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 Athasach
Name of provider:	St Hilda's Services
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	06 January 2026
Centre ID:	OSV-0008547
Fieldwork ID:	MON-0049185

About the designated centre

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

Teach Athasach provides residential services for up to four adults of mixed gender with an intellectual disability from the age of 18 years and above. The centre is staffed at all times with a waking night staff on each night. Staffing is a mixture between nurses and residential support workers. The centre is overseen by a person in charge and they are regularly on-site. The centre is on the outskirts of a large town within walking distance to many facilities. In addition, the centre has transport that can be made available for residents.

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 6 January 2026	10:10hrs to 18:15hrs	Karena Butler	Lead

What residents told us and what inspectors observed

This unannounced inspection found that while in the main good practice was observed and residents enjoyed a good quality of life, improvements were required. In total, 16 regulations were reviewed and of these, six were found to be non-compliant.

Specific improvements were required in relation to governance and oversight including audits, some residents' limitations on meaningful engagement in recreation and community access, ease of access to their own money, how records were maintained in the centre, ensuring staff had appropriate and up-to-date training, and in ensuring the submission of notifications within prescribed time frames. These matters will be further discussed later in this report.

The inspector met and observed the four residents that were living in the centre. Two residents had alternative communication methods and did not share their views with the inspector. Instead they were observed at different times throughout the course of the inspection in their home. They appeared content and comfortable in the presence of the staff on duty.

The other two residents spoke individually with the inspector in private. They both said they felt safe living in the centre and that they were happy living in the centre. They both felt they got on well with their housemates. Both said the staff that worked with them were nice. Both felt they got choice in their food and activity choices.

The person in charge was not on duty on the day of this inspection. The inspection was facilitated by the staff on duty, and at times by the residential services manager. The inspector had the opportunity to speak with the four staff on duty. Staff on duty demonstrated they were aware of support requirements for the residents.

Staff interactions with the residents were found to be kind and gentle. For example, one staff member was observed walking slowly through the hall matching the pace of a resident while chatting softly to them.

The provider had arranged for staff to have training in human rights. A staff member spoken with explained how they had put that training into every day practice. They communicated that in the past they may have heavily focused on providing care. They felt they may have sometimes believed that they knew what residents needed. Now they said they would try to support them to make more risk based decisions and supported them to weigh up the decision. They explained it was about the resident and their priorities and not staff. They felt they did not have an example of this occurring in practice as the situation had not arisen for them yet.

The inspector had the opportunity to speak on the phone with a family representative on behalf of two residents. Feedback was very positive. Both family representatives felt welcome to visit the centre. Both felt that the staff were really good in this centre. For instance, one representative stated that staff were 'kind, excellent, compassionate, and caring and that it was familiar staff that worked in the centre'. Neither had any concerns regarding the care provided. With one stating that they felt that staff cared for their family member and the other residents like they were all a ''little family'' and 'took such good care of them'. The other family representative communicated that their family member was 'happy living in the centre and that they wouldn't want to change it for the world'.

From a walkabout of the centre, the inspector observed it to be clean and tidy. Both sitting rooms had a television for use. Each resident had their own bedroom and they were decorated in line with their preferences. For example, one resident had a picture of themselves on a flag of their favourite football club. The residents also had personal pictures displayed in different parts of their home.

There was a front and back garden and a patio area to the side of the house, each of which was accessible to the residents. The back garden had a picnic table and benches for use to relax in times of good weather.

At the time of this inspection there were no visiting restrictions in place. There were no vacancies and the most recent admission to the centre moved in successfully in October 2025. There were no complaints received in 2025 or 2026 up 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 unannounced inspection was undertaken as part of the provider's application to renew the centre's registration. This centre was last inspected in January 2024. The findings of this inspection indicated that while the provider, person in charge, and staff team have the capability to deliver good quality, person-centred care, there were significant weaknesses in the provider's overarching systems for governance and oversight. Therefore, improvement in the provider's capacity to effectively monitor and manage the service was required.

The inspector found that while some improvements were noted in the manner in which some audits were conducted since the last inspection, the management systems in place were not sufficiently robust to ensure consistent compliance. For instance, it was not evident if all audits were conducted according to the provider's timescales, and identified actions were not always available for review in a timely

manner. In addition, regulatory notifications were often submitted outside of prescribed time frames.

Oversight of staff training required improvement to ensure staff possessed up-to-date knowledge and skills necessary to support residents safely.

Furthermore, improvements were required with regard to how records were maintained in the centre to ensure accuracy and promote consistent guidance for staff in order to support the residents.

A statement of purpose and function was in place and available as per 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).

From a review of the staffing arrangements, the inspector found that they were suitable for meeting the assessment needs of the residents.

Registration Regulation 5: Application for registration or renewal of registration

As required by the registration regulations, the provider had submitted an application to renew the registration of the centre. This included submission of required prescribed documents. For example, the provider had arranged for a revised statement of purpose, and residents' guide to be submitted for review.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre were sufficient in meeting residents' assessed needs. While some minor issues were identified with how the roster was maintained, the identified issues had not posed a risk to the residents at the time of this inspection and therefore this is being actioned under Regulation 21: Records.

The inspector reviewed the rosters for October and November 2025 as well as January 2026. There were planned and actual rosters in place as required. Adequate staffing levels were found to be available and maintained as needed. Rosters were amended in line with residents' changing needs. For example, three residents were off sick from their day programme and additional staff were rostered in order to provide adequate care while the residents recovered at home.

There was due to be a full staffing complement in place by the end of January 2026 with the commencement of one new staff member. This would facilitate consistency

and continuity of care. The staff on duty on the day of the inspection were observed to be caring and respectful towards the residents. For example, a staff member was observed talking in a reassuring and gentle manner with a resident as they walked with them in the house. Staff took their time and walked at the resident's pace so as not to rush them.

Staff personnel files were not reviewed as part of this inspection. The inspector did review the Garda Síochána (police) vetting (GV) certificates for three staff. The review confirmed the provider had arrangements for safe recruitment practices.

Judgment: Compliant

Regulation 16: Training and staff development

While training was provided to staff in order to support the assessed needs of the residents, a number of training or refresher training was found to be required. Improvements were also required to the oversight of the training oversight document in order to ensure it was an accurate representation and provided sufficient detail to facilitate oversight of staff training needs. Therefore, this regulation was found to be not compliant.

The inspector reviewed the training oversight document as well as a sample of certificates of training from eleven different training areas that staff completed. From this review, the inspector found that some staff required training across nine different areas.

Examples of training on the matrix that had expired or highlighted red with no retraining dates identified included;

- seven staff with regard to clamping of wheelchairs for transport which was required for this centre
- three staff with regard to cough etiquette and respiratory hygiene and this training had also been identified as required in the previous inspection
- three staff with regard to hand hygiene competencies
- one staff member with regard to personal protective equipment (PPE)
- two staff with regard to cardiac first response or basic first aid and this was important as staff worked alone at night
- one staff member with regard to training related to eating, drinking and swallowing
- two staff with regard to manual handling of people and hoist use
- two staff with regard to positive behaviour supports
- two staff with regard to fire safety training.

The absence of up-to-date infection prevention and control (IPC) training increased the risk of residents contracting a healthcare-associated illness.

In addition, the matrix was highlighted red in a number of places, meaning training was not in place or had expired with no dates recorded. In other cases, the matrix had a date recorded that did not match the dates on the training certificate on file. Therefore, the documentation for oversight of staff training required improvement to ensure it provided and accurate reflection of the training needs of staff..

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 'what residents told us and what inspectors observed' section of the report.

Judgment: Not compliant

Regulation 21: Records

While many records were suitably maintained, improvements were required in specific areas. Inconsistent or incomplete records could result in staff inconsistencies or care provided to residents not as intended. Therefore, this regulation was found to be not compliant.

The inspector reviewed an epilepsy care plan which contained conflicting information as to when a resident should receive their rescue emergency medication in the event of having a seizure. The resident's signed guidance (kardex) from their prescriber described a different maximum dosage that the resident could receive of their rescue medication if required. Those identified issues had the potential to put the resident at risk of inconsistent care not in line with their assessed needs.

While there was a behaviour support plan for one resident, it was not evident if it fully guided staff how to respond and support the resident once their behaviour had escalated post the anxiety phase or when the incident was over during the tension reduction phase. From speaking with a staff member and the residential services manager, they believed that this information was in place however, it could not be located on inspection. From speaking with the staff member, they were familiar with how to support the resident through periods when they were distressed. However, improvement was required to ensure that all applicable information was in place and easily accessible to ensure it was available to guide staff when necessary. Ensuring staff are familiar with this information is necessary for providing consistent support to the resident.

In addition, the transition plan for the most recent admission to the centre could not be located for review by the inspector.

The inspector observed some minor issues with how the roster was maintained as it was not always evident which document represented the final, actual worked roster. For example, in the case of the October 2025 roster it was not evident from the different rosters available if all required shifts had actually been worked. A staff member found another roster on the computer which appeared to show that all shifts had been worked. It was unclear if that soft copy roster was the final roster

and it was not filed in the folder with the actual rosters. In addition, the December roster was not available for review in the centre. Therefore, the system for overseeing rosters required improvement, as it was not sufficiently robust to ensure they were consistently and accurately maintained.

Judgment: Not 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. Evidence of the insurance was submitted to the Chief Inspector as part of the application to renew the registration of this centre.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that a number of improvements were required to the governance and management systems in place at the time of this inspection. The key issues related to the effectiveness of the provider's auditing and oversight systems and arrangements, the arrangements in place for safe evacuation, and infrequent team supervision. Therefore, this regulation was found to be not compliant.

While there were arrangements in place for auditing the centre, the provider's auditing systems required improvement. For instance, the inspector found that issues highlighted at this inspection were not being captured through these audits. For instance, that notifications were not being submitted within prescribed time frames.

The requirement for improvement in staff training was a repeat finding from the previous inspection. However, the provider's audits did not identify the specific gaps found by the inspector, noting only that the training matrix had not been reviewed. Therefore, greater oversight was required in this area to ensure a safe and effective service was being provided to the residents in line with their assessed needs.

There were arrangements for provider-led unannounced visits to the centre every six months as per requirements of the regulations. The inspector reviewed the previous two visit reports which took place in May, and the draft report from the November 2025 visit. The inspector observed improvements in how these visits were being conducted in terms of evidence recorded and what was audited.

The last visit had taken place on 17 November 2025. However, at the time of this inspection, the draft report was not made available to the person in charge while it was awaiting sign off from a senior manager. This delay prevented the person in charge from promptly addressing identified issues, potentially prolonging risks to residents.

In addition, some inaccurate information was contained in the report, stating that there were no safeguarding incidents in the previous six months which was incorrect, which called into question the accuracy of the audit.

Medication audits were due to take place in the centre on a quarterly basis; however, quarter three and four of 2025 were not present for review on the day of this inspection. Therefore, it was not evident if those audits had taken place.

The inspector also observed that there was no emergency lighting located at the back or side of the property. In the case of a power outage at night this could make it very difficult to safely support residents to their final assembly point away from the building in the event of a fire.

Additionally, from a review of the team meeting minutes for 2025, only six were present with the last one taking place in August 2025. From this review and from communication with the staff on duty, team supervision was not being maintained, which had the potential to create a risk to consistency and staff knowledge.

For example, when speaking with two staff members they were not made aware of the last safeguarding incident that was submitted to the Office of the Chief Inspector of Social Services (The Chief Inspector). This demonstrated to the inspector that learning was not being shared with the team in a timely manner to ensure staff were up-to-date on important aspects that may impact on the residents.

Furthermore, from a review of rosters and communication with staff on duty, it was not evident if the person in charge was regularly present in the centre to provide oversight and informal supervision. This had the potential for issues not to be identified or dealt with in a timely manner.

While all four staff spoken with felt comfortable raising concerns with the person in charge and found them very approachable, those areas for improvement identified by the inspector demonstrated that the overall governance and management systems required significant improvement to ensure consistent oversight and safety.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date, accurately described the service provided and contained all of the information as required by Schedule 1.

For example, it contained information on how residents are consulted, and the specific care and support needs of residents that the provider intends to support in this centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had not ensured that all required notifications were submitted to the Office of the Chief Inspector within prescribed time frame and therefore this regulation was found to be not compliant. The provider had not ensured that a written report was provided to the Chief Inspector within the prescribed time frame at the end of each quarter of each calendar year in relation to all occasions on which a restrictive procedure was used.

The inspector found that the required notifications for seven out of 10 quarters of this registration cycle were not being submitted within the prescribed time frames. While these notifications were now submitted, it is important that notifications are submitted as required in order to ensure accurate and timely information is being provided to the Chief Inspector.

In addition, three notifications due to be submitted within three working days were submitted outside of those time frames.

Those identified issues demonstrated to the inspector that further improvements were required to the arrangements in place for submission of notifications, to ensure that notifications would be submitted as required and within time frames prescribed.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that the residents living in this service were supported in line with their assessed needs. However, improvements were required with regard to the regulations related to personal possessions, and general welfare and development.

There was insufficient evidence to suggest that two residents had regular access to opportunities for leisure and recreation external to their home. Additionally, two residents in particular did not have easy access to their own money which required improvement.

There were adequate systems in place to meet the requirements of the regulations associated with: healthcare, protection, and communication. For example, residents had access to allied healthcare professionals as required, such as a neurologist. In addition, they had recorded guidance for staff on how to facilitate communication.

There were sufficient arrangements in place to ensure residents were safeguarded in their home and community. For example, there was a designated safeguarding officer (DO) nominated for the organisation.

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

There were suitable fire safety management systems in place, such as periodic fire practice drills. While improvements were required to ensure that external emergency lighting was provided to aid residents safe evacuation in the event of a fire, this was actioned under Regulation 23: Governance and management.

Furthermore, the inspection found that there was a residents' guide that contained the required information as set out in the regulations.

Regulation 10: Communication

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

From a review of two residents' files they had documented communication guidance in order to support staff to better understand and facilitate communication in a manner suitable for the residents. For example, a 'pain assessment', 'getting to know me' document or 'who am I' document which guided staff to know how to tell if the resident was happy, sad, angry or in pain etc. For example, one resident's information stated that they can put their hands in the air when happy. Another resident's documentation stated that if they didn't want or like something that they might clamp their mouth closed and look away.

A staff member spoken with was very familiar with the residents' communication styles. For instance, when one resident was making a grinding sound with the mouth and making some bubbles the staff member explained that they were happy.

A review of staff training demonstrated that, the provider had arranged for the majority of staff members to receive training in communicating with people with an intellectual disability.

A family representative stated that they had observed staff chatting to their family member while on a visit and that their family member who uses non verbal communication was responding. They felt that their family member 'gets the care they need and that staff know how to get through to them even when their family member may not fully understand'.

The inspector observed some visual aids that supported residents' understanding and choice, such as pictures of food options.

Residents had access to phones, radio, personal electronic devices, televisions and the Internet while in the centre which would further support their communication and facilitate compliance with this regulation.

Judgment: Compliant

Regulation 12: Personal possessions

While residents had access to their personal belongings and there were systems in place to support their personal possessions to be safeguarded, two residents did not have easy access to their own money. In addition, there was a delay in transferring over another resident's account access from the designated centre they used prior to their move to this centre. Therefore, this regulation was found to be not compliant.

Two residents relied on their families for access to their own money and they did not have accounts in their own name. The residents were given an allowance by their families and had to request money from them if they wanted to purchase items or engage in paid activities that were not planned. Residents had not been provided with access to advocacy to explore this topic with them or on their behalf.

At the time of this inspection, another resident didn't have access to check their account balance, as the account had not been transferred over from their previous designated centre run by the same provider. This would prevent staff from verifying that the resident's spending records matched the actual funds in their account.

Judgment: Not compliant

Regulation 13: General welfare and development

While it was evident that two residents had regular access to opportunities for leisure and recreation, it was not evident for the other two residents. Based on the information presented to the inspector, this regulation was found to be not compliant.

From a review of three residents' daily record logs from 20 November to 24 December 2025, the inspector observed there was evidence of one resident engaging in a range of different activities as per their interests from attending sports clubs, visiting friends, and attending discos. From reviewing the records for the other two residents and from speaking with four staff members on duty, there was limited evidence to suggest that the residents had regular access to the community or engaged in activities of their interest.

Records for one resident across 17 dates showed frequent family visits. However, aside from attending their day programme, the only other recorded activities were going on four walks, helping decorate the house for Christmas, listening to music or watching television in their home. The review of the other resident's 12 recorded dates in their records, demonstrated that other than attending their day service programme, they had only left the house once to attend an appointment. Notwithstanding that, during that period they had received regular family visits. The records demonstrated that they had participated in limited in-house activities, for example watching movies, and having a foot spa.

Many gaps were observed in the recording of activities in all three residents' reviewed documents which made it difficult to verify if they had engaged in any activities on those dates. In the case of one resident, the inspector observed 21 out of 33 dates with nothing recorded to inform the reader if they participated in anything meaningful that day.

Furthermore, the centre did not have its own transport. It had access to a car owned by another centre. The car was not accessible for a wheelchair user who could not weight bear. The centre also had access to a wheelchair accessible bus. However, if the resident that was a wheelchair user was to use the borrowed bus it meant that there was no room for other residents. Two staff confirmed that approximately half the staff team did not drive. Without appropriate planning, this limited the residents' ability to access the community.

Judgment: Not compliant

Regulation 17: Premises

The layout and design of the premises was appropriate to meet residents' needs. The premises was found to be clean, tidy and in a state of good repair.

The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities.

Each resident had their own bedroom with sufficient storage space for their belongings. Bedrooms were observed to be decorated to suit their preferences and needs. For example, one resident had relevant equipment to support their mobility needs. Residents had personalised decorations and achievements displayed in their

bedrooms. For example, one resident had a picture hung on their wall of them participating in a sporting event.

There were facilities in place to support hand hygiene, such as hand wash in each bathroom, disposable towels in the shared bathroom, and residents that had their own bathrooms had individual towels for their use. There was a colour coded system in place for the cleaning that would help to minimise the chances of residents receiving a healthcare related illness. For instance, there were colour coded mops and buckets in place and they were found to be stored in a manner that would facilitate adequate drying of the equipment.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide available in the hall of the centre that contained the required information as set out in the regulations. For example, it described how people can be involved and consulted in their home.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, and firefighting equipment, each of which was regularly serviced.

The inspector observed that there was emergency lighting located internally and additional externally to the front of the property. As previously stated, while there was no emergency lighting at the back or side of the property, this was actioned under Regulation 23: Governance and management.

From a review of all four residents' personal emergency evacuation plans (PEEPs) it demonstrated to the inspector that there were fire evacuation plans in place for residents in order to guide staff as to evacuation supports required in the event of an emergency.

Monthly fire drills were completed in order to assure the provider that residents could be safely evacuated from the building at all times. From a review of five drill records, the inspector found that:

Alternative doors were being used for evacuation during practice drills to ensure residents could be evacuated from all areas. Additionally, a drill was completed during hours of darkness.

Fire containment doors were found to be fitted with self-closing devices, intumescent strips and cold smoke seals which would help contain a fire in the case of an emergency.

Judgment: Compliant

Regulation 6: Health care

The inspector found that residents were supported with their healthcare needs and had access to allied health professionals when required.

Two staff spoken with were knowledgeable in the areas related to residents' healthcare needs and supports required. There were healthcare plans in place to guide staff in order to provide consistent care in line with the residents' needs, for example. While one epilepsy plan required review to ensure accuracy of the information, this was actioned under Regulation 21: Records.

Residents were supported to access and receive vaccines when they were deemed recommended. For example, from a sample of two residents' healthcare records, the inspector observed that they were supported to receive a flu and COVID-19 vaccine.

Residents were found to have access to a range of allied health care services, such as a general practitioner (G.P), physiotherapist, psychiatrist, and speech and language therapist (SLT) when required. In addition, from the residents' records reviewed they were supported to have annual medical check-ups with their GP. This would facilitate any potential healthcare issues that may arise being identified and diagnosed in a timely manner.

Judgment: Compliant

Regulation 8: Protection

The inspector found, there were appropriate 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 February 2023
- the inspector reviewed the certification for eleven staff, this review demonstrated that staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a 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 and staff office.

There was one safeguarding incident since the last inspection and it was found that it was escalated, reviewed, and reported to the relevant statutory agencies. There was a safeguarding plan in place to minimise the chances of reoccurrence of incidents.

Both family representatives and all four staff felt comfortable raising concerns to the person in charge. At the time of this inspection, neither the family representatives nor the staff members spoken with had any concerns. Two residents spoken with said that they felt safe in the centre and if they were unhappy they would tell staff or a member of their family.

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.

From a review of the two 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 including preference of the gender of staff to support them in this area.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Teach Athasach OSV-0008547

Inspection ID: MON-0049185

Date of inspection: 06/01/2026

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: PIC will review the Training Matrix and Folder monthly going forward and set this as an agenda item for team meetings for updates. The PIC has put review schedule in place for staff training for purpose of effective oversight (8/2/26). The staff required training outlined in the report will be completed as follows :- • Clamping requested from HR on 8/2/26 • Cough etiquette and respiratory hygiene 17/2/26 • Hand Hygiene 14/2/26 • PPE 14/2/26 • First Aid requested from HR on 8/2/26 • Eating drinking and swallowing 18/2/26 • Manual handling requested from HR 8/2/26 • PETMA 7/2/26 • Fire Safety Training completed on the 8/2/26 • Nurse Manager will attend Teach Athasach Meeting re Medication on the 24/2/26 Matters relating to oversight of the actions above are dealt with under Governance and Management below.	
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Nurse on duty has reviewed the Epilepsy Care Plan and Medication Cardex (Updated 7/1/26).

Behaviour Supports and Staff Team to completed a review to include actions to respond to and support resident in relation to anxiety levels (17/1/26).
Behaviour Support Plans and review of same will be an Agenda Item for all Team Meetings – Next Team Meeting 24/2/26.

A Transition Plan was carried out for the most admission to the centre over the month of September 2025 – copy of same is now available on-site (6/2/26).

Going forward only planned and actual rosters will be in the Roster Folder.
Proposed Rosters, Adjustments and Actual Rosters will be submitted to the Operations Manager for oversight on a monthly basis.

Matters relating to oversight of the actions above are dealt with under Governance and Management below.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Schedule of Notifiable to HIQA has been completed (4/2/26).
All HIQA notifiable will be an agenda item on team meetings going forward (30/1/26).
PIC has confirmed with the Provider that quarterly HIQA notifiable will be returned on time (30/1/26).

The PIC has reviewed all training to identify any training gaps in order to ensure the accuracy of the matrix and that it reflects in the training certificates on-site (6/2/26).
PIC will schedule a review the Training Matrix and Folder monthly going forward and set this as an agenda item for team meetings (8/2/26).

The new emergency light has been installed (15/1/26).

PIC has confirmed with the Provider that the Medication Audits will be returned on time (30/1/26). Quarter 3 and 4 medications audits are now on site (4/2/26).

The Provider has address the issue re Team Meetings with the PIC.
The PIC has now scheduled Monthly Team Meetings as per the Services Policy.

The PIC has revised the times of the Monthly Team Meetings and reminded Staff that these meetings are mandatory (30/1/26).

PIC administration hours will now overlap with staff and residents to ensure that the PIC has a presence in the location re informal supervision, visibility and oversight (4/2/26).

The Compliance Tracker returns from this location is being monitored by Provider monthly.
This tracks internal 6 monthly / annual audit.
HIQA Action Plans for completion.

The Provider is conducting a review of the organisation's structures in relation to HIQA Compliance. In particular the review will identify how the organisational oversight can be more effective in identifying non-compliances in a more timely way.

The review includes –
• PIC Role & Responsibilities
• Use of Admin Hours
• Rosters
• Current PIC Structures
• Current Oversight Provision and Effectiveness
• 6 Monthly Audits

The Provider is working on this process with some actions underway and has identified the
1st April 2026 as the completion date for improvements.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Going forward the PIC will follow the Schedule for the Notification of incidents and ensure that they are submitted on time (4/2/26).

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
All residents inventory lists have been reviewed and updated (7/2/26).

Two residents are receiving support in discussing with their families around having access to their money (8/2/26).

Delay in transferring account access as a result of account issue rectified (11/2/26).

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Activity planner now in place generated by keyworkers in consultation with residents. PIC will ensure that planned activities and events are resourced (30/1/26).

Activities are a fixed agenda item on monthly team meetings for discussion and planning and allocation of resources (30/1/26).

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	18/02/2026
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.	Not Compliant	Orange	30/01/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	30/04/2026

	appropriate training, including refresher training, as part of a continuous professional development programme.			
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 inspection by the chief inspector.	Not Compliant	Orange	24/02/2026
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	24/02/2026
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	01/04/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support,	Not Compliant	Orange	01/04/2026

	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.			
Regulation 31(1)(b)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.	Substantially Compliant	Yellow	04/02/2026
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	11/02/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing	Substantially Compliant	Yellow	11/02/2026

	within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	11/02/2026