, was being used for staff training on the morning of the inspection which meant that it was not available if residents wished to use it.
  In the afternoon, the same oratory, was observed to be used by staff taking their break.

While overall the centre was well-maintained, an external area required repair to ensure it conformed to Schedule 6 requirements.

- The paving on the external grounds outside Suaimhneas household was raised and could present a trip hazard for residents, staff and visitors. This had been identified by the provider.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' care plans found that they were not fully in line with the requirements of the regulations. For example:

- The inspectors found that some safeguarding care plans for residents who had involvement in previous safeguarding incidents were updated on the day of the inspection; one care plan was not previously documented and the second had not been updated within a four month period.

Care plans which prescribed the required interventions to support residents' care were not consistently implemented in practice. For example:

- Requirements of two and four hourly repositioning were outlined in the care plan as informed by a risk assessment, but records showed that resident repositioning was not within the prescribed time frames. This posed a risk that residents assessed as being at risk were not effectively protected from the risk of pressure sore or skin breakdown.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Each resident experienced care that supported their physical, behavioural and psychological wellbeing. The person in charge ensured that all staff had up-to-date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Judgment: Compliant

Regulation 8: Protection

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

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities for residents' occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities. Residents expressed their satisfaction with the activities available to them. Residents were provided with the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' meetings and taking part in residents' surveys.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Moorehall Lodge Ardee OSV-0000147

Inspection ID: MON-0050836

Date of inspection: 18/08/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A quarterly care plan audit is completed by the CNMs and reviews a sample size of at least 16%. A sample from each of the five households is included in every quarterly audit. The provider acknowledges that this is a repeat finding. Following the inspection, the audit tool was reviewed and found to confirm that care plans were in place without checking that review dates had been set correctly in the electronic care plan system which is why the gaps were not identified. The audit now includes a review of the reminder dates entered in electronic care plan system, to ensure that the date has been entered correctly and falls within the four-month review period required. Every audit generates a quality improvement plan with actions, owners and completion dates. Audit results and progress against each improvement plan are reviewed by the DON and reported to the RPR at the weekly clinical governance meeting].

High risk residents, including those who require location checks or frequent repositioning (SSKIN bundle), have responsive behaviours, or are nursed on air mattresses, will be reviewed and recorded in separate registers. These registers will be maintained by CNMs and reviewed monthly (or sooner if required). This review will also include a check of the care plan to ensure it accurately reflects the resident's current needs. Review and completion of registers will be completed by 02/11/2026.

The staff member identified on inspection completed safeguarding training on 19/08/2026. A review of safeguarding training records for all staff was completed on 19/08/2026 and confirmed 100% compliance with no other staff member without safeguarding training. Training compliance is reviewed fortnightly by HR admin and reminders are sent to staff before training expires. Any outstanding training is escalated to the DON and ADON for action. Fortnightly HR meetings are held and attended by the RPR, DON and HR admin, with training compliance as a standing agenda item. Minutes and actions are recorded.

The oratory is a designated resident area and will remain as such. Training will no longer take place in this area, so that residents always have full access. On 9/10/26, all staff were informed in writing that the oratory is not to be used for training or staff breaks, and that breaks are to be taken in the civic area or the staff room in the extension.
The CNM on duty will check the oratory during daily walkabouts. Any inappropriate use will be addressed with the staff member at the time and reported to the DON.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The oratory is a designated resident area and will remain as such. Training will no longer take place in this area, so that residents always have full access. On 9/10/26, all staff were informed in writing that the oratory is not to be used for training or staff breaks, and that breaks are to be taken in the civic area or the staff room in the extension.
The CNM on duty will check the oratory during daily walkabouts. Any inappropriate use will be addressed with the staff member at the time and reported to the DON.

The external paving next to Suaimhneas had already been identified by management, and quotes were being obtained for the area to be tarmacked. As an interim measure, the existing paving bricks will be lifted and replaced with 804 and blinding stone, compacted with a whacker plate and roller, to leave a level surface free of trip hazards. This will be completed by 09/11/2026.
The area will be permanently resurfaced with tarmac by 30/06/2027.

The DON and RPR complete quarterly audits to review the premises. These are recorded, and each concern or hazard identified is given an action plan with a named owner and completion date.

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:

A review of all safeguarding care plans was completed on 25/08/2026 to ensure each was current and within its review date. The two care plans identified on inspection were

updated on the day of the inspection.

A safeguarding register is now in place and records the date each care plan was implemented and its date of review. It is managed by DON and ADON and reviewed monthly to confirm that no safeguarding care plan is overdue.

A review of care plan reminder dates recorded in the electronic care plan system was completed on 01/09/2026 to ensure that dates were entered correctly. It was identified that some reminders had been entered as six months instead of four. All were corrected at the time of review. The care plan audit has been revised to ensure that this aspect is checked. On 7/10/26, written communication was sent to all staff nurses reminding them of the four-month review requirement. This will also be included as an agenda item at future staff meetings. The electronic care plan system highlights care plans due for evaluation, which are reviewed weekly by the DON. These are actioned at the time of review and form part of the weekly KPIs.

The three CNMs are each assigned households to support staff and provide oversight. Any issues are escalated to the DON or ADON either immediately or at the weekly catch-up meeting.

CNM weekly checks will include a review of all residents on the SSKIN bundle register. These will be cross-checked with daily records from the electronic care plan system to ensure the required repositioning is completed. In addition, the nurse in charge will check repositioning records for these residents before the end of each shift and act on any missed repositioning at the time.
The residents whose repositioning records were reviewed on inspection had their skin integrity reassessed on 19/8/26 with no new pressure damage identified.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	16/10/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	09/11/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	02/11/2026

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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	02/11/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	01/09/2026