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:	Tralee Residential Services
Name of provider:	Kerry Parents and Friends Association
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	23 July 2025
Centre ID:	OSV-0003426
Fieldwork ID:	MON-0047567

About the designated centre

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

Tralee Residential Services is made up of three houses located in a town; one is a detached two-storey house, the second is a detached bungalow and the third is a two-storey building that is connected to a day services centre. This designated centre provides a residential service for a maximum of 11 residents of both genders, over the age of 18 with intellectual disabilities. Each resident in the centre has their own bedroom and other rooms throughout the centre include sitting rooms, dining rooms, bathrooms and staff rooms. Residents are supported by the person in charge, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 23 July 2025	08:10hrs to 18:35hrs	Lisa Redmond	Lead
Wednesday 23 July 2025	08:10hrs to 18:35hrs	Conor Dennehy	Support
Wednesday 23 July 2025	10:00hrs to 14:15hrs	Lucia Power	Support

What residents told us and what inspectors observed

This was an unannounced risk based inspection completed in the designated centre Tralee Residential Services. This designated centre comprised of three houses which provided full-time residential services to a maximum of 11 residents. On the day of inspection nine residents were living in the designated centre across these three houses.

This inspection was carried out following the receipt of an application to vary a condition of registration of the designated centre. In April 2025, the registered provider had informed the Chief Inspector of Social Services that following an emergency situation, they had identified difficulties in evacuating a resident from the first floor of their home. At this time, the registered provider indicated that they intended to transition the residents living in one of the centre's houses to an alternative premises approximately 35 kilometres away from their current home. This planned move was noted by the registered provider as a temporary relocation, as they continued to source a permanent home for residents in their local community. The registered provider had submitted the application to vary their registration conditions to remove the residents' current home from the footprint of the designated centre, and to add the new premises that residents intended to move into on a temporary basis.

Further information and assurances had been requested by the Chief Inspector to ensure that the proposed moved took into consideration the views and rights of residents, and that the new proposed premises was safe. There were delays in the receipt of this information which will be further discussed in this inspection report.

The purpose of this inspection was to seek these assurances with a view to progressing the application to vary to support the residents' proposed transition. Therefore, two inspectors only visited the house the registered provider intended to close, while a third inspector visited the provider’s head offices to review staff files. Overall, this inspection found that governance and management arrangements in place did not ensure that the service provided to residents was safe and in line with their assessed needs. It was also evident that the delays in the receipt of information requested by the Chief Inspector to progress the application to vary was not appropriate given the risks identified in the residents' current living environment.

Three residents were living in this house which was connected to a day service that was not part of the designated centre. A fourth resident had previously been living in this house. However, they had transitioned to another designated centre operated by the provider during 2024. It was indicated though that this former resident still attended the day services area so that they could keep in contact with their former housemates.

When inspectors arrived at the house to commence the inspection, they were let into the house by a staff member. Following a review of the electrics in this centre

by a competent person on behalf of the provider, the kitchen and one shower were no longer in use. Staff spoken with were aware of this. This staff member advised that one resident was having breakfast while the other two residents were in bed or being helped with personal care. It was later noted that the resident having breakfast at this time was having breakfast in bed. Staff members noted that this was the resident's preference and that this was supported by staff members as the resident had no identified support needs in relation to feeding, eating or drinking. Inspectors met with one of the other residents as they came downstairs. This resident did not interact significantly with the inspectors but they were noted to say "no toilet" or "no toilet working today" as they came down the stairs and went into one of the house's dining rooms.

This resident was followed down the stairs by a staff member who offered to make the resident breakfast. The resident briefly walked into the house's sitting room to pick up some magazines before returning to the dining room for their breakfast. After helping this resident with their breakfast, the same staff member went back upstairs to help another resident. Later that morning, an inspector asked the resident how their breakfast was. The resident responded by saying "nice" before again saying "no toilet working today". The resident also mentioned that someone "wasn't coming today" but the inspector was unclear who the resident was referring to. The resident then proceeded to read some magazines in the house's sitting room.

After supporting a resident to get ready for the day, a staff member was overheard to ask this resident to wait at the top of the stairs. The staff member then came down stairs and began to operate a stair lift and move it up to the top of the stairs for the resident to use. The staff member told an inspector that only this resident used the stair lift as their mobility had decreased in the past year. This resident came downstairs using this lift with two staff members present to support the resident. The resident was wearing a Manchester United bathrobe at the time, and they greeted both inspectors as they came down. The resident was then provided with a walker and was supported by a staff member to mobilise through a kitchen area towards a bathroom for a shower. Prior to its use by the resident, it was noted that the walker had been left near the bottom of the stairs in the doorway of a fire door that led to one of the house's dining rooms. This had the potential to impact the effectiveness of the fire door if required with some electrical equipment also present in the same dining room. This will be returned to later in this report.

After their shower, this resident was observed to be having their breakfast in the dining area. The resident appeared to be happy as they were observed smiling and laughing as they chatted with staff members and the inspector. The resident spoke about their plans to move to another house. The resident told the inspector that the reason they were planning to move stating 'kitchen gone'. When asked what they thought about the moved, the resident smiled. The resident spoke about plans to visit Killarney later that week to go shopping and have their dinner while there.

As the morning progressed, it was seen that staff from the day service entered the house via an interconnected door with such staff heard to greet two of the residents. After one of these residents had finished their shower they met one of the

inspectors again and shook his hand. The resident then seemed to be looking for someone before saying that something was "not working" but the inspector was unsure what the resident was referring to. A staff member then offered to make the resident breakfast which was accepted by the resident who again used their walker to mobilise into one of the dining rooms.

While completing a walk-around upstairs, it was observed that a resident's bedroom door was open as they ate their breakfast in bed. The person in charge entered the resident's bedroom to inform them that the inspection was taking place. At this time, the resident welcomed the inspector into their bedroom to say hello. The resident was observed sitting upright in their bed, eating their breakfast which was provided to them on a tray table. The resident took the inspector's hand noting that they had the same name as a staff member working in the centre. Staff spoken with noted that the resident liked to make connections in this way. The inspector explained they were in the resident's home to ensure they were happy and safe, and the resident was observed smiling as the inspector spoke with them. The resident was also met with when they were out of bed and moving around their bedroom. The resident smiled and hugged the inspector before walking towards one of the toilets on the first floor of the house. This resident was noted to walk slowly as they did so. A personal emergency evacuation plan (PEEP) for the resident highlighted that the resident would need to be encouraged to walk as fast as possible in the event that an evacuation of the house was required.

Soon after this, inspectors conducted an introduction meeting with the person in charge. After this it was observed that the three residents living in this house, had gone to the adjoining day services areas. These residents did return to the house for lunch along with some other day service attendees before going back to the day services area for the afternoon. In the final hours of the inspection, it was seen that all three residents had finished their day services and returned to the house and spent time in the communal areas of the house. As inspectors were reviewing relevant documentation at this time, their interactions and observations with residents during these final hours were limited. Staff members told inspectors that the residents had requested to go out to a restaurant for their evening meal, and staff members and residents were observed getting ready to leave the centre. When asked if they were looking forward to heading out for dinner, two residents smiled at the inspector.

Two of the residents did not communicate their view to inspectors about their plans to move to another house. Inspectors met with staff members supporting residents in their home throughout the inspection day. One staff member noted that residents had lived together in their home for a long time, and that the residents loved their home and their local community. This staff member had been involved in discussions with residents about the reasons for their move, due to the premises no longer being safe or suitable to meet the assessed needs of residents. The staff member noted that residents were happy to move as long as the three of them continued to live together. The staff member expressed that the resident previously mentioned as smiling and laughing as they spoke about their move as being 'delighted' about it. They noted that one resident had expressed that they wanted a big television for their new bedroom and that they wanted a friend to still be able to

visit them. The staff member stated that the resident was reassured that this would continue. According to staff, the third resident would move if the other residents moved.

At all times, residents appeared to be comfortable in the presence of staff members, with kind and respectful interactions being observed throughout the inspection day. The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Capacity and capability

This designated centre had previously been inspected by the Chief Inspector in January 2024. At this time, the registered provider had identified the suitably of the home of the three residents met with required review due to changing needs. At this time, there was a plan in place where the provider intended to source suitable accommodation in the nearby area to maintain the residents' relationships and routines. In response to this, the provider outlined that they had been searching for a new property for these residents. The registered provider had been at the closing stages of the sale of a house in 2024 however this sale had fallen through.

An incident had occurred in the designated centre in April 2025 where two residents required medical attention at the same time, which resulted in emergency services being called to support each of the two residents. Following this medical emergency, it took two ambulance crews to safely evacuate one of these residents from the upstairs bedroom in their home. The registered provider acknowledged that this premises was no longer suitable to meet the assessed needs of residents.

At this time, a provider assurance report was requested by the Chief inspector. A provider assurance report is requested when additional assurances are required to outline the actions taken, or to be taken by the registered provider to ensure the safety of residents and to meet regulatory compliance. The response received from the registered provider outlined a number of actions to be taken by the registered provider to meet regulatory compliance, ensure effective oversight and to ensure the safety of residents. Inspectors reviewed the actions outlined in this report as part of this inspection and found that a number of these had not been addressed by the registered provider as outlined. An urgent action was issued to the registered provider seeking assurances around the governance and management of the centre. This will be further discussed under Regulation 23, governance and management.

In response to the incident mentioned previously, the registered provider had made an application to vary the conditions of registration of this designated centre to remove the house visited on this inspection, and to add a temporary house for residents to live in while the registered provider sought a permanent home for residents in their local community. This application was made on 30 April 2025. Inspectors reviewed this application where it was identified that further assurances

and prescribed information was required to progress the application. These assurances and prescribed information were requested to outline that the premises the residents intended to transition to was safe. This included assurances that it met fire compliance. Multiple requests were made by the Chief inspector for this information to be submitted to progress the application in May, June and July 2025. However, adequate assurances were not received from the registered provider prior to this inspection taking place.

A meeting was held with the registered provider in June 2025 where the delays in the receipt of information being submitted to the Chief inspector were outlined. At this meeting, the registered provider outlined that governance arrangements at senior management level were reduced. It was noted that due to leave, only 1.5wte out of a 3.5wte was available to ensure oversight of the designated centre, with additional responsibilities including day services. At this meeting, management outlined that this posed a risk to the submission of information in a timely manner. On the day of this inspection, all but one member of the senior management team were absent due to various types of leave. The findings of this inspection identified that there was a lack of effective oversight from the provider in the designated centre, with evidence of actions not been addressed in a timely manner.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill-mix of staff was appropriate to meet the assessed needs of residents. As outlined in the designated centre's statement of purpose, residents were supported by a team of social care workers and support workers. When inspectors arrived at the house focused on during this inspection, two staff members were on duty. One of these had been a waking night staff while the other had been a sleepover staff. Such staffing arrangements were in line with the staffing arrangements for the house that were outlined to inspectors during an introduction meeting for the inspection with the person in charge.

The person in charge had ensured that there was a planned rota showing the staff on duty. This accurately reflected the staff members on duty on the inspection day. Inspectors reviewed staffing rotas were reviewed from the 01 March 2025 to 01 July 2025 and it was noted from these that core staff members were working in the house both day and night. The most recent statement of purpose provided indicated that 28 different staff were employed in the centre overall to work across all three houses. Although it was evident from a review of the rota in the centre that more than 20 staff members had worked in this house with residents in four month period, the staffing provided was consistent.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of a continuous professional development program. During the inspection, the training records of 12 staff members working in the house visited were provided in an electronic format. These records indicated that such staff had completed various trainings in areas such a safeguarding, medicines administration and first aid. Such staff were also listed as having done fire safety training but this will be returned to later in this report under Regulation 28 Fire precautions.

Judgment: Compliant

Regulation 21: Records

An inspector reviewed the provider's staffing files for their eight registered centres. The inspector reviewed these files at the provider's main office as all the files were stored in the central office. This was to ensure the provider was compliant with regulation 21(1)(a) - records of information and documents in relation to staff specified under schedule 2. The provider had given this permission to the inspector by prior arrangement.

The inspector reviewed a sample of forty eight files over the eight designated centres, these included staffing roles such as person in charge, care assistants, nursing and social care staff. The inspector also reviewed staff who had permanent and relief contracts of employment. All staff files reviewed had up-to-date Garda vetting which was furnished within a three year period. All other information as outlined under Schedule 2 was in the staff files. For example, contracts of employment, references, evidence of persons' identity, employment history and all other documents under Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that management systems in place in the designated centre meant that the service provided to residents was safe, appropriate to the residents' needs, consistent and effectively monitored. The

registered provider had not completed the actions outlined by the provider in the provider assurance report dated 23 April 2025. This included the following;

- The registered provider outlined that weekly safety meetings reporting to the director of services would be commence by 28 April 2024, and take place until residents moved to their new location. There was no evidence of these meetings taking place until the 23 May 2025.
- A monthly report on these meetings was to be completed with the chief executive officer for meetings with the board. The registered provider outlined that these would be completed by 28 April 2024. There was no evidence of these reports until a meeting held on 30 June 2025.
- The registered provider outlined that fire evacuation drills in the house visited by inspectors was to be increased to fortnightly, with a timeline for implementation outlined as 23 April 2025. Inspectors reviewed the record of fire evacuation drills occurring in the centre and it was noted that a drill had taken place on 13 March 2025 however there was no evidence of a further drill being carried out until 04 June 2025. At this time, the frequency of fire evacuation drills did increase to fortnightly.
- The registered provider committed to completing a review of the designated centre's safety statement with a timescale of 09 May 2025 provided. A total of five different safety statements were observed by inspectors in the designated centre. This included three 'site-specific' safety statements and two service level safety statements. Management in the centre were unsure which safety statement was the most recent however after some time it was identified that the site-specific safety statement dated February 2025 was the most recent safety statement. This had not been reviewed as outlined by the registered provider. It was also noted that one of the service-level safety statements had been documented as reviewed on the day of the inspection which was also not in line with the dates outlined in provider assurance report. It was also noted that the service level safety statement on the organisations online system was dated for review in July 2025, and was not the one provided to inspectors on the inspection day.

In addition, a risk assessment dated 08 May 2025 outlining the risk of fire in the property as 'high' was observed by inspectors. This risk assessment outlined deficiencies in the premises to include the fire detection and alarm system, emergency lighting, fire doors, and electrical certification which posed a risk for the decreased detection, subsequent slower evacuation and insufficient containment of smoke in the event of a fire.

It was evident that there was no plans to address these deficits in the centre, as the registered provider planned to transition residents to a new premises. Following the application to vary the condition of registration of the centre on 30 April 2025, further information and assurances were requested from the chief inspector to ensure the move takes into consideration the views and rights of residents, and confirmation of building compliance to include fire compliance. This was requested on 13 May 2025 however no response was received from the registered provider until 18 June 2025. This response noted that outstanding works and actions were required on electrical works, fire doors, fire detection and alarm system, emergency

lighting and fire-fighting equipment. It was noted that prescribed information to progress this application, and to provide assurances that the proposed new premises met fire compliance were not submitted before this inspection took place on the 23 July 2025. This was significant given the level of risk highlighted in the risk assessment dated 08 May 2025, and the findings of the periodic inspection report in the residents' current home in June 2025 (as mentioned under Regulation 17 premises). It was also noted that there was no evidence provided that this risk had been escalated to the registered provider's board of directors since March 2025, despite these meetings being held on a monthly basis.

Management and oversight systems in the designated centre included the centre's annual review and six-monthly unannounced visit reports. There was no evidence of a six monthly unannounced visit report having been carried out in the designated centre since April 2024. Management in the centre outlined that one had been completed in October 2024 however there was no documented evidence that this had occurred on the centre's online auditing schedule. It was noted that the annual review completed in December 2024 did not include any actions in relation to seeking an alternative residence for residents living in this house however, it did state that the premises was 'old' and that maintenance work was ongoing due to the age of the building.

An urgent action was issued on the day of this inspection under this regulation. The response received did not provide assurances that the actions outlined would ensure compliance with the regulations.

Judgment: Not compliant

Quality and safety

The registered provider had failed to ensure that residents living in Tralee Residential Services were provided with a safe level of service in line with their assessed needs and wishes. It was evident that continued delays in the receipt of assurances about the new premises combined with the evidence of non-adherence to actions and areas for improvement to be addressed posed a risk to residents. It was not evident throughout this inspection that residents' rights were protected and respected, and that they consulted and participated in the operation of the designated centre.

At the time of this inspection, residents could not safely use their kitchen. This impacted on residents' safety, and their right to make choices about mealtimes. An upstairs bathroom was also not in use due to risks identified which are discussed later in the report. Improvements were required to the oversight and management of the centre to ensure residents could live in a safe home that was safe.

Regulation 17: Premises

The registered provider had not made provisions for the matters set out in Schedule 6 of the regulations. A periodic inspection report of the electrical installation in the residents' home was completed by a competent person on 25 June 2025. This report identified that the quality of workmanship in relation to the electrics in the centre as 'poor'. As a result of this, the kitchen and an upstairs shower were not being used. Staff spoken with on the morning of the inspection were aware of this. A 'make-shift kitchen' had been made in a dining room where residents had access to microwaves, a kettle, toaster, blender and an air-fryer. The majority of residents' meals were being made in another house and transported to the residents' home where they could be reheated.

The building in which the three residents lived was an old building, and it was observed to be aged in terms of style and appearance. In areas of the house, it was not evident that the building was of sound construction or that it was kept in a good state of repair. For example, upstairs flooring was uneven in areas on route to the external fire escape. It was also noted that parts of the stairs appeared to be uneven and sunken. A downstairs bathroom was also observed to be in dis-repair with cracked tiles and broken fixtures evident.

Each resident had their own private bedroom located on the first floor of their home. Efforts had been made to personalise residents' bedrooms with photographs and personal items in line with their likes and interests on display. For example, a collection of C.D's and D.V.D's were observed in one resident's bedroom. There was also an armchair present where they could sit and watch their television.

Judgment: Not compliant

Regulation 28: Fire precautions

A monitored alarm system had been put in place following the incident where one resident experienced difficulties in evacuating their home in a medical emergency. In addition, a ski-pad had been purchased to support residents' evacuation. A system had also been put in place where a staff member wore a lanyard with emergency contact information while on duty. A staff member was observed wearing this lanyard on the morning of the inspection.

Despite these actions, the registered provider had not ensured that effective fire management systems were in place in the designated centre. This was evidenced on the day of the inspection as outlined;

- The house visited was provided with fire doors which are important in containing the spread of fire and smoke and providing for a protected evacuation route if required. Despite this, during the early stages of the

inspection, it was seen that one fire door was wedged open while the other had a walker in its doorway. Both of these would prevent the fire doors from operating as intended although it was seen that later in the inspection both the door wedge and walker had been removed from their initial location.

- For other fire doors in the house, it was seen that two fire doors had gaps under them and three other fire doors did not fit snugly into their doorframes. The locking mechanisms for some fire doors were also observed to be different compared to others and it was unclear if all locking mechanism offered a sufficient level of fire containment. Documentation provided related to the fire doors in the house visited was indicated as being valid until July 2016 and July 2019. It was also observed that two fire doors present in halls areas were not indicated on the floor plans for the centre.
- In the entrance hall of the house, it was seen that two different fire evacuation plans for the centre were on display on opposite walls. While these evacuation plans did contain some similar information, there was also differences in their content. For example, one stated staff were to close all the doors despite the upgrades to the fire alarm meaning that all doors would close automatically. It was also noted in one protocol that staff members were to call emergency services and another house to support the evacuation of residents. The second protocol stated that the alarm system was now being monitored by an external company who would contact the other house in the event of an emergency to support the residents to evacuate. This required review to ensure the guidance provided to staff members was consistent and correct, and did not delay the evacuation of residents given their assessed needs.
- An enhanced fire safety protocol for the centre had been developed. It was noted that this protocol outlined a number of measures that were not in place in the designated centre. For example, it indicated that all staff working in the centre were to undergo fire warden training every six months. Training records provided for 12 staff of the house inspection indicated that this was not occurring. The records provided did indicated though that the staff did undergo some fire safety training but an inspector was informed that this alternated between practical training and online training. It was also indicated that the practical fire safety training given was valid for two years.
- In addition, the registered provider had indicated that centre specific fire evacuation training would be provided for all staff in the centre by 30 May 2025. Records reviewed during this inspection indicated that eight of 12 staff working in this centre had received such training on 12 May 2025. As such not all staff working in this house had completed this training at time of inspection. This included a staff member who worked regularly in the house at nights.
- A make-shift kitchen had been made in the dining area to provide light meals for residents in response to the kitchen no longer being in use. This area contained electrical equipment such as a kettle, toaster, air-fryer and microwaves. There was no evidence of fire-fighting equipment in this room. However, a H2O fire extinguisher was located in the hallway outside this door. A carbon dioxide extinguished was also located at the opposite side of this hallway, outside the laundry room. A staff member spoken with told inspectors that in the event of an electrical fire in the make-shift kitchen area,

they would use the H2O extinguisher. It was noted that this type of extinguisher was not suitable to be used in an electrical fire.

Judgment: Not compliant

Regulation 6: Health care

Each resident must have a personal plans in place which are intended to set out the health, personal and social needs of residents. Such plans should be informed by comprehensive assessments of needs that must be carried out to reflect changes in need and circumstances. During this inspection, the personal plans of two residents were reviewed. From these it was noted that there was a clear assessment process which covered various resident needs including their health. Where a need was identified in such areas, a corresponding support plan was put in place to provide guidance for staff in meeting this needs.

It was noted such support plans and corresponding assessments were noted to have been reviewed in recent months and took account of some recent health related incidents for these residents. These residents had also been supported to available of health reviews following this incidents based no records reviewed. It was also noted that a record of one resident's recent health check was incomplete and some of the information that was in the record seemed inconsistent with other records reviewed. The person in charge indicated that this health check had been conducted by a general practitioners who had no concerns about the resident.

Judgment: Compliant

Regulation 9: Residents' rights

As previously mentioned, assurances had been sought to ensure that the proposed move included the views and rights of residents. When the registered provider outlined their initial plans to transition to residents to the new premises following the residents' medical events, it was communicated that residents were not aware of the proposed move. Although inspectors had been advised in June 2025 that residents had been informed of the plans, and that the will and preference of residents had been documented, there was no detail provided as to what the view of residents were. This had been requested as the inspection in January 2024 had identified that it was important that residents continued to live in their local community to maintain relationships. At the introductory meeting, inspectors were informed that this was documented within residents' transition plans.

When reviewing the transition plans provided, it was not documented if this proposed move was in line with residents' will and preference. In the provider

assurance report response submitted in April 2025, the provider had indicated that some specific meetings would take place with residents and their families around the proposed move. One of these meetings was stated as being used to establish what residents' will and preference in relation to the move was. Records reviewed made reference to such meetings taking place but it was unclear what residents' will and preference was. Inspectors specifically requested notes of such meetings on multiple occasions during this inspection but none were provided. As such, no documented recording were provided around residents' will and preference about the proposed move.

It was acknowledged though that notes of regular resident meetings that occurred in the house visited. These made reference to the proposed move being discussed with residents and it was noted that resident was recorded as looking forward to the move and that another resident was happy with this. One resident spoken with during this inspection also indicated that they were looking forward to the move. Resident meeting notes were reviewed for May, June and July 2025 and these also made reference to resident being informed about the kitchen and bathroom issues affecting their home as well as other matters such as fire safety.

The transition plans for all three residents were reviewed during this inspection and it was noted that the content of the plans for all three residents were largely the same. It was also observed that transition plan for one resident was a folder for another resident and vice versa. The transition plans reviewed did contain relevant information related to residents' proposed transition elsewhere such around their health support and visits to the premises that residents were intended to transition to. However, from the three transition plans, it was unclear what the exact status of the transition plan. For example, while the transition plan did reference residents driving by the proposed premises, it was unclear when residents would actually visit premises. When queried, it was indicated by the person in charge that resident had gone to visit this premises twice and last went there earlier in July 2025.

It was highlighted though that residents had not actually gone into the proposed premises as it was awaiting a deep clean with the person in charge also highlighted that this premises was unfurnished and that there was some floor damage also. The person in charge did indicate though that residents had been shown photographs of the inside of the premises and that an easy-to-read document was being created to help residents with this move. When queried, it was clarified by the person in charge that this easy-to-read document was in a draft format and so had not yet been shown to the residents at the time of inspection.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tralee Residential Services OSV-0003426

Inspection ID: MON-0047567

Date of inspection: 23/07/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Weekly safety meeting are in place and will continue until the residents' transition to the new premises. Monthly reports to the board are in place apart from August 2025 where no board meeting will be held due to Annual Leave. Fortnightly fire evacuations are all scheduled identifying different scenarios for evacuation. The safety statement for the DC has been reviewed and updated. The service safety statement will be reviewed when the CEO returns from Annual leave.

All 3 ADOS`S have returned from leave to their posts.

Funding for additional ADOS and clerical grade 4 has been secured for a period of 12 months to enhance senior management oversight. Proposal to assign responsibility for Day Services to one ADOS, leaving the remaining three to support residential and respite services with a regional model of North and South of the County.

The ADOS department has a reporting structure in place to escalate if actions are not going to be completed in time. The additional administrative staff will support the Services department to review action plans regularly to highlight deadlines. The administration staff or ADOS colleague will monitor ADOS emails while on leave to identify actions required. Protocol around the escalation of red risks to be developed and circulated to ensure that risks are escalated to the provider's board of directors.

Red risk to be discussed at Operations meetings monthly, or more frequently when required. The provider will develop a contingency plan in the event that the capacity of the senior team is impacted by unplanned and significant absence. A number of actions are in progress for the fire and electrical works in the new premises in order for the residents to safely transition there, a time limited action plan will be developed to complete any outstanding works as per the fire engineers report.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The plan is that all residents will be supported to transition to a new home as an interim measure for their safety. While the residents remain in their current residence, weekly health and safety meetings will continue and fortnightly fire evacuation drills will continue with different scenarios and conditions which provide opportunities to review and improve procedures based on feedback and observations. The Fire Engineer has completed the inspection report for the new residence and has commenced the inspection for the remaining two houses in the designated Centre on the 21.8.2025. A number of actions have been progressed from the Inspection Report for the new residence and the deep clean is scheduled to take place on the 27.8.2025. The provider is actively looking for a residence in the resident's local community so that they can return to their community in Tralee. The residents will be informed and involved in all stages of this process. The current house will be put up for sale to support the purchase of a new home for the residents locally. The provider will ensure that the designated centre is kept in a good state of repair and will request maintenance input when required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC has informed all staff by email that wedges are not to be placed on any doors to keep them open, signage has also been put in place to enhance this. The older version of the fire evacuation plan has been removed and the correct updated version is now the only one on display. The enhanced fire protocol that was developed has been reviewed and updated. Additional fire safety training was facilitated on 13.08.25, all permanent staff are now trained, and there are 3 outstanding relief staff who require this training. A copy of the Fire Evacuation plan has been circulated to all staff. A fire blanket and an additional Powder extinguisher was placed in the temporary kitchen near the electrical equipment. Additional signage has also been put in place. A number of actions are in progress for the fire and electrical works in the new premises in order for the residents to safely transition there, a time limited action plan will be developed to complete any outstanding works as per the engineers report.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All residents have been to visit the new home, they have all been involved in purchasing new items for their new home. Transition plans have been further developed to explore further the residents' individual will and preference. Easy read documents have also been

developed to support each resident. Each resident has a scrap book to support them individually with their transition plan. The individual transition plans now include the Consent Journey for each resident. The provider will ensure that they remain connected to their community by accessing their day service and accessing social activities, and maintaining their natural supports in their community. The Provider is actively looking to purchase a residence in their local community. Residents will be kept informed and involved in this process.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	29/04/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2025
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	Red	28/07/2025
Regulation 23(2)(a)	The registered provider, or a	Not Compliant	Orange	19/09/2025

	person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	29/04/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	19/08/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Not Compliant	Orange	31/08/2025

	and control in his or her daily life.			
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	31/08/2025