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:	23 September 2025
Centre ID:	OSV-0000147
Fieldwork ID:	MON-0046437

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:	112

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 23 September 2025	07:30hrs to 15:50hrs	Sinead Lynch	Lead
Tuesday 23 September 2025	07:30hrs to 15:50hrs	Maureen Kennedy	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors met with many residents to gain insight into their experience of living in Moorehall Lodge Ardee. Residents told the inspectors that they were 'perfectly happy' living in the centre, that the staff were 'very nice to us' and they would 'do anything for you'. The inspectors also spoke with some family members who were visiting on the day, who said that 'these people have a vocation, they are not just doing a job' and that 'as a family, we have peace of mind' that their loved one is being looked after. There were 112 residents living in the centre on the day of this unannounced inspection.

The centre comprised of five houses. Each house had a secure well-maintained courtyard, all of which had flowerbeds and garden furniture including seating for residents. The secure courtyard in the dementia unit had its own car for residents to interact with if they wished. Some of the courtyards contained shelters which facilitated residents who wished to smoke to do so while being protected from the elements of the weather.

Communal areas were seen to be well-used by residents throughout the day. Resident bedrooms were found to be clean and organised and many were decorated in a manner that reflected the residents' preferences, including personal photographs.

Throughout the day of inspection staff were visible within the nursing home tending to residents' needs in a caring and respectful manner. Call bells were answered without delay and residents informed inspectors that they did not have to wait long for staff to come to them.

Residents were supported to make choices about their daily routines. For example they could choose when to get up and go to bed, what activities they took part in, what choice of food they preferred and how to spend their day. Throughout the morning residents were seen attending the dining room for their breakfast from 7.30am to 11.30am. Staff were observed to be obliging and available to serve meals at a time that suited each resident. The inspectors observed orders for breakfast such as scrambled eggs and bacon while another resident ordered boiled eggs.

Residents spoke positively about the meals and the great choice they were offered. Menus were on display in each dining room and all residents spoken with were very complimentary of the amount and variety of food on offer. Staff were available in each dining room and there was a pleasant atmosphere, with staff and residents chatting and laughing with each other. Residents were observed to be offered drinks regularly and discreet assistance was provided if and when needed.

The centre provided a laundry service for residents. All residents whom the inspectors spoke with on the day of inspection were happy with the laundry service,

and there were no reports of items of clothing going missing. A family member told the inspectors that the 'laundry service was great'.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Overall, this was a well governed centre which ensured that residents were well cared for in a supporting, caring and well resourced way. There was good leadership evident from the management team.

Moorehall Living Limited is the registered provider of Moorehall Lodge Ardee and part of the wider group structure Virtue Health Care Group. The senior management structure comprised of, a Regional director, health and finance personnel to provide operational and management oversight and leadership in the designated centre and support the person in charge. A full-time assistant director of nursing (ADON) supports the person in charge at an operational level.

The staffing and skill mix on the day of inspection appeared to be appropriate to meet the care needs of residents.

Staff were provided with appropriate training to meet the needs of their role. Staff training was closely monitored to ensure all staff completed training requirements, which proved effective in improving staff knowledge and practices.

The provider had an audit schedule covering areas such as complaints, safeguarding, health and safety, care planning, falls, wounds, call-bell response times and weight loss. Where these audits identified deficits and risks in the service, the provider had a time-bound quality improvement plan. However, to ensure representativity, an increase in the sample size used was required in order to give the provider a clearer understanding of areas for improvement. This is detailed further under Regulation 23: Governance and Management.

An annual review of the quality and safety of care delivered to residents took place in 2024 in consultation with residents and their families. Residents and families had been consulted in the preparation of the annual review through surveys and the residents' forum meetings. Within this review, the registered provider had also identified areas requiring quality improvement.

Each resident had a contract for the provision of services which met the regulatory requirements.

There was a directory of residents made available to the inspectors. This contained all the required information and details of each time a resident attended hospital or was out of the centre for short periods of time.

Regulation 16: Training and staff development

Staff had access to appropriate training. All staff had attended the required mandatory training to enable them to care for residents safely. There was an on-going schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. There was good supervision of staff.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents which met the regulatory requirements and was made available when requested.

Judgment: Compliant

Regulation 21: Records

The registered provider had in place all records set out in Schedule 2 of the regulations. These were made available for inspection.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the good governance arrangements in the centre, further improvements were required in relation to the management systems in place to monitor the effectiveness of care delivery. For example;

- The sample used for the monthly call-bell audits was not representative as it only recorded the timing for one call-bell rang at random. This would not inform the provider of the effectiveness of their service as the sample size was too small.

- The monthly hand hygiene audits only recorded the actions of three staff. Again, for a large centre like this, such a sample size is not sufficient to assure the provider that there is a safe system in place and that the staff are consistently implementing the principles of training into practice.
- The oversight of care plans required further strengthening. Care plans were not always reflective in directing care as detailed in Regulation 5: Individual assessment and care plan.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of contracts of care between the resident and the registered provider and found that they were transparent and accurate. They clearly set out the terms and conditions of the resident's residency in the centre and any additional fees charged were clear. The contract also stated the bedroom to be occupied, and the occupancy number of the room.

Judgment: Compliant

Regulation 30: Volunteers

There were five volunteers working in the centre at the time of inspection. Each person had a vetting disclosure in accordance with the National Vetting Bureau Act 2012 in place. They had their roles and responsibilities set out in writing.

Judgment: Compliant

Quality and safety

Overall, the inspectors were 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 inspectors observed that some residents had difficulties communicating verbally. Staff were respectful and knowledgeable of residents' communication needs. Communication strategies were formulated and the inspectors observed these residents and staff spending time communicating and laughing together.

Residents with communication difficulties had their communication needs documented in their care plan.

Residents' bedrooms were found to be warm, homely spaces. Some were personalised with ornaments, soft furnishing and photographs from home. Bedrooms were observed to have sufficient storage space for residents' clothing and personal possessions with a lockable unit available for storage if required. There was an on-site laundry and a labelling system in place that ensured that all clothes were returned to residents in a timely manner.

Care planning documentation was available for each resident in the centre. A sample of resident care plans were reviewed. Of the sample reviewed, each resident had a pre-admission assessment carried out to ensure the centre could meet the residents' needs and assessments were completed within 48 hours of admission. However, some gaps in the updating and review of care records were noted which meant that key information was not available to support a comprehensive overview of residents' care as further detailed under Regulation 5.

Staff had access to relevant training on responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). A policy on caring for residents with these behaviours was also available to staff. Care plans on responsive behaviours detailed triggers and de-escalation measures to relax and reassure residents. From a sample reviewed, inspectors found incident documentation which evidenced that these measures were trialled with residents. In addition, on the day of the inspection, inspectors observed staff providing person-centred care and support to residents who experienced responsive behaviours.

The inspectors found that all reasonable measures were taken to protect residents from abuse. A notice board was available to residents, staff and visitors which included relevant information on advocacy service, Ombudsman, complaints officer, and residents' rights service. There was a policy in place which covered all types of abuse and the inspectors saw that all staff had received mandatory training in relation to detection, prevention and responses to abuse. Staff had An Garda Síochána (police) vetting prior to starting work in the centre. Inspectors saw evidence that where required, appropriate referrals to external agencies such as the safeguarding and protection team were completed.

Residents' rights and choice were promoted and respected within the centre. Residents with dementia were supported by staff to join in group activities in smaller groups or individual activities relevant to their interests and abilities. Residents and staff were seen spending time chatting as residents went about their daily routines, all interactions observed during the day of inspection were person-centred and considerate. Residents had access to television, radio and newspapers.

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 communication requirements.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were facilitated to have access to and retain control over their personal property, possessions and finances. They had access to lockable space to store and maintain personal possessions. Clothes were laundered regularly and promptly returned.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' care plans found that further improvements were required to fully meet the requirements of the regulations. For example:

- Resuscitation care plans were not reviewed every four months.
- For a resident at risk of absconsion, the care plan was not implemented in practice. The safety check records carried out were a lesser frequency than advised within the care plan.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The designated centre's policy was available for review. The use of any restraints was minimal and where deemed appropriate, the rationale was in accordance with national policy.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents. All staff had completed safeguarding training. The provider was a pension-agent for a number of residents. The inspectors were assured that monies collected on behalf of residents were being lodged into a residents' account, in line with the Social Protection Department guidance.

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.

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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	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-0046437

Date of inspection: 24/09/2025

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Moorehall Lodge Ardee has effective leadership, governance and management arrangements in place with clear lines of accountability. The senior management team consists of DON, ADON and 3 x CNMS. All members of the team work supernumerary and a member of the management team is always on duty each day of the week. There is also an on-call rota for out-of-hours cover. The team is supported by a Human Resources Administrator, Facilities manager and the Registered Representative. Weekly governance meetings take place between the DON/ ADON and Registered Provider representative. There is also a fortnightly Human resources and facilities meeting to enable a comprehensive review of the service. There is an auditing schedule in place and it is completed by DON, ADON and CNM.

The sample size for the monthly call bell audit has been reviewed. In total 12 bells will be audited across 2 households (6 bells in each) ensuring that all households will be audited within each quarter. The call bells will be activated at different times during day and evening ensuring further oversight. This commenced in October 2025. Currently, the management team completes monthly night audits in the home, and part of this is to review call bell/ alarm mat response which will continue.

The sample size for the hand hygiene audits will be increased from 5 audits to 10 audits per month following a submission to the electronic audit management company. This request has now been completed and will commence in the November monthly audit.

The 3 CNM's have their own assigned households to support staff and ensure oversight. Any issues or concerns will be brought to DON or ADON with daily occurrence of management meetings . A quarterly care plan audit is completed. The audit tool is detailed and uses a sample size of at least 16%. A quality improvement plan is then formulated to action any non-compliances. Following a resident's admission a detailed post admission audit is completed and actions recorded.

A safety check register will be introduced to include residents that require increased monitoring due to responsive behaviors, thus ensuring that the times specified in the care plan are consistent with what is implemented in practice. The ADON will oversee this action and review on a monthly basis.

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:
Moorehall Lodge Ardee has an up-to-date policy in place to ensure that each resident is provided with care in a person-centered manner that is safe, effective and appropriate to their individual needs and wishes. All prospective residents have a preadmission assessment completed to ascertain if their holistic needs can be met within the home. A comprehensive assessment is completed on admission. This is used to identify the need for more specific assessments and inform the required person-centered care plans within 48 hours of admission. These are reviewed at least every four months or sooner if required.

The 3 CNM's are assigned their own households to support staff and ensure oversight. Any issues will be brought to DON or ADON. An agenda item will be added to the weekly catch-up meetings.

A safety check register will be introduced to include residents that require increased checks due to responsive behaviors. This will be used to ensure that the times specified in the care plan are consistent with what is implemented in practice. The ADON will oversee this and review on a monthly basis.

A review of all resuscitation status forms and corresponding care plans will be completed by 9/12/25. This will ensure that all have been updated within the last 4 months and that the decision made is reflected in the care plan. The care plan audit tool has been updated to include these checks and will continue to be completed on a quarterly basis.

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 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	30/11/2025
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	09/12/2025