



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Aingeal Lodge
Name of provider:	Embrace Community Services Ltd
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	25 November 2025
Centre ID:	OSV-0008505
Fieldwork ID:	MON-0040156

About the designated centre

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

Aingeal Lodge provides a residential service for up to five male and female residents from 18 years plus. Located in the countryside within walking distance to a nearby village and within a short driving distance to two larger towns. The centre is made up of a two storey house. Each resident has their own bedroom. The centre is managed by a person in charge with support from two team leaders. The residents are supported by a team of social care workers and direct support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 25 November 2025	09:45hrs to 18:00hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this announced monitoring inspection, the inspector found a warm and positive atmosphere where the residents were receiving a good standard of person-centred care in their home. They appeared relaxed and comfortable in the company of a staff team who were patient, and understood their individual needs.

While the service was performing well in many areas, the inspection did identify some areas for improvement to ensure the safety and care in the centre would be consistently met. One regulation was found to be not compliant as the inspector was not assured that residents could all be evacuated safely and in a timely manner from their home. In addition, some minor improvements were needed in relation to the timeliness of provision of equipment for residents and a specific healthcare review, to ensure one resident was supported to access the local community in line with their preference, and to ensure the centre had its required staffing quotas using a reliable contingency in order to ensure consistency and continuity of care. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe four of the five residents that were living in the centre. One resident had alternative communication methods and did not share their views with the inspector. They were instead observed in their home after they arrived back from their day service programme. They appeared relaxed and comfortable in the presence of the staff on duty. One resident chose not to speak with the inspector and that choice was respected.

The inspector had the opportunity to speak with the five staff on duty, the person in charge, and the assistant director of services for the organisation. Staff were observed to be calm and respectful in their interactions. For example, a staff member was observed to knock to see if they could enter a resident's bedroom.

The provider had arranged for staff to have training in human rights. A staff member spoken with communicated how they had put that training into everyday practice. They felt that prior to having the training that they may not have always waited enough time to support the residents' understanding of what was being said to them. They explained that since completing the training, they were giving residents more time to process information and choices.

The inspector had the opportunity to speak with one family representative on the day of this inspection. Feedback received was positive. The family representative communicated that they felt their family member was safe and had their assessed needs met by the staff team. They said they had no concerns at present and that if they were to have a concern they would feel comfortable raising it to staff or management. They felt they would be listened to as they said in the past they had raised an issue and that staff had responded appropriately.

As part of this inspection process residents' views were sought through questionnaires provided by the Office of The Chief Inspector of Social Services (The Chief Inspector). Feedback from the five questionnaires was returned by way of one staff representative completing the questionnaires on behalf of the residents and for the remaining four, staff representatives supported the residents to complete the questionnaires. Feedback was positive and the majority of questions were answered and when answered the majority were ticked 'yes' for happy when asked about the service and care provided. One resident stated that the 'staff were very kind to them' and that 'they were looking forward to having an apartment close to their family'. That resident was being supported to source alternative accommodation due to wanting to live closer to family. Other comments related to a resident requiring some staff support in some areas. One resident had selected that "it could be better" with regard to staff members knowing what they like and dislike and if they got along with the people they lived with. That resident was the latest admission to the centre and staff were still in the process of fully getting to know them.

The inspector observed the house to be bright, clean and tidy. It was nicely decorated and looked homely. The sitting room and dining area had televisions for use.

Each resident had their own bedroom. The bedrooms had adequate storage facilities for any personal belongings. There were personal pictures displayed as well as personal achievements and in the case of one bedroom there were pictures of the resident's favourite celebrities.

There was a large wraparound garden with lots of areas for parking. There was a garden table with benches, and a basketball net in the back garden that residents could use in times of good weather.

At the time of this inspection for the most part there were no visiting restrictions in place. There was a visitors' protocol specific to one resident for specific required reasons. At the time of this inspection there were no vacancies. One resident had moved into the centre in May 2025. They informed the inspector that they had a chance to visit the centre prior to moving in.

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

Capacity and capability

This inspection was announced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in November 2023.

The findings of this inspection indicated that the provider had the capacity to operate the service within substantial compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). The provider, assistant director, and the person in charge were operating the service in a manner which ensured the delivery of care was meeting the residents' needs.

The inspector reviewed the provider's governance and management arrangements and found that the current systems in place at the time of the inspection were appropriate in order to ensure the quality and safety of the service. For example, there were local audits scheduled for completion each month in order to assess the centre's compliance levels and identify any actions required, such as vehicle checks.

From a review of a sample of rosters across three months, the inspector found that while there was adequate staffing in place to meet the assessed needs of the residents, improvements were required to the staff contingency arrangements while the centre did not have a full complement of staff.

Staff were found to be in receipt of training that would facilitate them to effectively support the residents, for example fire safety training that included the use of ski sheets for evacuation purposes.

The inspector also found that any complaints made were observed to be adequately reviewed and responded to. Additionally, the provider ensured that the centre was sufficiently insured against risk to the residents.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre. The application contained the required information set out under this regulation and the related schedules. For example, an up-to-date statement of purpose, and residents guide was submitted as part of the application to renew the centre's registration.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and had the necessary experience and qualifications to fulfil the role. For example, they held a qualification in people management. They demonstrated a good understanding of the residents and their needs, for example what healthcare needs the residents required support with.

They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process. For instance, they were aware that it was their responsibility to ensure the reporting of any adverse incidents that occurred to the Chief Inspector.

They were responsible for three designated centres with a plan for this to be reduced to two centres in the coming months. They attended the centre regularly in order to provide oversight and provide informal supervision for staff. They were supported in this role by a team leader and recruitment was on-going for a second team leader to support the person in charge.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that while the staffing arrangements in the centre were effective in meeting residents' assessed needs, improvements were required to ensure a reliable, consistent staffing contingency was in place.

The inspector reviewed a sample of rosters over a three-month period from September to October 2025. The review demonstrated that planned and actual rosters were being maintained, which contained the full names and titles of staff working in the centre. The centre did not have a full staffing complement and required two staffing posts to be filled. The inspector was informed that a 0.5 staff post was filled and the staff member was currently going through pre-employment checks. The centre also required one team leader post as per their statement of purpose.

While safe staffing levels were found to always be maintained in the centre, the inspector found that there was an over-reliance on the goodwill of the core staff to complete additional shifts. This was not a sustainable staffing contingency plan. The provider had access to relief staff and from the months reviewed up to seven different temporary staff were required to fill the vacant shifts. This had the potential for inconsistent care to be provided to the residents.

The staff on duty on the day of the inspection were observed to be caring and respectful towards the residents. Three residents told the inspector that the staff were nice and supported them properly when they needed help.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of three staff members' Garda Síochána (police) vetting (GV) certificates as well as their police clearance certificates. All three GV were completed within the last two years. This demonstrated that the provider had arrangements for safe recruitment practices in line with best practice.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were mechanisms in place to monitor staff training needs and to ensure that adequate training levels were maintained and meet the requirements of this regulation. The inspector reviewed the certification of ten training courses for all staff that worked in the centre. Those reviews demonstrated to the inspector that staff received training in areas determined by the provider to be mandatory as well as refresher training. Staff had also received training in additional areas specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- training related to positive behaviour supports that included de-escalation techniques
- medication management
- percutaneous endoscopic gastrostomy (PEG)
- feeding, eating, and drinking
- epilepsy awareness and emergency epilepsy medication administration
- hand hygiene
- introduction to Autism
- fire safety.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in the 'what residents told us and what inspectors observed' section of the report.

From speaking with the person in charge and from a review of three staff members' files, this confirmed to the inspector that supervision was occurring as per the frequency decided by the provider and that it was an opportunity to raise concerns if any.

Judgment: Compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents and evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that at the time of this inspection there were appropriate governance and management systems in place.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by the person in charge. A staff member spoken with was familiar with the reporting structure, and the on-call system for out of normal working hours support.

There were management systems to ensure that the service provided was safe, consistent and monitored. A suite of audits were carried out to assess the quality and safety of care and support provided to residents in the centre. For instance, an annual review, six-monthly unannounced provider-led visit reports, and monthly audits completed by the person in charge on a number of different areas, such as health and safety, and finances. When necessary, the provider with the help of the assistant director of services, identified areas needing improvement and took steps to address them. From a sample of four of the actions from the most recent provider-led report from October 2025, the inspector found they had been completed by the time of this inspection.

The inspector observed from a review of the records of the team meeting minutes that they were occurring monthly. A review of three team meeting minutes, May, October and November 2025, demonstrated that any incidents that occurred within the centre were reviewed for shared learning with the staff team. Topics at meetings included, a discussion on the residents, complaints, risk, restrictive practices, safeguarding, and health and safety.

Additionally, all three staff spoken with communicated that they would feel comfortable going to the team leader or person in charge if they were to have any issues or concerns.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector observed that there were appropriate arrangements in place to manage complaints.

For example, there was a complaints policy last reviewed April 2025, and associated procedures in place. A copy of the easier-to-read complaints procedure was displayed in the hallway. There was also a designated complaints officer nominated and their picture was displayed in the hall.

The inspector observed any complaints made had been suitably recorded, reviewed and attempts were made to resolve any identified issues. From a review of the complaints log and associated paperwork, the inspector observed that there were nine complaints in 2025. Some complaints were found to be upheld and learning was taken and implemented in the centre. For instance, one resident had been gaining weight and eating food that may not have been the healthiest choice for them. A family representative had raised this as a concern. The centre management arranged for educational work to be completed with the resident and staff were encouraged to promote healthy choices. The appeals process was found to be used on occasion when a family representative was not happy with the outcome of the complaint and meetings were held to attempt resolution. The majority of complaints were closed at the time of this inspection with the complainant informed of each outcome.

Judgment: Compliant

Quality and safety

Overall, the inspection found that the residents living in this service were supported in line with their assessed needs. However, improvements were required in relation to assuring safe evacuation of all residents from the centre. Some improvements were required with regard to healthcare and general welfare and development.

While there were many appropriate and suitable fire safety management systems in place, such as regular servicing of detection and alert systems, improvements were required to ensure residents that used wheelchairs could be evacuated in a timely manner at all times from all evacuation routes.

The inspector found that while many residents appeared to engage in regular community access, it was not evident if one resident was facilitated to engage as frequently as the others which would impact on them having a meaningful day.

There were adequate systems in place to meet the requirements of the regulations associated with: positive behaviour support, protection, and communication. For example, residents had recorded guidance for staff on how to facilitate communication. Residents had positive behaviour support plans in place as required to guide staff as to how best to support them should they be experiencing periods of distress. There was a safeguarding policy in place to guide staff should they have any safeguarding concerns.

The inspector observed the house to be clean and tidy which also facilitated in the arrangements for good infection prevention and control (IPC).

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

The assistant director confirmed that all residents were assessed by a speech and language therapist upon admission in order to assess if the correct supports were in place and whether any further recommendations could be made to facilitate communication. It was recommended for one resident that visuals were used to support them; however, they chose not to engage with them and that choice was respected.

From a review of two residents' files they had documented communication needs in a communication passport as well as in other documents in order to guide staff as to what they may be trying to communicate and support effective communication. For example, one resident's guidance document described how to know when they were angry by informing staff that a vein in their forehead would be more prominent. While some further elaboration and guidance was required in the documents to ensure a more complete understanding of how to know when one resident was happy or sad or when they meant 'yes' or 'no', this information was included in the plan on the day of the inspection.

The inspector observed there were visuals available in the centre to aid residents' understanding and promote choice of their daily routine, such as an activity planner with pictures was used for one resident.

There were easy-to-read documents and social stories to help support residents' understanding of certain topics. For example, how to brush your hair, brushing your teeth, healthy eating, female health, and mental health.

The inspector also observed that residents had access to radio, televisions and the Internet while in the centre which would further support their communication and facilitate compliance with this regulation.

Judgment: Compliant

Regulation 13: General welfare and development

While it was evident the majority of the residents were supported to participate in activities of interest, improvements were required in relation to one resident's engagement to ensure they too had opportunities for a meaningful day.

Residents engaged in activities of interest in their home and community and were supported to maintain relationships with family.

From a review of the two residents' files over a two-week period in November 2025, which included online daily reports and activity planners, the inspector observed that residents were being offered activities that interested them. Ranging from music sessions, cinema, trips to different towns or cities, attending the gym, family visits, and equine therapy.

In the case of one resident, however, it was not evident from speaking with a staff member or reviewing the documents related to activities undertaken, if the resident was supported to engage in recreational activities both in the centre and in the community. The inspector reviewed a two week period for this resident. While they did participate in music therapy, sound therapy, and attended an external day service two days a week, it was not evident if they participated in any other activities other than listening to music. From speaking with a staff member, they communicated that the resident has gone on occasional drives and to sensory spaces. However, they said that the resident often didn't leave the centre and that sometimes it was due to the wheelchair accessible vehicle already being in use.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, from a review of a sample of two different residents' goals, they were undertaking goals related to gaining financial independence and an advocate was engaged in order to support with this.

The other resident wanted to go on holidays to a specific country. Due to their medical and physical supports required they were first planning on trialling a flight within Ireland and build towards the holiday abroad. They also requested to move to another area while remaining under the support of the organisation, in order to live closer to their day service and family. The provider was exploring this and they were currently trying to secure a property that was found.

Judgment: Substantially compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises was found to be in a state of good repair and was observed to be clean and tidy. The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities.

There were facilities in place to support hand hygiene, such as hand wash and disposable towels. There was a colour-coded system in place for the cleaning of the centre to minimise the chances of residents receiving a healthcare related illness. For example, there were colour-coded mops and buckets in place and they were found to be stored correctly.

Each resident had their own bedroom with sufficient space for their belongings. From a sample of three bedrooms reviewed, each resident's bedroom was observed

to be individually decorated to suit their preferences. For example, they had a very feminine bed and matching lockers in their favourite colour.

Judgment: Compliant

Regulation 28: Fire precautions

Due to concerns regarding the timely safe evacuation of residents in the event of an emergency, this regulation was found to be not compliant.

The inspector was not assured that the provider could safely evacuate all residents in a timely manner at night time with minimum staffing levels. In some practice drills the time taken using minimum staffing ranged from just under four minutes to six minutes and 15 seconds. Two of those drills used staff volunteers to be evacuated using ski sheets and therefore may not be representative of the actual time it may take to evacuate all residents to safety when minimum staffing levels were present. The assistant director of services had already identified this issue and the situation was under review.

In addition, the inspector was not assured that the provider could safely evacuate all residents from all areas of the centre. There was no evidence to suggest that one resident that used a wheelchair could be evacuated from the back door if required. There was a raised area of the door and then a slope that the wheelchair would have to be manoeuvred over for evacuation. From reviewing the practice fire drill records for the last four drills and from speaking with the person in charge, and a staff member, it was not evident when or if staff had ever supported the resident to evacuate using that exit.

In addition, from a review of three residents' PEEPs, the inspector found that two out of the three provided staff with inaccurate guidance. It guided staff that the quicker way to evacuate the two residents that used wheelchairs, was to use a hoist to support them from their bed to their wheelchairs in the event of a fire. However, the centre management communicated that this method was not intended as a first response, as the time required to evacuate residents using a hoist was considered too long. Therefore, it was believed that it would put the residents more at risk from the fire. While the preferred method, of using a ski sheet, was mentioned in the document, it was described as the secondary method if required. This guidance document meant that staff had conflicting information provided which could result in a slower evacuation in the event of an emergency, potentially putting the residents at greater risk from a fire.

The inspector found that there were detection and alert systems, emergency lighting and firefighting equipment in place, each of which was regularly serviced. There were fire containment doors in place fitted with intumescent strips, cold smoke seals and self-closing devices. Staff had received training in fire safety.

Overall, while there were a number of suitable fire safety management systems in place, due to the concerns raised regarding safe evacuation, improvements were required in order to ensure residents could be safely evacuated from their home.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that there were suitable arrangements in place with regard to the receipt and storage of medicines.

A medications stock check was completed upon receipt of medication into the centre and when it was being removed from the centre, for example for family visits. The inspector found that when medicines were returned to the pharmacy that a returns form was completed and signed by the pharmacist.

Medication was found to be stored in locked presses in each resident's bedroom. The inspector reviewed a sample of one resident's medications and found that there were pharmacy labels attached and there was a description sheet in place for what each medication should look like. From a review of the medication documentation for two residents, this confirmed that residents had a medication administration kardex in place signed by the GP within the last six months.

From a review of two medication audit records, the inspector found there were weekly stock counts occurring for medicines to be used only when needed. This was in order to ensure accuracy of stock and identify potential medication errors.

The listed practices and systems that were in place would facilitate safe medicines practices that would facilitate residents receiving the correct medicines that were meant for them alone.

Judgment: Compliant

Regulation 6: Health care

While residents were supported with their healthcare needs and for the most part had access to allied health professionals when required, improvement was required in the timeliness of access to certain healthcare professionals, and recommended equipment.

Improvements were required to ensure residents always had timely access to all applicable healthcare reviews and equipment to support mobility during times of relaxation. The inspector found that a resident was waiting several months in order to have a specific chair ordered for them that was recommended by an occupational

therapist (OT). The resident explained that they needed the chair in order to comfortably relax in the sitting room to watch television as the sofas were too low for them. The provider was following up with the external funder in relation to sourcing the chair; however, they were waiting on an additional assessment with no date for when this might happen.

On the day of this inspection, it could not be evidenced to the inspector if another resident had received a formal review of their PEG plan or eating, drinking and swallowing plan for two and a half years. While they had received a review the week prior to this inspection, the formal report had not been issued to the provider. While the inspector acknowledges that the provider's nurse had made several attempts to have the plan reviewed and receive the updated report, this did not assure the inspector that all required healthcare reviews were provided in a timely manner for residents. This meant that staff could be providing care and support to residents that is not up-to-date. In the absence of regular reviews, there was a risk that residents were receiving care that was not in line with their current needs.

While two staff spoken with were knowledgeable in a number of areas with regard to required healthcare supports for residents, the inspector found that there were some gaps in knowledge with regard to a bowel care protocol, and with regard to the method for cleaning a resident's PEG site. Therefore, improvements were required to ensure care would always be provided in line with each resident's assessed needs.

While one plan required some minor amendments, the provider's nurse updated the plan the day of the inspection.

Residents were found to have access to a range of allied healthcare services, such as an optician, ophthalmologist, chiropodist, and physiotherapist when required.

Where applicable, there were healthcare plans in place to guide staff as to what supports residents required, for example epilepsy, and eating, drinking and swallowing plans, and an epilepsy care plan and protocol. The protocol for the administration of emergency epilepsy medication was signed off by the resident's general practitioner (GP).

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health. Where required they had access to the support of a senior behaviour support therapist.

From a review of the two residents' files, the inspector observed that where required, residents had a positive behavioural support plan in place which was reviewed by the behaviour specialist. They were found to have been reviewed within

the last year to ensure accuracy of the information provided to staff. This in turn ensured that the residents were receiving up-to-date appropriate supports.

Behaviour support plans were found to outline strategies that staff needed to follow to support the residents in times of distress.

For example:

- proactive responses staff could engage in with the resident
- responses to when the resident is becoming anxious or experiencing behaviour that may cause distress to themselves or others
- the response to be taken and what it may look like when the resident is returning to baseline.

While restrictive practices were in place, such as bed rails and lap belts, they were found to be in place for the residents' safety. Restrictive practices were periodically reviewed by the centre management. Social stories were completed with residents and to gain their consent for the use of restrictive practices in the centre.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse. For example:

- there was an organisational safeguarding policy in place which was last reviewed April 2024
- staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- two staff spoken with were able to identify who the DO was to the inspector, and the identity of the DO was displayed in the hall.

The inspector reviewed safeguarding incidents for the last year and found that any potential safeguarding risks were escalated, investigated, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of recurrence of incidents.

The family representative and the three staff spoken with felt comfortable raising concerns. At the time of this inspection, neither the family representative nor the staff members spoken with had any concerns. While one resident spoken with said that while they sometimes didn't always get on personally with another peer, they felt safe in the centre. The other two residents spoken with communicated that they felt safe in the centre and all three residents said they would tell staff if they felt unsafe.

While one staff member spoken with was familiar with the majority of the steps to take should a safeguarding concern arise including a witnessed peer to peer incident or an unwitnessed disclosure, some enhancement of their knowledge was required. The centre management had already identified this for the staff team and in person safeguarding training was already booked for the team on 8 December 2025. From a review of the three residents' files, the inspector observed that there were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care. These plans promoted dignified care practices and reflected residents' preferences. For instance, it described how one resident preferred to shave before their shower.

The inspector also found, from a review of two residents' finance records over a number of weeks in October and November, that staff were completing daily balance checks to ensure the residents' money was safeguarded.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Aingeal Lodge OSV-0008505

Inspection ID: MON-0040156

Date of inspection: 25/11/2025

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> • Recruitment to focus on filling open lines within the Centre to support with bringing the Centre in line with their SOP. Due Date: 28th of February 2026 • Agency to be utilized to fill gaps in roster, review to be completed with external agency organisation to determine if consistent agency can be provided to the Centre to support with consistency of staffing. Due Date: 8th of January 2026 • Recruitment to focus on open lines to be filled with drivers. Due Date: 28th of February 2026 • Team Leader post to be filled. (Internal promotion has been offered and accepted. Start date is 1st of January 2026) Due Date: 1st of January 2026 (Completed) 	
Regulation 13: General welfare and development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 13: General welfare and development:</p> <ul style="list-style-type: none"> • Person in Charge (PIC) to submit OT referral to review appropriate additional activities for Resident to complete in the community. 	

Due Date: 31st of January 2026

- Weekly Planners to be sent to the Assistant Director of Operations weekly to allow for an ongoing review of activities the Resident has engaged in.

Due Date: 31st of January 2026

- Person in Charge (PIC) to complete training with Team Members on activity planning through the Team Meeting.

Due Date: 31st of January 2026

- Person in Charge (PIC) to complete Record Keeping training with Team Members on recording of activities on Epiccare.

Due Date: 31st of January 2026

- Recruitment to focus on open lines to be filled with drivers.

Due Date: 28th of February 2026

Regulation 28: Fire precautions

Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- Maintenance to implement additional Fire Exit in one Resident's room.

Due Date: 15th of February 2026

- Person in Charge to implement additional Night staff to be implemented to support with reduction of time of evacuation as an interim measure until door is implemented.

Due Date: 1st of December 2025

(Ongoing)

- Person in Charge (PIC) to ensure Fire Drill is completed following implementation of door. Review to be completed with Assistant Director of Operations (ADOS) and Fire trainer to determine if additional staffing remains in place.

Due Date: 22nd of February 2026

- Person in Charge (PIC) to update Personal Emergency Evacuation Plans (PEEPs) ensure they are reflective of Residents' needs.

Due Date: 15th of December 2025

(Completed)

- Person in Charge (PIC) to complete fire drills schedule which outlines alternating exit points with Residents in wheelchairs to ensure all routes are suitable for all Residents.

Due Date: 31st of January 2026

Regulation 6: Health care	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <ul style="list-style-type: none"> • Person in Charge (PIC) to link with maintenance to source a suitable chair for Resident in the absence of External Funding Body OT assessment. Due Date: 10th of January 2026 (Completed) • Protocol to be implemented for annual medical reviews where these are not provided by the original professional. Due Date: 10th of January 2026 	

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	28/02/2026
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/01/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of	Substantially Compliant	Yellow	28/02/2026

	purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	28/02/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	15/02/2026
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	10/01/2026