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:	Teach Saoire
Name of provider:	GALRO Unlimited Company
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	17 February 2026
Centre ID:	OSV-0005726
Fieldwork ID:	MON-0043798

About the designated centre

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

Teach Saoire provides a respite service to adults with an intellectual disability, autism or individuals who display behaviours of concern relating to their diagnosis. The centre can support up to nine residents at any one time. The centre is a large detached two-storey house with 10 bedrooms and a number of communal living rooms which are bright and comfortable. It is located in a rural setting but in close proximity to a large town. Each of the residents availing of respite has an individual bedroom with en-suite facilities. There is a good sized enclosed garden to the rear of the centre for use by residents. This includes a seating area, built in trampoline, tennis court and nest swing. There are two vehicles available for residents to use. The centre does not provide a service to residents who require wheelchair access or full time nursing support.

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
Tuesday 17 February 2026	10:15hrs to 18:25hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this unannounced monitoring inspection, the inspector found a relaxed and friendly atmosphere where the residents were receiving a good standard of person-centred care while on their respite break.

While the centre was performing well in many areas, the inspection identified improvements required to ensure consistent safety and care, specifically regarding records, communication, and medicine administration guidance. 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 attending the respite centre. Two of the residents were leaving the morning of the inspection as their respite breaks were over. The four residents briefly shared their views with the inspector and they said they liked respite and that staff were nice. The inspector observed them in the centre at different times during the inspection. They appeared very relaxed and comfortable in the presence of the staff on duty. One resident spoke in a little more detail to the inspector and said that the food was nice and that they had a choice in what food they ate and the activities they chose to engage in while on their break.

One resident went out for part of the day with some staff from their proposed new residential centre and had lunch out. Two staff from Teach Saoire commented how much they would miss this resident when they moved into their new residential home. One resident went out for personal shopping and said they had a good day. They relaxed listening to music in the kitchen for the remainder of the inspection and said they hadn't decided on their plans for the evening. The third resident who was present during the day went for lunch out and a trip to a lake.

The inspector did not get to meet with the resident who arrived late afternoon as they went straight to their room to relax and check in their belongings. However, the inspector did get the opportunity to chat with their family representative who dropped them off for their stay.

The inspector had the opportunity to speak in total with three residents' family representatives in-person on the day of this inspection. Feedback received was very positive. The family representatives communicated that they felt their family members were 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 with staff or management. They felt they would be listened to. One stated that their family member "loves it here". All three stated that the communication was very good. They received a text message each night with an update on how their family member's day went. They confirmed at the end of the stay they received written documentation on a breakdown of their family members'

stay. One family representative stated that their family member's food preferences and support needs were catered for and that staff knew their family member well.

The inspector met with the four staff that had been on duty, the respite manager, and the person in charge. Staff were observed to be patient, respectful and caring in their interactions. For example, a staff member asked one of the residents they were supporting, did they mind if they spoke to the inspector before supporting them with their shower. The resident confirmed it was okay and the staff member thanked them.

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. Since having the training, they had reflected on people's right to freedom of speech. They were more conscious to include people in conversations that may have limited or non-verbal communication methods.

The inspector observed the large house to be clean and tidy. The three sitting rooms had televisions for use as well as some of the bedrooms.

Each resident attending on a respite break had their bedroom with an en-suite bathroom. The bedrooms had adequate storage facilities for any personal belongings residents may want to bring with them on their respite stay.

There was a front garden mainly used for parking. The back garden contained some tables with benches, a built in trampoline, and a bucket swing that residents could use in times of good weather.

As this was a respite centre there were new admissions and discharges occurring. The inspector found that one resident who was on their respite break was due to transition to a residential placement with another provider and staff from Teach Saoire were supporting the resident with the transition.

There were no volunteers used in this centre. The inspector was informed that there were no complaints in 2025 or to the date of this inspection.

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 unannounced and was undertaken as part of on-going monitoring of 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). 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 regulations. While the service was generally operating in a manner which ensured effective, person-centred care to the residents, some improvements with regard to how records were maintained were identified.

The inspector reviewed the provider's governance and management arrangements and found that there were appropriate systems in place to ensure an effective and safe service for residents. For example, weekly and monthly oversight audits covering a range of areas, such as health and safety, were completed by the respite manager.

From a review of a sample of rosters across four months, the inspector found that there was adequate staffing in place to meet the assessed needs of the residents. Staffing rostered each day was found to be based on the assessed needs of the residents attending the service.

The respite staff were found to have access to training that would facilitate them to effectively support the residents, for example fire safety both in-person and online training.

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 social care, and leadership and management skills. They had just recently taken over the running of this centre and were responsible for this and one other centre run by the provider. They split their times between the two centres to provide oversight and provide informal supervision for staff. They were supported by a respite manager in order to provide appropriate oversight for this centre.

They were also found to be aware of their statutory responsibilities under 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 of Social Services (The Chief Inspector).

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre were effective in meeting residents' assessed needs.

The inspector reviewed a sample of rosters over a four-month period from November 2025 to February 2026. The centre had a full staffing complement. This supported continuity of care for the residents and reduced the risk of them receiving inconsistent support from unfamiliar staff.

The roster review demonstrated to the inspector that there was a planned and actual roster in place and that it was appropriately maintained. It contained the full names and titles of staff working in the centre. In addition, it had a staff member nominated each day on the roster to be the lead staff for the shift.

The inspector compared a sample of three weeks of the respite attendance calendar of who attended for respite and found that appropriate staffing levels were found to match the assessed staffing needs of the residents.

One family representative stated that staff were "approachable" and that staff 'treat their family member with respect'.

While full staff personnel files were not reviewed, the inspector did review a sample of three staff members' Garda Síochána (police) vetting (GV) certificates as well as two police clearance certificates. All three GV certificates were dated within the last three years. This demonstrated that the provider had arrangements for safe recruitment practices in line with best practice.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with opportunities to access a suite of 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.

A review of a sample of certification of six training courses for staff that worked in the centre demonstrated to the inspector that staff were in receipt of the required training.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- medication management
- epilepsy awareness and emergency epilepsy medication administration
- hand hygiene, and a number of other training courses related to infection, prevention and control (IPC)
- diabetes

- 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.

The inspector reviewed a sample of three staff members' supervision and found that it was an opportunity to raise concerns if any. In addition, staff also received another form of supervision called operational supervision which ensured that staff had the appropriate knowledge on certain key areas, for example safeguarding.

Judgment: Compliant

Regulation 21: Records

All required records were for the most part adequately maintained and available for inspection, including records of staff meetings. However, the standard of some documentation required improvement to ensure consistent safe care would be maintained. A review of a sample of files indicated that not all guidance documents were up-to-date or accurate.

Some hospital passports (guidance document for hospital staff should the resident require a stay in hospital), did not elaborate on all applicable information. For instance, one plan stated "if my behaviour becomes difficult for you please support me by……". However, the plan did not explain what type of behaviour the resident may display. Another plan stated that a resident had epilepsy and that the resident could have seizures at night; however, it didn't explain what type of seizures they may have or if they were prescribed emergency epilepsy medication. The absence of this information could lead to ineffective care in a hospital setting.

Of the four intimate care plans reviewed, they all contained a generic statement that was not reflective of the individual residents' assessed needs. They stated 'when staff are assisting with my intimate care, it may be necessary to leave the door ajar so that staff members can observe if required to do so.' As this was not based on assessed support needs of the residents, this had the potential to impact on residents' dignity and privacy.

One resident's personal emergency evacuation plan (PEEP) contained misleading information. The resident had mobility issues and the plan correctly guided staff that the resident required the downstairs bedroom; however, the plan went on to explain that staff would assist them through the fire exit to the house car and then guide them to the upstairs 'safe room' and wait for the fire services to arrive to evacuate them from the balcony. This incorrect guidance could put the resident at increased risk from fire if staff followed the incorrect guidance provided. Notwithstanding that, staff spoken with were familiar as to that resident's evacuation support needs and therefore this was a documentation error.

Some healthcare plans were overdue a clinical review to ensure the information was still applicable for supporting the residents appropriately. For example, some speech and language therapist (SLT) eating and drinking plans.

In addition, one resident's diabetes support plan did not guide staff as to their normal blood sugars, whether staff were supposed to check their blood sugars while on a respite break or what signs of high or low blood sugar to look out for and what steps to take should they experience high or low blood sugar. A staff member spoken with was familiar with this information and how to deal with high or low blood sugar and communicated that they would seek medical attention if the resident was not improving after support provided. While the information was known, the plan required updating to ensure all staff were familiar with how to effectively support the resident with their diabetes.

From reviewing one resident's epilepsy medication protocol, it was not evident where the direction for the time frame for administration of emergency epilepsy medication came from. There was no evidence the guidance to staff with regard to time frames for administration that were recorded, were directed by the prescribing professional. The separate documentation signed by the prescribing professional had not described any specific time frames of when to administer this medication, just the dosage that could be administered within a 24 hour period.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the provider had appropriate governance and management arrangements in place.

The provider had carried out an annual review of the quality and safety of the centre, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis, of which the inspector reviewed the unannounced visit reports from July 2025 and January 2026. There were action plans in place for any areas identified as requiring improvement. The majority of the actions from the January 2026 visit were completed by the time of this inspection.

There were weekly and monthly audits being completed on different aspects of the service to facilitate a safe and effective service. Some of the areas covered included: IPC, incidents, care planning, restrictive practices, fire safety.

A review of team meeting minutes confirmed that they were occurring monthly. A review of three team meeting minutes, November and December 2025, and January 2026 demonstrated that any incidents that occurred within the centre were reviewed for shared learning with the staff team. Other examples of topics discussed at the meetings included residents' support needs, updates on clinical inputs, safeguarding, training, and restrictive practices.

All four staff and the respite manager spoken with communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and felt that they would be listened to.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the residents attending this service were receiving appropriate care and support. However, some improvements were required in relation to communication, and medicines management.

While there were many appropriate arrangements in place for medicines management, improvements were required to ensure that records relating to prescribing documentation were reviewed within recommended time frames to ensure the validity of the residents' prescriptions.

The inspector observed the house to be tidy and in a good state of repair. There were adequate fire safety management systems in place, such as regular servicing of detection and alert systems. For example, the fire extinguishers were serviced annually.

While staff were familiar with how residents communicated and there was guidance in place to inform staff how to promote effective communication, some improvements were required to ensure the plans contained all relevant information. In addition, further visuals were required in the centre to promote effective communication.

Staff were familiar with residents' healthcare support needs and there were healthcare plans in place for identified needs.

There were sufficient systems in place to meet the requirements of the regulations associated with: positive behaviour support, protection, and general welfare and development.

For example, where required, residents had positive behaviour support plans in place to guide staff should the resident be experiencing periods of distress. There was a safeguarding policy in place to guide staff should they have any safeguarding concerns. The inspector found that the residents appeared to engage in activities and community access in line with their preferences.

Regulation 10: Communication

Staff were found to facilitate communication for residents in accordance with their needs and preferences. However, some improvement was required to the current communication plans to ensure that all applicable information was captured, and to ensure sufficient visuals were available to support residents' communication.

From a review of three residents' files they had documented communication needs in a communication support plan to guide staff as to what they may be trying to communicate and support effective communication. For example, one plan stated that a resident doesn't like direct eye contact.

However, the majority of plans reviewed did not explain how to recognise if the resident was saying 'yes/no', how to know when they were happy, sad or in pain.

In the case of one resident who was on a respite break, the plan did not contain all information known by the supporting staff member on duty. For instance, it did not state that the resident may pull on their jumper frequently meaning they want to change it or that the staff response was to reassure and redirect where possible.

The inspector observed that while some visuals were in use, they were not always being used effectively. For instance, a visual menu was displayed as a sample menu on a notice board in the kitchen for the week, although it didn't actually state it was a sample. There were some visuals of examples of activities that could be chosen. One resident's communication plan suggested the use of visuals would help their communication. However, due to the limited visuals available and it was not evident from speaking with two staff members if the visuals were being consistently used, this could impact on residents' ability to make an informed decision in relation to daily choices. In addition, the sample menu displayed had the potential to confuse residents into thinking that was what they would be eating that day.

Despite these gaps, staff were observed communicating well in practice and from speaking with three staff members they were familiar as to how residents communicated. For instance, they were aware that one resident was shy and could present anxious and may pace faster if feeling anxious. However, they may pace at a slower rate in general as this was their way of relaxing themselves. Although the resident may respond in simple word answers, they could understand a lot more of what was being said to them.

The inspector found that individual key-working sessions were completed with residents to support their understanding of certain topics, such as restrictive practices in use that may impact them. On occasion social stories which contained pictures were available and used to further support understanding of the topic. As previously stated, staff from Teach Saoire were supporting the resident with the transition and had completed a social story with them to help them understand the move. They had pictures of the new proposed centre for the resident to review.

The inspector also observed that residents had access to a radio, a phone, televisions, and the Internet while on their respite break which would support their communication.

Judgment: Substantially compliant

Regulation 13: General welfare and development

This inspection found that the residents had access to opportunities for leisure and recreation. Residents engaged in activities in the respite centre and community.

From a review of the three residents' files over a period from September 2025 to February 2026 and from a review of the finance accounts for two residents, the inspector observed that residents were being offered to engage in activities. Activities ranged from baking, sensory play, lake visits, trips to the cinema or bowling, going for walks, going out for lunch, and personal shopping.

One resident and the three family representatives spoken with believed that the residents had choice in their activities and engaged in lots of activities while on their respite breaks.

Judgment: Compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs.

The premises internally was found to be in a good state of repair. The house was observed to be clean and tidy. The facilities required by Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities.

There were several communal areas available for use, for example three sitting rooms with televisions, and an activity room with art supplies, games, and jigsaws.

Each resident had their own en-suite bedroom with sufficient space for their belongings while on their respite break.

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 cloths, mops and buckets in place. A staff member spoken with was familiar as to the colour coded system in place. The inspector also observed personal protective equipment available, such as gloves and masks if required.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety practices in place which included staff having received training in fire safety.

A review of five fire practice drills, demonstrated that regular fire evacuation drills were being completed in order to familiarise the residents with safe evacuation in the event of an emergency. Some drills were completed during hours of darkness and the documentation demonstrated residents were supported to use alternative evacuation routes.

From a sample of four personal emergency evacuation plans (PEEPs), the inspector found they were in place and outlined the specific support required during an emergency. While one PEEP contained inaccurate and conflicting information, this was addressed under Regulation 21: Records as the correct information was known to the management and a staff member on duty.

There were fire containment doors in place fitted with self-closing devices. All of the fire containment doors were tested to see if they closed properly and two were found to not close fully. The person in charge arranged for the doors to be fixed prior to the end of the inspection.

The inspector found that there were detection and alert systems, emergency lighting and firefighting equipment in place, each of which was regularly serviced. Internal and external emergency lighting was found to be working.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that for the most part there were adequate arrangements in place for medicines management within the centre. However, improvements were required as some records relating to prescriptions were not reviewed in line with the regulations. Consequently, this regulation was not fully met.

Prescribed medicines were dispensed to the resident by their local pharmacy and came into the centre with the resident when they were attending on a respite break. They were found to be appropriately stored in a locked medication cabinet within the centre. There was a separate locked press for the storage of medicines that were expired or spoiled and due for return to the pharmacy. The inspector reviewed a sample of records of returned medications, which were signed by the pharmacist.

The inspector reviewed a sample of two medicines stock counts belonging to one resident in the presence of a staff member. They were found to be correct and had pharmacy labels attached to support correct administration as prescribed.

Staff completed a daily reducing stock balance of medications in order to ensure that any medication errors should be picked up in a timely manner. This assured the inspector that there was appropriate oversight over residents' medicines.

Staff reviewed and signed in medication into the centre when it was received and was signed back out when returned home with the resident.

A review of five residents' medicines documentation, demonstrated that their medicines were prescribed by appropriate medical professionals. Each resident had a signed administration guidance document in place (Kardex) in order to ensure that medicines would be administered as prescribed. However, they were not reviewed within time frames considered best practice. This was in order to ensure that staff and residents were administering medication from a valid prescription sheet. For example, only one of the five Kardexes was reviewed within the last six months. In the case of two residents their Kardexes had not been reviewed since 2024. While staff communicated with family representatives prior to each respite break, the current arrangements did not ensure that valid prescription sheets were available. Therefore, improvements were required to ensure that safe medication practices were in place.

Staff were in receipt of training to support them to administer each resident's medication. There was a folder available in the centre with details on the different medications administered in the centre and what each medication should look like. This supported staff to ensure that the correct medication was received into the centre in order to ensure the correct medications would be administered to the correct residents.

Judgment: Substantially compliant

Regulation 6: Health care

The residents were found to be supported in line with their healthcare needs.

One staff member spoken with was knowledgeable with regard to required healthcare supports for residents.

Where applicable, there were healthcare plans in place to guide staff as to what supports residents required, for example, a diabetes management plan, an altered diet plan, an epilepsy care plan and associated emergency epilepsy medication administration protocol, and hospital care plans to guide hospital staff should a resident require a hospital stay. While some improvements were required to certain healthcare documents, this was addressed under Regulation 21: Records.

From a review of one resident's assessment of need document, it contained information related to what healthcare support needs a resident may need and provided information on their last medical appointments, such as dental.

Due to this being a respite house and not the residents' primary residence, healthcare appointments and access to allied healthcare professionals was supported by each resident's family. A staff member confirmed that if required centre staff would support residents to attend a doctor or hospital should they become unwell during a respite stay.

Judgment: 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 behaviour support worker.

From a review of three residents' files, the inspector observed that as required, residents had positive behavioural support plans in place which were reviewed by the behaviour support worker. They were found to have been reviewed within the last year to ensure accuracy of the information provided to staff.

The behaviour support plans were found to outline strategies that staff needed to follow to support the residents in times of distress and provided clear information to staff. For example, they included likely triggers of behaviours, what behaviours of concern the resident may display as well as reactive and proactive strategies to undertake with the residents when the resident is becoming anxious or experiencing behaviour that may cause distress to themselves or others. They also included the response to be taken and what it may look like when the resident is returning to baseline.

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
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- staff had received training in safeguarding vulnerable adults

- two staff members spoken with were able to identify who the DO was to the inspector, and the identity of the DO was displayed in the centre.

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

The three family representatives and the five staff spoken with felt comfortable raising concerns. At the time of this inspection, neither the family representatives nor the staff members spoken with had any concerns.

Two staff members spoken with were familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, the staff member explained that they would ensure the safety of the resident impacted by a peer-to-peer incident, check for any injuries, and report to their manager. Regarding unwitnessed disclosures, staff confirmed that they would not promise confidentiality due to the fact this was a safeguarding concern, and that they would document the facts and report.

From a review of four residents' files, the inspector observed that there were care plans in place that outlined residents' support needs with regard to the provision of intimate care. This was to ensure residents received the correct level of support and promoted their independence where possible. While a generic statement was contained in the plans that had the potential to impact on residents' privacy, this was addressed under Regulation 21: Records.

The inspector reviewed a sample of two residents' finance balance checks and found that staff were completing daily checks of residents' money. The inspector counted one resident's money in the presence of the respite manager and found it to match the amount recorded on the finance balance sheet. This assured the inspector that there was appropriate oversight over residents' finances while on their respite break.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Teach Saoire OSV-0005726

Inspection ID: MON-0043798

Date of inspection: 17/02/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A structured review schedule has been implemented, prioritising residents who regularly utilise the respite service. Each resident's personal plan and associated documents will be reviewed to ensure they are accurate, comprehensive and reflective of their current care and support needs. As part of the pre-admission process, the plans will be reviewed with the resident's Next of Kin to verify accuracy and ensure any necessary amendments are completed so that the plans remain current and up to date.	
Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: The communication plan template will be revised to include additional headings to ensure that residents' communication needs and preferences are clearly documented and accurately reflected in their personal plans. The range of visual communication supports available within the centre has been expanded to provide a greater variety of resources, ensuring that residents are supported to communicate effectively using their preferred communication methods.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Each residents' Kardex will be reviewed and updated at least every six months or sooner if required to ensure that they are reflective of the resident's current prescription.	

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	10/03/2026
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/06/2026
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for	Substantially Compliant	Yellow	30/06/2026

	inspection by the chief inspector.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/06/2026