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 Drogheda
Name of provider:	Moorehall Healthcare (Drogheda) Limited
Address of centre:	Dublin Road, Drogheda, Meath
Type of inspection:	Unannounced
Date of inspection:	28 August 2025
Centre ID:	OSV-0000737
Fieldwork ID:	MON-0048069

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 121 male and female older persons with low, medium, high and maximum dependency levels. The range of needs we intend to meet for residents are: Older persons care, Dementia Specific Care, Physical Care, Physical and Intellectual Disability, Young Chronis Care and Aquired Brain Injury. Respite, convalescent, short and long term care is provided.

The philosophy of care adopted is the "Butterfly Model" which emphasises creating an environment and culture which focuses on quality of life, breaking down institutional barriers and task driven care, while promoting the principle that feelings matter most therefore the emphasis on relationships forming the core approach. The 'household model' has been developed to deliver care and services in accordance with the philosophy. The designated centre is a purpose-built three storey building situated on the outskirts of a town. It is divided into households; Rosnaree and Newgrange households, located on the ground floor, Millmount and Mellifont households situated on the first floor and Oldbridge and Beaulieu households on the second floor. 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:	118

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 28 August 2025	09:30hrs to 17:45hrs	Sheila McKevitt	Lead

What residents told us and what inspectors observed

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

On the day of inspection 19 residents and three visitors provided verbal feedback about life in the centre, it was overwhelmingly positive. Residents said their rights were upheld and they felt safe and secure living in the centre. Those spoken with said they were always treated with dignity and respect by staff. The provider had put appropriate measures in place to ensure that residents were safeguarded against all forms of potential abuse.

There was a calm and relaxed atmosphere within the centre, as evidenced by residents moving freely and unrestricted around each of the units in which they lived. It was evident that management and staff in each unit knew the residents well and were familiar with each resident's daily routine and preferences. One relative described it as having hotel services in a home-like environment.

On the two units located on the first floor there was a high level of residents who were living with a diagnosis of dementia or cognitive impairment who were unable to express their opinions on the quality of life in the centre. Those residents who could not communicate their needs appeared comfortable and content. Staff were observed to be kind and compassionate when providing care and support in a respectful and unhurried manner. Residents identified as displaying responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) from time to time were engaged in activities or supervised by staff when followed-up on during this inspection.

Residents and relatives spoken with all commented on the wide variety of activities available to them and a number spoken with said that their choice not to attend was always respected. One relative said there was a nice balance of activities and rest. Another relative said that they liked the way residents were encouraged to attend activities and to interact with other residents, which helped their loved one settle into the centre.

Several residents spoke about the summer parties they had attended in the centre, one of which had taken place the day prior to this inspection. The magician was definitely a highlight. One resident said it was not just the magician but the reaction on the young kids' faces was a joy to behold, describing it as 'magical' especially when the rabbit appeared.

Visitors were observed to be welcomed by staff at the main reception and at the front door of each unit. It was evident that staff knew visitors by name and actively engaged with them. Visitors also complimented the quality of care provided to their

relatives by staff, who they described as approachable, attentive and respectful. They also said that the communication between them and the nursing staff was open and transparent with any issues they had being addressed immediately.

There was unrestricted access to the secure gardens from the ground floor and balconies on the upper floors. Residents who wished to smoke were supported to smoke in a newly designated smoking area located to the rear of the building, however they explained how this was having a negative impact on their independence status, as discussed under Regulation 17: Premises. Residents were observed walking throughout the units and accessing the outdoor spaces. The main front door of the centre was controlled by a receptionist who was positioned just inside the front door.

The complaints procedure and advocacy contact details were on display in each unit. Residents in each unit had a meeting approximately every six weeks where they discussed issues in relation to life in the centre. However, it was not evident from a review of the minutes of these meetings that all issues brought up by residents were addressed, by whom and within what timeframe.

All the residents spoken with used compliementary language when speaking about the staff. One resident spoke about an accident that they had in their bedroom and how a number of staff were there in a flash, thankfully they were not injured. All residents in their bedroom had their call-bell within reach.

Residents and visitors said that the centre provided a safe and secure space in which their rights were upheld.

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

Capacity and capability

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

This centre has capacity and capability to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). Residents were receiving a good standard of care where their individual social, religious and healthcare needs were being met in a safe and secure environment.

The level of compliance in this centre continued to be good. The governance and management arrangements remained stable. The statement of purpose described the current management structure of the designated centre. This structure ensured

that arrangements were in place which contributed to residents experiencing a quality service, where they were safeguarded as far as possible from all incidents of abuse.

The provider was Moorehall Healthcare (Drogheda) Limited. The management team was made up of the provider representative and person in charge. Both the person in charge and assistant director of nursing worked full-time in the centre and on any given day, one of them was nominated to provide out-of-hours on-call support if needed.

There was evidence to indicate that the centre was well-resourced. The centre was clean, warm and well-furnished. There were sufficient numbers of staff on duty at the time of the inspection. Mandatory and relevant training was provided and completed by all staff and staff demonstrated a good knowledge of what constituted abuse and what procedure they would follow if they witnessed any form of abuse.

There was an audit schedule in place for 2025 and a range of tools were used to monitor and audit the quality of care delivered to the residents such as incidents, assessments and care plans, falls, and medication management, although stronger oversight of some audit results was required. In addition, a more proactive approach to responding to feedback provided by residents was required. Both these issues are discussed further under Regulation 23: Governance and management.

Regulation 15: Staffing

There was a sufficient number of staff rostered on duty to ensure the care needs of the residents were met in a prompt and safe manner. The staffing levels were adjusted according to the number and assessed needs of residents on each unit.

There was one qualified nurse on duty on each of the six units each day.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training.Training records were maintained and updated and the inspector was assured that all staff working with residents in the centre had completed all the required mandatory training on safe-guarding vulnerable residents in place. All staff had completed safeguarding vulnerable residents training online and most had also completed face-to-face safeguarding vulnerable residents training. Staff were in the process of completing training on a human rights-based approach to care with just one quarter of staff yet to complete all four modules of this training.

Supervision of staff and residents was evident on the day of inspection.

Judgment: Compliant

Regulation 23: Governance and management

The system in place for reviewing audit results required review, for example;

- There were no action plans for some audits completed that required action plans when the audit had not achieved full compliance. For example, care plans had been identified as an issue in audits but had not been addressed in any of the recent action plans. This meant that issues identified were not effectively actioned to prevent recurrence and demonstrate continuous quality improvement.
- Although a resident feedback survey was completed on residents' discharge, there was no analysis completed of the feedback provided to date. This meant that such feedback was not used to improve the service.
- The issues highlighted by residents at their meetings were not always addressed, for example access to the smoking shelter.

Judgment: Substantially compliant

Quality and safety

Overall, residents were in receipt of a good standard of care from dedicated and kind staff who promoted each resident's individual human rights. Residents were safeguarded from abuse and were respected as individuals.

The feedback from residents informed the inspector that safeguarding measures were in place and followed by staff.

Residents had computerised care plans in place. Where there was a safeguarding concern or risk there was a comprehensive care plan developed to direct care. Each resident was assessed prior to admission and on admission their safeguarding risk was re-assessed. However, the inspector found there were some opportunities for improvements in relation to COVID-19 and visiting care plans as further outlined under Regulation 5.

Residents were encouraged to live their lives as they wished and a 'positive risk-taking' approach was utilised. Residents were provided with the right and ability to decide what they wanted to do and how they lived their lives. The inspector was informed that due to a reported incident the two designated smoking areas had been moved from the ground floor courtyards to the rear of the building. A small

number of residents were adversely impacted by this decision as they could no longer access the smoking shelters independently, as further outlined under Regulation 17: Premises.

Where residents presented with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), there was a specific care plan in place to guide staff in how best to support the resident. The monitoring of these behaviours was well-documented and from this, triggers were identified and measures put in place in mitigate the risk of re-occurrence.

Residents were provided with access to a wide range of activities. Residents were given the choice to attend if they wished, while other residents preferred the one-to-one time with staff. Residents' wishes were very well respected in relation to their choice of activities and how they spend their days. Residents had access to the centre's complaints procedure, advocacy services and they attended regular residents meetings, however as mentioned under Regulation 23: Governance and Management it was not always clear if the issues they brought up were addressed.

The person in charged had notified the Chief Inspector of incidents of alleged and confirmed abuse. The inspector reviewed the investigations and action plan in place. These were found to be comprehensive and at all times ensured residents were safeguarded and protected. Where learning was identified this was shared with all staff when appropriate.

Regulation 10: Communication difficulties

There were adequate systems in place to allow residents to communicate freely. Care plans reflected personalised communication needs. Staff were knowledgeable and appropriate in their communication approach to residents.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the fact that the building was well-maintained internally and externally, access to the smoking shelter required review:

- The newly designated smoking shelter for residents was located at the rear of the building. Residents required the assistance of staff to mobilise safely around the building to this smoking shelter, this was having a negative impact on a number of residents. They had lost a degree of their independence and were now dependent on staff to assist them to go out and have a cigarette. On mentioning this to the provider representative on the

day, the smoking shelter was promptly relocated to one of the two courtyards prior to the end of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the person-centred care plans in place for those residents who required a safeguarding care plan and a care plan on how to manage behaviours that are challenging, improvements were required, as follows:

- Residents had care plans in place, when their was no identified problem/need on assessment. For example, several residents who had their care plans reviewed every four months had a specific visiting care plan and COVID-19 care plan in place although they did not have any need for either of these care plans.
- One residents restrictive practice care plan stated they had two alarm mats in place, one on their bed and another on the floor by their bed, however on review the resident only had a bed alarm mat in place.
- Several residents had an admission care plan, which detailed information about their admission status. This was not actually a care plan that was relevant to the current needs of the resident post-admission.
- One resident who was assessed as being at risk of developing pressure ulcers, had preventative measures such as a pressure reliving mattress in place, however they did not have a care plan for this assessed need to guide care and monitoring.
  but was not actually a care plan.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

All restrictive practices were implemented in line with the centre's local policy and guided by the national guidance. Where alternative less restrictive practices were trialled this was detailed in the resident's restrictive practice risk assessment. There was a multi-disciplinary team approach to the use of restrictive practice, the resident and with their consent, their next-of-kin were communicated with prior to any form of restrictive practice was implemented.

Staff had received appropriate training in how to manage behaviours that are challenging.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken all measures to safeguard residents living in the centre. All staff had safeguarding training in place prior to commencement of their role.

The person in charge investigated all allegations of abuse and referred residents to the appropriate supports when required or requested.

The provider was a pension-agent for a small number of residents. There was clear and transparent documentation in place ensuring residents' finances were safeguarded.

Judgment: Compliant

Regulation 9: Residents' rights

The provider and the person in charge were striving to promote a rights-based service for all residents. Residents were encouraged to partake in activities of their choice and staff took a positive risk-taking approach that upheld residents' rights.

Residents were invited to attend regular residents' meetings. There was a good attendance at each of these meetings as evidenced in the attendance records and the minutes reviewed by the inspector.

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 Drogheda OSV-0000737

Inspection ID: MON-0048069

Date of inspection: 28/08/2025

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: The senior management team will review each audit finding comprehensively with the associated quality improvement plan. The Director of Nursing will sign off on each quality Improvement plan going forward. An analysis will be completed on all electronic surveys received going forward with an associated quality improvement plan. The Director of Nursing will review all minutes from resident meetings and will create an associated Quality Improvement plan which will then be discussed at the following resident meeting.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The smoking area for residents in courtyards was relocated following a serious incidnet which was reported to the authority.The smoking shelter was relocated in the Rosnaree house courtyard on the day of inspection with all safety measures – call bell , solar lighter in build and the fire extinguisher. • 2 additional smoke shelters were ordered on the day of inspection ; approximate time of delivery is the last week of September 30/09/25 . • The 2 additional smoking shelters will be placed – 1) Newgrange house courtyard and 2) staff smoking shelter rear of the building. Both smoking shelters will have all the required safety equipment's upon commencement of its use and in conjunction with the	

associated risk assessment .
• Communication of the above additional smoke shelter and their locations will be circulated both verbally at resident's forum and team meetings and in writing to both residents and staff. The additional smoke shelters will be included in the central risk register .
Going forward residents' rights will be at the foremost in conjunction with the associated risks.

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:
• Following inspection ,a care plan review was completed by 05th September 2025 resulting in residents having care plans in place only for an identified problem or need following assessment .
• Care plan training is currently in progress for all nurses including Clinical Nusre Managers and will be completed by 30th September 2025 .
• Current Care plan audit tool is under review and will include restrictive practice measures and that all care plans are created if and when there is an identified problem or an need for the individual resident.
• Frequency of care plan audits using the revised Care plan audit tool will be completed at monthly intervals with effect from 30th Septemeber 2025.
• Care plans is an agenda item on all clinical meetings going forward.

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(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	28/08/2025
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	30/09/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after	Substantially Compliant	Yellow	30/09/2025

	that resident's 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.	Substantially Compliant	Yellow	30/09/2025