Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Culfore Lodge
Name of provider:	Embrace Community Services Ltd
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	25 February 2026
Centre ID:	OSV-0009050
Fieldwork ID:	MON-0047838

About the designated centre

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

Culfore Lodge provides full-time residential care to adults with physical disabilities, intellectual disabilities, autistic spectrum disorder, and/or acquired brain injuries. The house is a detached dormer bungalow with large gardens to the front and rear. The house is staffed on a twenty-four-hour basis by a team comprising team leads and direct support workers. It is located in a rural setting in Co. Louth and is close to a large town. Residents can access a range of amenities from their home.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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
Wednesday 25 February 2026	09:00hrs to 16:45hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

This was the first inspection carried out in the service since it opened in August 2025. The provider was notified of the inspection the day before it took place.

Overall, the inspection findings were mixed. Some aspects of the service were performing well, while others required improvement. The inspector found that the governance and management arrangements were not ensuring effective oversight of the service. This included poor response to audits, staff training not being kept up to date, and staff not always demonstrating the required knowledge to support residents across several key areas.

Although the provider had identified the need for improvements before the inspection, and a person in charge solely dedicated to this service was in the process of taking up the role, governance and management issues were still evident at the time of inspection.

In other areas, good practice was observed. A review of information for all four residents showed appropriate systems for assessing individual needs and developing person-centred care plans. Residents were supported in accessing a range of allied health care professionals and assessments, including communication assessments had been completed. Staff had been provided with guidance on how best to communicate with each resident.

During the inspection, the inspector met three of the four residents, the person in charge, the incoming person in charge, and four of the five staff members on duty. Residents presented with varied support needs. Staffing levels were high, with five staff rostered each day and three rostered each night. This level of staffing was required due to residents' mobility and transfer needs. Two residents were wheelchair users, and one required some assistance with mobility.

Residents were observed engaging in community activities and spending time in the kitchen, sitting room, and their bedrooms. The inspector saw that one resident had just returned from an outing and was watching a sporting documentary with a staff member. They engaged briefly with the inspector and appeared comfortable with staff. This resident had recently transferred into the service and attended a day service part-time, with staff actively identifying activities they would enjoy.

A second resident had returned from their full-time day service. Although non-speaking, they were observed effectively communicating needs to staff through physical touch and pointing and appeared content in the environment.

The third resident was resting after being out earlier in the day. They reported enjoying living in the service, highlighted the convenience of being close to family,

and discussed therapies they were beginning to engage in, which were important to them.

The inspector found that when reviewing information regarding the residents, person-centred plans and social goals had been created for each resident

The inspector found that the property had been modified to meet residents' needs, with appropriate mobility and transfer aids available. While some areas of the home required attention, the provider had already identified these and scheduled works for completion on 28/02/2026. Overall, the home was well presented, and efforts had been made to create a homely environment.

In summary, the inspection highlighted both strengths and areas for improvement within the service. While residents benefited from person-centred care and a supportive environment, deficiencies in governance, staff training, and oversight were identified. The provider had begun to address some of these issues, but further action was needed to ensure consistently high standards of care.

Capacity and capability

The inspector reviewed the provider's governance and management arrangements and determined that improvements were required. Concerns were identified regarding the performance management of the staff team, as staff members demonstrated knowledge gaps in several areas.

The inspector also found that, while audits were being completed, responses to identified actions were inadequate, with outstanding actions remaining at the time of inspection. For example, some staff members had not completed required training. Although the provider had identified this issue, the response to addressing it was insufficient.

The inspector reviewed additional aspects of staffing arrangements and found that safe staffing levels were maintained and a consistent staff team was in place.

In summary, the inspection found that, although safe and consistent staffing levels were maintained, significant shortcomings remained in governance, staff performance management, and the timely response to identified issues.

Further improvements were required to ensure that all staff were adequately trained and that audit actions were addressed promptly.

Regulation 15: Staffing

The inspector found that suitable staffing arrangements were in place. This was established following a review of a sample of staffing rosters and an examination of Schedule 2 documents for a selection of staff.

A review of the current roster, along with a two-week period in December 2025 and January 2026, showed that safe staffing levels were consistently maintained. It was also noted that there was a stable and consistent staff team, which supported continuity of care for residents.

The inspector also reviewed a sample of staff information. Two staff files belonging to staff members who were on duty were examined. The inspector found that the provider had ensured all information required under Schedule 2 of the Regulations had been obtained and were available for review.

In summary, the inspection confirmed that staffing levels were safe and staff files were compliant with regulatory requirements. While staff demonstrated good knowledge of residents' needs, some gaps in knowledge were identified regarding safety procedures and communication supports, indicating areas for improvement in staff training and performance management.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found that improvements were required in the management and oversight of staff training needs. There were gaps in staff training in several areas. Of particular concern was that these issues had already been identified in the monthly audits for October 2025 to January 2026, yet they had not been fully addressed by the time of the inspection. Although some progress had been made, further action was still required.

A review of records indicated that one staff member had not completed the required refresher training in medication management since 2023. After the inspection, the provider submitted information stating that this staff member completed a medication competency assessment in 2025. Although the staff member was not currently administering medication, the delay in completing the necessary refresher training was still concerning.

Additionally, the review conducted on the day of the inspection revealed that two staff members had not completed their training in infection prevention and control (IPC). After the inspection, the provider stated that both staff members had completed the training; however, this information was not available at the time of the inspection.

One relief staff member had, until recently, been outstanding on almost all required training. They were informed that they could not continue their duties until all

mandatory training was completed, and they were in the process of addressing these requirements.

In summary, monitoring of staff training needs requires improvement to ensure that all staff have completed the training necessary to safely and effectively carry out their roles.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector reviewed the provider's governance and management arrangements and found that improvements were required to ensure that staff training needs were adequately addressed and that staff were receiving appropriate support for their professional development.

Gaps in the performance management of staff members were identified following the inspector's meeting with four of the five staff members on duty.

In preparation for the inspection, the inspector identified several key areas to review with staff in order to assess their knowledge.

The inspector sought staff members' understanding on the following topics:

- their roles in supporting residents on a daily basis
- staff were asked to describe the needs of the residents they were supporting
- what they would do if they had a concern regarding a resident's safety or well-being
- how they promoted residents' independence
- how they reported and recorded adverse incidents or near misses
- their knowledge of fire evacuation procedures
- supports in place to enable effective communication with residents.

Following discussions with the staff members, the inspector was satisfied that they understood the residents' needs and discussed their roles in supporting them. However, the four staff members' responses regarding the actions they would take if they had concerns about a resident's well-being or safety were limited and did not demonstrate adequate knowledge in this area. Furthermore, a staff member did not demonstrate appropriate knowledge of the safe evacuation plan for a resident at night, and two staff members did not demonstrate sufficient knowledge of the communication support guidelines for two residents.

The provider is required to have appropriate measures in place to manage staff members; the gaps in staff members' knowledge did not demonstrate that these measures were effective.

The inspector found that systems were in place to promote effective oversight of the service provided to residents, that monthly visits by senior management were occurring, and audits were being conducted by local management. The inspector found that areas which required improvement were being identified and actions to address the identified deficits were listed. The inspector reviewed the monthly audits completed by senior management from the period of October 2025 to January 2026 and found that a number of actions had not been addressed; in particular, staff training remained outstanding, despite being identified as a concern during each audit. This raised the concern that the provider was not responding appropriately to their own governance arrangements and this needed to be improved.

In summary, the inspection identified that while systems for oversight and management were in place, there were significant gaps in staff training and performance management. These gaps indicate that systems in place were not sufficiently effective in ensuring staff competence or addressing actions identified in internal audits. Strengthened oversight and targeted staff development are required to achieve regulatory compliance.

Judgment: Not compliant

Quality and safety

The inspection concluded that residents were receiving a good service that met their needs. Assessments of residents' needs had been completed, informing the development of their care and support plans. The inspector reviewed samples of these plans and found them to be well-written and reflective of the residents' needs.

Key areas, including risk management, premises, communication, safeguarding, and behaviour support, were examined and found to be compliant with regulatory requirements.

In summary, residents were found to be receiving appropriate care and support.

Regulation 10: Communication

The inspector noted that steps were being taken to support residents' communication. Residents' communication skills and needs had been assessed by a speech and language therapist (SALT).

The inspector reviewed two of the residents' communication plans and found that the plans were person-centred and well-written, providing clear guidance to support residents' communication.

When discussing two residents' communication plans with two staff members, the inspector identified that staff could demonstrate some aspects of the plans, but improvements were required. For example, a recommendation for one resident was to use a 'first and next' sentence structure. However, when asked about using sentence structures with the resident, the staff member did not reference using the recommended approach. This issue has been addressed under Regulation 23: Governance and Management.

In summary, an appropriate assessment of residents' communication needs had been completed, and clear communication guidance had been developed for staff to follow. However, when asked, two staff members did not demonstrate sufficient knowledge of the guidance.

Judgment: Compliant

Regulation 13: General welfare and development

The inspector found that efforts were being made to encourage and support residents in engaging in activities they enjoyed. The inspector found that person-centred plans had been developed for each resident. The inspector also found that social goals had been set for the residents. The inspector reviewed the goals in place for the four residents and found that, where possible, the residents identified the goals with some staff support.

Short- and long-term goals were identified for the residents. An example of a long-term goal for one resident is for them to regain their independence in activities of daily living. For another resident, their short-term goal was to increase their mobility, and their long-term goal was to live in the town they are from.

In summary, the inspector found that the staff team were taking steps to support the residents in achieving their goals, doing so in a manner that respected the residents' wishes and maintained their safety.

Judgment: Compliant

Regulation 17: Premises

The person in charge showed the inspector around the residents' home. They identified issues with the flooring and in one of the bathrooms. The flooring had lifted in some areas but was not posing a risk. The provider had already identified

these issues prior to the inspection and had arranged for appropriate personnel to address them on 28.02.26.

As stated in the opening section of the report, the provider and staff team had taken steps to promote a homelike environment for residents. The building had been adapted to meet the needs of residents, and the necessary equipment was available when required.

In summary, the inspector found that the premises had been modified to suit the residents. When issues arose, the provider responded promptly to ensure that the residents' home remained suitable for the group.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector found that appropriate risk management strategies were being employed. This conclusion was reached after reviewing three residents' risk assessments and studying adverse incidents that had occurred in the service.

The risk assessments were linked to residents' care plans, needs assessments, and positive behaviour support plans. Upon reviewing the risk control measures implemented to maintain resident safety, the inspector found that they were proportionate to the level of risk and necessary to ensure safety.

The inspector found that, upon reviewing the adverse incidents, staff members managed the incidents well and maintained residents' safety.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector reviewed the fire safety measures in place and found that staff had received appropriate fire safety training.

The inspector reviewed the fire safety management folder and found evidence that fire detection and firefighting equipment had been regularly serviced, ensuring that the systems remained in good working order.

Records confirmed that both residents and staff could be safely evacuated during daytime and night-time scenarios. The inspector reviewed the Personal Emergency Evacuation Plans for the four residents; while brief, these plans provided sufficient information to ensure residents could be evacuated safely.

The inspector asked two staff members to describe the fire evacuation procedures for residents during both day and night-time scenarios. The discussions revealed that staff understood some aspects of the plans. For example, when asked, a staff member stated that they would transfer a resident from their bed to a wheelchair to evacuate them at night. However, the correct method was to use a skisheet provided for this purpose. The concern regarding staff knowledge has been documented under Regulation 23: Governance and Management.

In summary, the inspector found that robust fire safety measures and regular equipment servicing were in place. While staff had received appropriate training, improvements were needed to ensure full understanding and implementation of evacuation procedures.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector found that the provider had effective systems in place for the ongoing assessment and review of residents' needs, in line with Regulation 5. Upon reviewing the information for four residents, the inspector noted that up-to-date personal plans had been developed, reflecting each resident's assessed health, social, and behavioural support needs.

The personal plans were detailed, person-centred, and provided clear guidance for staff on how to best support each resident according to their preferences and identified goals. Follow-up assessments were conducted after residents' admission to the service, and the inspector observed that multidisciplinary involvement occurred when necessary. There were examples of residents receiving mental health support, physiotherapy, and occupational therapy.

Overall, the provider demonstrated a commitment to delivering individualised support through well-maintained and responsive personal planning processes

Judgment: Compliant

Regulation 6: Health care

The inspector found that the health needs of the residents' had been appropriately assessed, and care plans had been developed for staff to follow. In particular, the inspector noted that a detailed and well-written plan for managing a resident's epilepsy was in place. Furthermore, a staff member spoke with the inspector about the steps they would take if seizure activity occurred, which aligned with the resident's protocol.

Additionally, there was evidence that residents had access to allied health professionals and were supported in attending appointments with general practitioners. There were instances of residents' medications being regularly reviewed and adjusted to meet their needs. Discussions with the service management team revealed that following changes to a resident's medication, there had been a deterioration in their mobility. This issue had been raised with the prescribing doctor, and a review of the medication was scheduled to take place.

In summary, the inspector reviewed healthcare plans for three of the four residents and found them to be well-written and under regular review. At the time of the inspection, the residents were in good health, and efforts were being made to maintain this status.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found that the provider had effective measures in place to promote positive behavioural support. The inspector reviewed two of the residents' behaviour support guidance documents.

They were clearly written, under review, and informed by appropriate multidisciplinary input. These plans provided clear guidance to staff on proactive and reactive strategies tailored to each resident.

As part of the review of information, the inspector reviewed adverse incidents that had occurred for the current residents over the previous four-month period. The appraisal showed that staff members were responding to the residents' presentation, supporting them, and managing the residents and their safety. Many of the incidents related to the residents' diagnoses and periods of frustration. Staff members were found to be responding to the incidents in a person-centred and proportionate manner.

Judgment: Compliant

Regulation 8: Protection

Inspectors reviewed the systems in place to ensure that residents were safeguarded from all forms of abuse. The review found that appropriate safeguarding measures were in place, but some concerns were identified following discussions with staff members. As noted earlier, staff members, when asked, demonstrated limited knowledge of how to respond to safeguarding concerns. The inspector raised these concerns during the inspection with the service's management team. Although staff

had received training on safeguarding residents and additional training on the topic, they had not demonstrated this knowledge when speaking to the inspector. The inspector has actioned this issue under Regulation 23: Governance and Management, with a focus on the performance management of the staff team.

The inspector did find that the service's management team had responded to safeguarding concerns and had initiated investigations. There were three open safeguarding plans at the time of the inspection. The inspector reviewed these and found the review and response to the concerns to be appropriate.

In summary, the inspector found that the provider had ensured that systems were in place to protect residents. However, improvements were required to ensure that staff members could effectively demonstrate their knowledge.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Culfore Lodge OSV-0009050

Inspection ID: MON-0047838

Date of inspection: 25/02/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Communication to be released across organization to communicate with Team members steps to take on HSEland should certificate not be issued following completion of training. Due Date: 24th of March 2026 Person in Charge to ensure Medication training is closed out for Team Member outstanding. Due Date: 24th of April 2026 Having Difficult Conversations, Investigations and Disciplinary Hearings training to be completed with Person in Charge (PIC) and Assistant Director of Services (ADOS) by Human Resources Manager to ensure future non completion of training is addressed appropriately. Due Date: 24th of April 2026	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Single Person in Charge (PIC) to be in situ in the Designated Centre to support with the Governance and Management of the Centre. Due Date: 24th of February 2026 (Completed)	

Having Difficult Conversations, Investigations and Disciplinary Hearings training to be completed with Person in Charge (PIC) and Assistant Director of Services (ADOS) by Human Resources Manager.
Due Date: 24th of April 2026

Safeguarding competency to be completed with all Team Members in the Designated Centre by the Person in Charge (PIC). Mentoring to be completed with any Team Member scoring below the required threshold.
Due Date: 30th of April 2026

Fire Safety competency to be completed with all Team Members in the Designated Centre by the Person in Charge (PIC). Mentoring to be completed with any Team Member scoring below the required threshold.
Due Date: 30th of April 2026

Assistant Director of Services to update the Induction booklet to include Fire Safety and Safeguarding competencies to ensure all new Team Members are assessed and supported.
Due Date: 16th of March 2026
(Completed)

Communication Passports to be reviewed for all Residents by the Person in Charge (PIC) and all Team Members to be educated on same in Team Meeting. Competency to be completed on Team Meeting surrounding Residents' specific communication needs.

Due Date: 30th of April 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	24/04/2026
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/04/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support,	Not Compliant	Orange	30/04/2026

	develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.			