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:	Camphill Community Dingle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	21 March 2025
Centre ID:	OSV-0003609
Fieldwork ID:	MON-0046650

About the designated centre

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

The designated centre is a large detached two-storey house located in a rural area outside a small town. The centre can provide residential services for a maximum of eight residents of both genders, over the age of 18. Residents with mild to moderate intellectual disabilities, physical disabilities, sensory disabilities and autism are supported. Support to residents is provided by the person in charge, a team leader, social care workers, social care assistants and volunteers. Each resident has their own bedroom. Other facilities in the centre include bathrooms, a sitting room, a dining room, a kitchen, a utility room and a staff office.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Friday 21 March 2025	09:15hrs to 18:50hrs	Kerrie O'Halloran	Lead
Friday 21 March 2025	09:15hrs to 18:50hrs	Lucia Power	Support

What residents told us and what inspectors observed

Following the receipt of unsolicited information of concern to the Chief Inspector of Social Services, this unannounced risk inspection was completed. The inspection was focused on different areas related to the information received. The most recent renewal of the registration of this designated centre had occurred on December 2022. This designated centre was last inspected in October 2023.

The centre was comprised of a large detached two-story house located in a rural setting. Residents living in the centre had access to amenities including a working farm, gardens and a day service building. The centre could accommodate up to eight residents and also accommodated volunteers that lived in the centre as part of the model of care provided by the service.

On arrival to the centre the inspectors were greeted at the gate by a volunteer who was leaving the designated centre to attend their work in the day service. The inspectors introduced themselves and proceeded to the centre. The inspectors met a resident who was in the hallway of the centre and the inspectors then introduced themselves to a member of staff and showed them their identification. The staff member asked the inspectors to sign in to the centre's visitors book.

The inspectors were introduced to the team leader. The staff members on duty were seen to be wearing face masks. Prior to the inspection the centre had notified the Chief Inspector regarding an outbreak of flu like symptoms for some residents. The inspectors followed the guidance of the centre's management and wore face masks when required during the inspection.

The team leader completed a walk around of the designated centre with the inspectors. On the day of the inspection seven residents were living in the designated centre. Throughout the course of the inspection day the inspectors had the opportunity to met the six residents. Some residents attended the day service, while others were seen to have a later start to the day. The team leader informed the inspectors that the centre currently had one vacancy.

Some residents independently walked to the farm and day service building and were observed to enter and leave the centre as they wished throughout the day. Other residents had one-to-one staffing in place to support them as per their assessed needs. The inspector met a resident who was relaxing and watching some television as they were feeling unwell that morning. Later in the afternoon the inspectors met three more residents. One resident enjoyed gardening. They told the inspectors they were happy and liked living in the centre. The resident appeared very happy and content in their home. They were very pleased to talk about their gardening.

One resident spoke to the inspectors for a period of time about their life at present, new activities they had started and issues they were having at times while living in the centre. The resident spoke to the inspector and they stated they felt their

medicines time was affecting their new activities and they had discussed this with staff in the centre. The resident said they were happy living in the centre and treated well by staff in the centre. The resident told the inspectors they attended house meetings regularly, however they found them to be short at times. They also informed the inspectors they were hoping to move in the future.

The inspectors saw two residents' bedrooms. They were seen to be decorated in line with the residents' own preferences. The centre was seen to be homely. Pictures and art work were present throughout the centre. Some areas of the centre required review as they were observed to require maintenance, such as the laundry room area. Washing machines and dryers here had broken drawer covers and panels. The downstairs bathroom was out of order on the day of the inspection and, as identified by the provider, it required repair. Areas of the centre required attention to ensure they were kept clean, for example, a bin in the upstairs bathroom was overfull and a loose disposable glove was left beside the bath area.

The inspectors did not get the opportunity to speak with on duty staff directly during the inspection, however staff in the centre were observed to interact with residents positively. Staff appeared to be familiar with the residents and interactions were observed to be respectful.

During the course of the inspection, an inspector completed a second walk about of the premises. During this, the inspector met a person who informed the inspector that they were a staff member in the designated centre and were off duty on the day of the inspection. During the conversation with the inspector it was identified that two staff members were living in a registered bedroom in the designated centre. As the centre currently had one vacancy this room was being used to accommodate the staff members. The staff members had access to a living, dining and kitchen area which was located in the designated centre and also used by two volunteers that also lived in the centre. While this had been done with good intentions to improve staff resources, it did raise a concern as to whether the provider was fully aware of the requirements of the Health Act 2007.

As mentioned earlier, the centre had volunteers in place. These volunteers also lived in the designated centre. The provider had a contract in place with these volunteers that identified their hours to be worked each week and their terms and conditions. The volunteers were identified to cover some evening shifts on the roster of the designated centre and also worked in the day service building near the designated centre.

In summary, from what residents told inspectors and what the inspectors observed, while some residents engaged in activities they enjoyed, ongoing improvements were required in relation to governance and management, staffing, staff training and development, statement of purpose, individualised personal plans and care plans, health care, protection and residents rights. Such matters will be discussed further later in this report. The provider was issued with an urgent action regarding two regulations which will also be discussed later in the report.

The next two sections of the report present the findings of this inspection in relation

to the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection of the designed centre.

The provider had management systems in place that were not consistently overseeing and monitoring residents' care and support. Inspectors found that while some provider audits were occurring as required, such as an annual review and six monthly provider unannounced visits, actions arising from these were not consistently completed within the identified time lines. In addition, centre based audits had not identified all compliance issues raised to the provider during this inspection. A number of actions in place from these centre based audits had not been completed within the providers own identified time line.

Due to the findings on this inspection, the registered provider was requested to submit an urgent compliance plan with regard to the governance and management of the designated centre. This will be discussed under Regulation 23.

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 inspectors reviewed a sample of the rotas in place for the designated centre from October 2024 to the end of March 2025. From the rosters reviewed the full staffing compliment for the centre was not in place as per the centre's statement of purpose. On the day of the inspection, the centre had five staff team members, one team leader and one person in charge. As outlined in the centre's statement of purpose, the full staffing in place would be 11.5 full-time equivalent staff members, one team leader, one house co-ordinator and one person in charge. Therefore the centre had a large staffing deficit.

In order to maintain staffing levels in the centre, agency staff was seen to be used on a weekly basis. For example from 2 December to 15 December 2024, five agency staff were used to cover shifts. The person in charge and team leader discussed with the inspectors that the centre did not have a consistent staff team in place, with agency staff being used weekly in the previous months. The team leader discussed that they tried to maintain consistent agency use to provide continuity in the centre but this was not always possible.

The centre had two volunteers in place in the centre. These volunteers also covered shifts in the designated centre. The inspectors were informed that the volunteers were present in the centre each night as support for staff and residents in the event of an emergency taking place. However, from a review of the rotas in place it was not documented that the volunteers were present in the centre each night. For example for the rota reviewed from 10 March to 23 March 2025 did not indicate hours that both volunteers would be present for each night.

Three residents in this centre required one-to-one staff support while there could be up to seven residents residing in the centre at the time of the inspection. From the review of the rosters it was mainly seen that three staff were on duty during the day in the centre. For example from 10 March to 20 March 2025, three staff were on duty by day, while one staff was rostered for night. These staffing levels in place did not provide assurance that all one-to-one staff support could be maintained while supporting four additional residents. It was noted though that some residents were very independent while not all residents used the centre seven days a week.

Judgment: Not compliant

Regulation 16: Training and staff development

An inspector reviewed the training matrix which indicated twelve staff members (including some agency staff working in the centre) had completed a range of training courses to ensure they had the appropriate levels of knowledge skills and competencies. This training included managing behaviour that is challenging, manual handling, medicines management, infection prevention and control, and safeguarding of vulnerable adults.

All of the staff team had completed training in fire safety. Where refresher training was required staff had been identified and would be booked into the next available training dates. For example, one staff was awaiting manual handling training and another staff was awaiting medicines management training.

The team leader had provided support and formal supervision to staff. However, the team leader had not received supervision in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider's management systems within the designated centre had not ensured the service provided to residents was safe, appropriate to the assessed needs of residents, consistent and effectively monitored. In particular, improvements were

required in the following:

- The registered provider had not ensured that appropriate action had been taken to come into compliance with the regulations following the inspection completed in Camphill Community Dingle October 2023. A number of actions from the compliance plan received were not completed in the time line identified by the provider. For example, the provider had identified that by April 2024 identified actions from internal audits would be consistently monitored to ensure the centre stays on track with compliance plans, audits and provider six monthly unannounced visits. This consistent monitoring and oversight was not seen on the day of the inspection as a number of actions were overdue.
- The designated centre had a certificate of registration displayed which had expired in December 2022. As per Section 56 (1) of The Health Act 2007 a designated centre shall ensure that the certificate of registration issued for the centre is displayed in a conspicuous place at the centre.
- The registered provider had breached Condition 1 of the designated centre's conditions of registration. This was due to the living arrangement of staff members within the designated centre. The designated centre registration was last renewed In December 2022, this was done so against the centre's statement of purpose and floor plans. The floor plans identified eight residents bedrooms. The statement of purpose has no reference to staff using one of these identified bedrooms therefore this was contrary to the information provided in the centre's statement of purpose and Condition 1 of registration. This was discussed with the management of the centre on the day of the inspection.
- Six-monthly unannounced visit had been completed by representatives of the provider in the designated centre in June 2024 and January 2025. Repeated actions had been identified on these internal audits and/or had not been addressed in a timely manner at the time of this inspection. For example, in June 2024 an issue with was highlighted in the provider's unannounced visit around the quarterly care and support audit that had been completed. In January 2025 the audit was identified as was not compliant and to be completed by 23 January 2025. A care and support audit was completed by the person in charge on the 11 March 2025, however this audit had identified actions which had not been completed within the time frame. On the day of the inspection following a review of four personal plans not all areas that required action had been identified. These included identifying actions required to support residents with their health and support related assessments.
- The registered provider had an audit schedule in place for internal audits to be completed in the centre. These audits included infection prevention and control audits, medicines audits, safeguarding audits, risk management audits, care and support audits. From a review of these audits it was seen that some audits had not been completed. Audits which had been completed had action plans in place but some identified actions had not been completed within the identified time line indicated by the provider. Therefore, there was no assurance on the day of the inspection to demonstrate that the provider had oversight in relation to the actions and follow up identified in their action

plans, nor was there evidence that reviews had taken place in line with their identified time lines.

- It was noted that audits completed did not identify the repeated non-compliance with the regulations in relation to individual assessment and personal plans, fire precautions and staffing. These issues had been identified during the previous inspection of the centre in October 2023. For example, it had been identified in the previous inspection that some audits were not being carried out and administration duties were being affected due to staffing issues in the centre.
- The provider's audits had not identified issues with personal information files of residents being unorganised, containing out of date information and ensuring up to date information was in place for residents and staff to access. For example, resident's files were not kept up-to-date in an accessible format and not all information was available for staff to access, such as an open safeguarding plan.
- An annual review had been completed in January 2025. The report indicated that a safe and good quality service was being provided. Not all improvements required had been identified as an action following the review. For example, the annual review identified a copy of the Health Act 2007 needed to be made available to all staff however, this was not on the action plan. The annual review also did not include details of consultation with residents had their representatives. It did reference in one part of the review that family members who were consulted and noted the high staff turnover and agency use, however they did express the caring staff team in place.

It was not evident on the day of the inspection that the management and oversight systems were in place to have effective oversight of the centre. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response was received by the Office of the Chief Inspector on 27 March 2025.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspectors reviewed contracts in place for the residents that were living in the designated centre.

The service had individual contracts in place for residents which clearly outlined the terms and conditions in the designated centre. It also included information such as the contribution residents were paying.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre. This required review to ensure the centre was operating as per Condition 1 of their registration.

- The centres staffing profile identified in the centres statement of purpose did not reflect the staffing in the centre on the day of the inspection. For example, the staffing profile identified one team leader and one house co-ordinator was in place.
- The statement of purpose did not include the current registration conditions for the centre.
- The statement of purpose did not include details of staff members that were living in a registered bedroom of the designated centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not ensured the Chief Inspector had been notified in writing within three working days of all adverse incidents. Following a review of the fire evacuations completed in the designated centre in 2024 and 2025, it was evident at that four incidents had not been reported in line with regulatory requirements. These were four unplanned fire evacuations that had taken place in the designated centre which had not been reported to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. There was a designated complaints officer nominated.

The inspectors reviewed a sample of complaints for the designated centre in 2024 and 2025. These had ensured the satisfaction of the complainant had been recorded.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies required under Schedule 5 were in place. However, three of these policies were in date on the day of the inspection. 17 of these policies had exceeded the three year review period by the provider. These included:

- Prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies had been due review since 30 November 2023
- Incident where a resident goes missing had been due review since 21 December 2023
- Provision of intimate care had been due review since 7 February 2024
- Provision of behaviour support had been due review since 7 July 2024
- Residents' personal property, personal finances and possessions had been due review since 19 January 2025
- Communication with residents had been due review since 25 February 2024
- Visitors had been due review since 16 February 2024
- Recruitment, selection and garda vetting of staff had been due review since 16 July 2023
- Staff training and development had been due review since 23 march 2024
- Monitoring and documentation of nutritional intake had been due review since 11 February 2024
- Provision of information for residents had been due review since 5 February 2021
- The creation of, access to, retention of, maintenance of and destruction of records had been due review since 21 December 2023
- Health and safety, including food safety, of residents, staff and visitors had been due review since 14 December 2023
- Risk management and emergency planning had been due review since 27 December 2024
- Complaints had been due review since 15 March 2025
- Access to education, training and development had been due review since 15 January 2024
- Closed circuit television (CCTV) in designated centres had been due review since 8 January 2024.

The inspectors had also noted that some of these policies had exceeded the identified review date had been signed by staff members. For example, staff had signed the intimate care policy in February 2025, although the policy was identified for review in February 2024.

Judgment: Not compliant

Quality and safety

Residents were being supported to engage in activities that they enjoyed. Further action was required to ensure that improvements were completed in relation to care and support so that residents were in receipt of a safe and good-quality service.

Residents were not being protected by the procedures and practices relation to protection in this centre. The centre had one open safeguarding plan in place during the inspection and this plan was unavailable for staff, yet other closed safeguarding plans were in place in residents' files.

In line with findings of the previous inspection, inspectors found that the systems in place for residents' individual assessments and personal plans and fire precautions was inadequate and required significant review.

Due to the findings on this inspection the registered provider was requested to submit an urgent compliance plan with regard to residents' rights. This will be discussed under Regulation 9.

Regulation 28: Fire precautions

Fire-fighting systems were in place including a fire alarm system, fire doors, fire extinguishers, and emergency lighting/signage.

There was a procedure in place for the evacuation of the residents, volunteers and staff on duty in the centre.

The inspectors requested to review the fire evacuation drills that had taken place in the centre in 2024 and 2025. It was evident that planned fire drills were not being completed as per the provider's policy. For example, one planned fire evacuation drill had been completed in October 2024, which was completed for staff training. One unplanned evacuation took place in March 2024, two in August 2024 and one in March 2025.

The provider had also not ensured that fire drills had taken place in the designated centre to ensure all residents could be evacuated safety with the minimum staffing in place.

Each resident had a personal emergency evacuation plan (PEEP) in place which provided guidance to staff on the arrangements and supports required to ensure a safe evacuation from the centre. It was documented in three of the personal emergency evacuation plans reviewed that these residents required one-to-one staffing support to evacuate in the event of an evacuation. However, as noted under Regulation 15 Staffing, this was not evident from rotas reviewed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed four residents' personal plans. Personal plans were kept in a locked cabinet in the office and the provider also had an online system in place for staff to complete reviews for personal plans. The team leader informed the inspectors that all staff had access to the residents' plans online so that they could be reviewed and updated. Once this was completed updated information would be printed and placed in the residents' folders. This would ensure volunteers who worked in the centre could access up-to-date information regarding care and support required for residents.

The personal plans viewed were not seen to be regularly reviewed and updated to reflect changes in the residents' lives. For example, one plan identified voluntary work and classes one resident participated in, however these activities were no longer taking place for the resident.

Residents' personal plans were not available to them in an accessible format. Each resident had personal plan files in place, however on the day of the inspection these plans did not contain all information relating to the residents in place or updated information in place. For example, interests and hobbies documented for one resident was volunterring at a local shop however this was no longer taking place. Inspectors reviewed some information regarding residents' personal plans on an online system, however this also did not reflect that reviews had taken place. For example, residents' goals had not been documented regularly. For example, one resident had a goal in place to make their own appointments. This goal had been put in place in January 2024, steps had been outlined for the resident to achieve the goal. However, the goal had only two documented recordings, with no other information.This goal was not clearly recorded to identify if it had been completed.

The inspectors had been informed regular key worker meetings take place with residents. These meetings were not seen to be available in the residents' files. The inspectors saw that some residents had monthly meetings recorded on the online system in place. In one resident's February 2025 key worker meeting, goals had been discussed, this identified the resident had commenced to attend a running club which took place weekly. However, this had not been documented as a goal in the resident's personal plan.

Judgment: Not compliant

Regulation 6: Health care

The inspectors reviewed the health care supports in place for residents.

From the four personal plans reviewed, the inspectors found that the residents were not being supported with their identified health care needs. Residents had identified

health care needs but no information was available in residents' plans to inform staff on the supports residents required. For example, a resident had diabetes. No documented evidence was available on how the resident is being supported and how the provider was ensuring this resident's health was being monitored and maintained.

Another resident had a weight increase since the previous inspection in 2023. Both the person in charge and team leader had recognised this weight gain. No weight recording charts were in place for this resident. The resident also attended regular physiotherapy appointments which recommended daily exercises to be completed by the resident. The inspectors reviewed the daily notes of the resident for a three week period.It was seen that these exercises were recorded as being completed on three days over these three weeks.

On review of the residents personal plans, there was no evidence of national screening programmes being offered or availed of to residents who were eligible for such screening services.

Judgment: Not compliant

Regulation 8: Protection

The designated centre had ensured that incidents of safeguarding nature had been reported to the national safeguarding office and notifications had been submitted to the Chief Inspector. The inspector reviewed the safeguarding plans in place for the designated centre. The centre had one open safeguarding plan. The interim safeguarding plan was not in place in the resident's file. The inspectors reviewed the interim safeguarding plan on the online system and were informed that managers only had access to this. The safeguarding plan identified controls in place to ensure the resident was safe. When the inspectors spoke to the person in charge and team leader it was evident that the staff team had not been made aware of the safeguarding plan in place. The inspectors were informed it had not been discussed with the staff team at the time of the inspection. This safeguarding plan had been reviewed on the 6 February 2025.

While inspectors were reviewing personal plans, the inspectors saw interim safeguarding plans were in place in resident's multi-disciplinary folders. For example, one resident’s multi-disciplinary file had an interim safeguarding plan in place which was dated 4 October 2023 and had a review date of 24 October 2023. The inspectors spoke to the team leader who confirmed this plan was closed.

The person in charge and team leader spoken with during this inspection demonstrated a awareness of how and who to report safeguarding concerns to. Training records provided indicated that all staff had completed relevant safeguarding training.

During the inspection, the inspectors met a staff member who was living in the

designated centre. It was identified that two staff members were living in a bedroom of the designed centre. The provider had not identified this as a risk of safeguarding.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were supported to exercise choice and control in their daily lives. Residents choose the daily activities they would like to complete. If a resident requested not to complete an activity this was respected. The inspectors had the opportunity to meet six of the residents living in the centre. Some residents informed the inspectors they were happy living in the centre. During the inspection day, some residents attended the day centre which was located in a different building next to the centre. The inspectors spoke to a resident who had declined to attend the day centre in previous weeks prior to the inspection and this choice was being respected. Other residents were supported to the shop or for a walk during the day.

However, resident's rights were impacted. This was due to poor staffing levels and residents not having a voice in the running of the designated centre. The provider had also not identified areas that were affecting the rights of the residents.

Residents had not been consulted with in relation to how their home was run. The provider had moved two staff members into the residents' home. These staff members moved into the designated centre on the 20 December 2024. The person in charge provided inspectors with a residents house meeting that took place on 17 December 2024. This meeting informed residents two people would be moving into the centre on the 20 December 2024 and they would be working in the centre to support residents. Staff living in the centre had access to the designated centre laundry facilities, along with use of a kitchen, dining and living room when they were not on duty.

From a review of the residents' contract and the staff living in the centre contracts it was seen that residents were paying contributions to live in the centre that were substantially higher than the rent that was required to be paid by the staff members.

On arrival to the centre, the inspectors observed that all residents' personal emergency evacuation plans were placed on a folder in the communal hallway of the centre. This contained personal information for each resident. However, this required review to ensure the resident autonomy.

Inspectors were not assured that the centre ensured that the rights of the residents was consistently and effectively monitored. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response was received by the Office of the Chief Inspector on 27 March

2025.
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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Camphill Community Dingle OSV-0003609

Inspection ID: MON-0046650

Date of inspection: 21/03/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
A full review of the staffing compliment required in the service has been completed by the Person in Charge and the Head of Services. Additional staffing is now in place to ensure all residents are adequately supported throughout the day and at night. This included the allocation of four staff during the day, increasing to five where required. In addition, an additional staff is in place at night to ensure adequate supports are in place in the event of an emergency.

A full review of the Statement of Purpose and Function has been completed and now reflects details relating to the staffing and roles associated with the service.

A number of staff also work additional hrs to ensure consistency with care provision.

A review has been carried out to identify appropriate skill mix and profile of staff team to ensure appropriate supports are in place for residents each day.

All agency staff are supported with a comprehensive induction to ensure their awareness and understanding of the needs of the residents. All agency staff are also supported with supervision in line with CCoI organisational policy, this has been further enhanced to supervision being provided on a 6-weekly basis.

All agency staff have a full schedule file in place prior to attending the service.

Since the inspection on 21/03/2025, two new staff members have onboarded and a further two interviews are scheduled for week commencing 28/04/2025. The service also utilises three consistent agency staff who are being supported through the organisational induction, training and supervision processes.

The service continues to work closely with the HR Department and the Marketing Lead with a view to recruiting staff in line with the Statement of Purpose.

Where there are volunteers in place supplementing the support in place for residents with meaningful activities and also support with fire evacuations at nighttime, this is now reflected on the rota and available to staff and residents.

Bimonthly audits on all HR files associated with the service in line with organisational schedule of audits will be completed and this will be overseen by the Head of Services.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A full training needs analysis was completed in conjunction with the National Training Officer and training has been scheduled with staff in the following areas:

- HIQA Regulations and Report Writing-
- Applied Safeguarding- 06/06/2025
- Key Working Sills/ Risk Assessments-
- Person Centered Planning-

All outstanding mandatory training required by staff and new staff have been scheduled and additional bespoke training specific to the provision of care to the residents has also been scheduled.

Supervision has been completed with all staff in line with the organisational policy. Further enhanced supervision is also provided for all staff, including agency staff, on a six-weekly basis and the House Co Ordinator will receive supervision on a 4-weekly basis.

Training is a standing agenda item at the Community Management meetings where training needs are discussed including the status of staff training needs and provision.

Quarterly meetings are held with the organistaion's Training Officer where progress of training and feedback of same is discussed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The registration certificate containing the most up to date information in line with associated conditions of registration and persons associated with the designated centre has replaced the expired Certificate of Registration in place on the day of inspection. The Person in Charge is present on site every day and measures are in place in the event they are on leave. The newly appointed Compliance, Safeguarding and Risk Manager is undertaking an unannounced provider audit to identify areas for improvement in the service. This will be accompanied by a clear action plan which is being implemented by the Head of Services. Individual audits on each resident care and support files are currently in progress with action completed in a timely manner. A comprehensive schedule of audits is in place by the organisation and all aspects of the running of the service are currently being audited. The Head of Services is present on site each week to review the progress of actions on identified areas for improvement. In their absence a suitable nominated person will be present. Weekly meetings are held in the service lead by the Person in Charge who is currently implementing the actions with the staff team.	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: A full review of the Statement of Purpose and Function has been completed and now reflects details as set out in Schedule 1. This also includes: • The profile and number of staff compliment required. • The conditions of registration. • At the time of completing the compliance plan, no staff members are residing in the Designated Centre. The Statement of Purpose and Function will be reviewed at least annually and will be shared with residents and also made available to their family/ representatives.	

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All incidents and accidents are reviewed by the PIC on a daily basis and any notifiable incidents are notified to HIQA in line with regulatory requirements.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A full review of Schedule 5 policies has been completed. While they were not available on the day of inspection, they were available to staff on SharePoint. The following is the current status of all identified Schedule 5 policies on the day of inspection.

• Prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies had been reviewed on 22/01/2025 and is next due for review on 22/01/2028.
• Incident where a resident goes missing had been reviewed on 06/11/2023 and is next due for review on 06/11/2026.
• Provision of behaviour support had been reviewed on 07/07/2024 and is next due for review on 07/07/2027.
• Communication with residents had been reviewed on 20/05/2024 and is next due for review on 20/05/2027.
• Visitors had been reviewed on 20/05/2024 and is next due for review on 20/05/2027.
• Recruitment, selection and garda vetting of staff had beeen reviwed on 06/12/2023 nd is next due for review on 06/12/2026.
• Staff training and development had been reviewed on 06/04/2024 and is next due for review on 06/04/2027.
• Monitoring and documentation of nutritional intake had been reviewed on 11/07/2024 and is next due for review on 11/07/2027.
• Provision of information for residents had been reviewed on 20/05/2024 and is next due for review on 20/05/2027.
• Health and safety, including food safety, of residents, staff and visitors had been reviewed to include the following policies:
· Infection Prevention and Control Policy has been reviewed on 12/01/2024 and is next due for review on 12/01/22027.
· Fire Safety Policy haas been reviewed on 09/07/2024 and is next due for review on

09/07/2027.
• Risk management and emergency planning had reviewed on 13/05/2024 and is next due for review on 13/05/2027.
• Access to education, training and development had been reviewed on 31/07/2024 and is next due for review on 31/07/2027.
• Closed circuit television (CCTV) in designated centres had been reviewed on 08/01/2024 and is next due for review on 08/01/2027.
The following policies are currently under review and will be available to all staff on 31/05/2025.

• Residents' personal property, personal finances and possessions had been due review since 17/01/2025. This Policy is currently under review and will be available to all staff by 31/05/2025.
• The creation of, access to, retention of, maintenance of and destruction of records had been reviewed on 08/12/2023. This Policy is currently a working draft and will be reviewed and available to all staff on 31/05/2025.
• Provision of intimate care had been due review since 7 February 2025. This Policy is currently under review and will be available to all staff by 31/05/2025
• Safety Statament has beeen reviewed on 28/04/2025 and is next due for review on 28/04/2026.
• Emergency planning policy was reviewed on 20/05/2024. This Policy is currently a working draft and will be reviewed and available to all staff on 31/05/2025.
• Complaints had been due review since 15 March 2025. This Policy has been reviewed on 22/04/2025 and is available to all staff since 22/04/2025.

The Provider will ensure policies are reviewed as per regulation and in line with the policy review schedule which will be governed by the Head of Service and the Compliance, Safeguarding and Risk Manager to ensure they are in place to promote positive outcomes for the residents within the centre.
All policies are available to staff via SharePoint. Any updates made to policies will be communicated to staff via Camphill Digest and staff will electronically sign to state they have read and understand each policy.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A schedule for fire evacuations has been implemented to ensure fire evacuations are occurring at least quarterly and one of these planned evacuations occurs with minimum staffing in place.

Any follow-up learnings and actions from each evacuation will be shared with and escalated to the Head of Services and appropriate measures taken to ensure the safety of all residents and to enhance staff learning.

A full review of all residents' PEEPs has been undertaken to ensure appropriate measures and staffing are in place to safely evacuate each resident present in the centre.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Each resident's comprehensive needs assessment is currently being reviewed to ensure the needs of each resident, and the associated supports are accurately outlined.
A full review of each resident's personal plan is currently underway including a care and support audit completed by the Compliance, Safeguarding and Risk Manager. All associated actions will be clearly outlined coupled with a definitive timeline for completion. The PIC in conjunction with the Head of Service will oversee completion of identified actions.
Plans are currently being updated in consultation with the residents to ensure their plans accurately reflect the information pertaining to each resident, this includes their daily activities and goals. Each resident's support plan is being updated to ensure staff are aware of how best to support the resident in line with their assessed needs.
Plans are also being updated to ensure they are in an accessible format for all residents in line with their needs.
Annual review/ circle of support meetings have been scheduled for all residents.
Following these meetings a further review of goals will be completed with each resident and their Person-Centred Plan will be updated accordingly. This PIC in conjunction with the Head of Service will oversee this process.
Monthly key working for each resident has commenced in the centre and will consistently be completed going forward. This will be overseen by the PIC in conjunction with the Head of Service.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
An appointment schedule has been implemented for each resident, outlining all appointments required for the year with different healthcare professionals appropriate to each resident and this is included in their individual files.
Each resident support plan is being updated to ensure staff are aware of how best to support the resident in line with their assessed needs. Following the review of, and updates made to the comprehensive needs assessments for each resident, a further review of support plans will be undertaken to ensure all information is clear and

accurate, including any contributions from the MDT.
Health monitoring in line with each resident's needs has been introduced, to include weight monitoring.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The two staff members living in the designated centre on the day of inspection were supported to move out of the designated centre on 25th March 2025.

Further enhanced training is scheduled to be provided by the National Safeguarding Lead which will provide staff with guidance on the processes involved identifying, reporting and responding to any concerns relating to the welfare of any resident.

All safeguarding concerns are reported via ViClarity and also through internal reporting forms in place which are escalated to the Head of Services by the Person in Charge and measures to safeguard all residents are implemented as a priority. All measures are reviewed at local house meetings and also at Monthly Community Management meetings.

Monthly staff meetings are scheduled, which will incorporate all aspects of each resident's life and will also review all safeguarding plans in place. This will also ensure all closed safeguarding plans have all relevant measures in place documented in the support plan and an appropriate risk assessment relevant to the residents associated with the plan. This will be overseen by the Person in Charge.

All safeguarding plans in place will be made available to all staff through house meetings and also communicated through handover each day.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The two staff members were supported to move out of the Designated Centre on 25th March 2025.

A review of the staffing requirements of the designated centre was completed by the PIC and Head of Services. The roster now reflects the staffing levels required to ensure all residents are supported adequately during the day and also at nighttime.

All personal information relating to residents is stored in a secure location accessed only by staff and residents should they wish to access their information. All PEEPs are accessible to staff and available to individual residents in an accessible format.

Resident meetings are occurring weekly and will be consistently completed each week to ensure residents voices are heard in relation to the running of the centre.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/07/2025
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/04/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	01/04/2025

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	01/04/2025
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	Orange	21/03/2025
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	31/05/2025
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	24/03/2025
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the	Not Compliant	Orange	24/03/2025

	designated centre and bringing them to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	24/03/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	24/03/2025
Regulation 31(1)(c)	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 fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.	Not Compliant	Orange	31/03/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as	Not Compliant	Orange	31/05/2025

	often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	31/05/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/05/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and	Not Compliant	Orange	31/05/2025

	new developments.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/04/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	25/03/2025
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	26/03/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	26/03/2025