



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

Issued by the Chief Inspector

Name of designated centre:	Camphill Community of Ireland Greenacres
Name of provider:	Camphill Communities of Ireland
Address of centre:	Dublin 14
Type of inspection:	Unannounced
Date of inspection:	07 July 2025
Centre ID:	OSV-0003623
Fieldwork ID:	MON-0045438

About the designated centre

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

Greenacres provides residential care for up to four adults with an intellectual disability who require low to medium supports. The centre is comprised of two buildings located in a suburb in South Co. Dublin. The first property is made up of a seven bedroom house and a stand alone building which is used as a social hub in the back garden. The house is home to up to three residents and has a kitchen and dining room, and a sitting room and each resident has an en-suite bathroom. The second property is a spacious apartment for one resident. It consists of a kitchen-dining room, two bedrooms, one of which had an en-suite bathroom, a laundry room, and a main bathroom. There was also an outdoor balcony and a shared facilities such as a gym and conference facilities which the resident could use if they wished to. Both premises are close to a variety of public transport links. There are shopping centres, pubs and local shops within close proximity of the centre. Residents have the opportunity to attend day services or avail of training, employment or volunteer work in their local community. Residents are supported 24 hours a day, seven days a week by social care workers and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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
Monday 7 July 2025	11:00hrs to 16:40hrs	Erin Clarke	Lead
Monday 7 July 2025	11:00hrs to 16:40hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to provide assurance that safe and good quality care was being provided to residents in this centre. The inspection was carried out as part of a wider regulatory programme of inspections of centres operated by this provider in response to information received by the Chief Inspector of Social Services. The inspection was conducted by two inspectors over the course of one day and focused on five key regulations. Inspectors identified concerns regarding the wider governance of the centre and the provider's capacity to effectively oversee the quality and safety of the service. These concerns were linked to the imminent departure of key leadership roles, including the area service manager and the interim head of service, which posed a risk to continuity and oversight within the centre. Within the designated centre, however, residents were found to be happy with their living environment, demonstrated compatibility with one another, and expressed that they liked the staff supporting them.

The centre comprises two premises. The first is a house located in a suburban area of South County Dublin, registered to accommodate three residents, with one vacancy at the time of inspection. The second is an apartment for a single resident. Both properties are centrally located with access to good public transport links, which residents reported using regularly to support their independence and engagement in the community.

Inspectors were welcomed to the centre by the team leader, who had been in post since 2022. The centre had not had a full-time person in charge in place since November 2022; however, a newly appointed person in charge had commenced the previous week but was not available on the day of inspection. Inspectors met one resident who was relaxing in the sitting room, watching a film. Inspectors introduced themselves and thanked the resident for inviting them into their home. Support staff shared that the resident enjoyed taking part in a variety of community-based activities, including attending a local Men's Shed and participating in a community hub service operated by the provider. The resident was awaiting a scheduled appointment at a local barbershop later that day.

The inspectors met with another resident who was utilising the social hub located in the back garden of one of the premises in the designated centre. The resident described a personal project they were working on, building a computer, and explained how staff were supporting them with a money management plan to help budget for the required parts. The resident shared that they had lived in several other locations before moving to this centre and spoke positively about the current service, describing it as supportive and well-located, with convenient access to public transport. The resident highlighted that while staff sometimes accompanied them on outings, they were generally independent and would reach out for assistance if needed.

The resident also reflected on recent changes in staffing, noting that agency staff had been supporting the house. They shared that regular staff members consulted with them about their experience with new agency staff and asked whether they felt the individual was a "good fit" for the house. If so, efforts were made to secure that agency staff member's return for continuity of support. They stated to inspectors that they "would not like to live anywhere else".

In the afternoon, inspectors visited the resident living in the apartment, who was being supported by a member of staff. The resident was enjoying watching television and expressed that they liked their apartment. Based on their assessed needs and personal preferences, inspectors found that the resident was best supported living alone, with evidence of positive outcomes since moving into the apartment two years ago. Inspectors spoke with staff working in the apartment, who provided information on the fire safety arrangements and evacuation procedures in place. Staff confirmed that the resident was familiar with these procedures, had participated in fire drills, and had no difficulties or concerns in doing so.

In the afternoon, inspectors reviewed documentation and residents' personal plans to evaluate the assessment of needs and the support plans in place to guide staff practice in meeting those needs. The inspectors found that the supporting guidance for staff in managing one resident's healthcare condition required additional detail to ensure the resident's needs could be safely met in the centre, while also taking into consideration the resident's dignity.

Inspectors also found that residents were engaged in a range of activities aligned with their individual interests and strengths. These included structured day services, book club participation, visits to family, attending religious services, beauty appointments, and watching films. Residents in this centre told the inspectors that they felt safe and happy in their home. Residents reported that they got on well with each other and that they knew who to talk to if they had a concern.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

This inspection found that improvements were needed to ensure the sustainability of staffing and the overall governance systems necessary to deliver a quality service.

At the time of inspection, there were clear efforts to ensure continuity of care despite ongoing staffing vacancies. Two whole-time equivalent posts remained unfilled, and the centre was reliant on agency staff to maintain safe staffing levels. While this included full agency cover on some shifts, regular agency personnel were

used to support consistency, and staff spoken with were knowledgeable and familiar with residents' needs.

However, inspectors found that the current staffing and management structure was impacting oversight and key operational systems. There was no defined clinical governance in place, with the clinical support officer post vacant. Gaps in clinical guidance for staff and delays in addressing critical systems contributed to non-compliance under governance and management.

While a newly appointed person in charge had taken up their role, inspectors found broader gaps in the governance structure. According to the centre's statement of purpose, the person in charge reported to an area manager, who in turn reported to the head of service, with the head of service reporting to the Chief Executive Officer (CEO). However, at the time of inspection, both the area manager and head of service had vacated their roles. Furthermore, this instability was ongoing, with inspectors informed that several managers across the provider's services had recently submitted their resignations.

Regulation 14: Persons in charge

A new person in charge had been appointed on 30 June 2025 and had recently taken up the role at the time of inspection. The person in charge had the relevant qualifications and experience to undertake the role. A formal assessment of fitness was to be conducted following the inspection, as they had only recently been appointed to the position.

Judgment: Compliant

Regulation 15: Staffing

At the time of inspection, the designated centre had two whole-time equivalent (WTE) staff vacancies. Inspectors reviewed staff rosters from May, June, and July 2025 and found that agency staff were regularly deployed to maintain safe staffing levels. On average, agency staff covered four shifts per week. Inspectors also noted that on certain dates, specifically 06 and 14 June 2025, all rostered shifts in both premises of the centre were filled entirely by agency staff. However, the person in charge and team leader had mitigated this by consistently deploying a small group of four regular agency staff to promote continuity of care and familiarity for residents.

During the inspection, inspectors spoke with three staff members and found them to be knowledgeable regarding residents' assessed needs and the supports in place. In conversations with all residents living in the centre, inspectors were informed that staff were helpful, respectful, and supportive in enabling residents to maintain their

independence, engage in community life, and stay connected with family and friends.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that leadership vacancies in the designated centre were impacting the provider's ability to review and audit key operational systems consistently. For example, inspectors identified deficits in medicine management oversight. A review of one resident's medicine folder found duplicate prescriptions, each containing different dosage instructions for the same medicine. While the resident's General Practitioner (GP) had reduced the dosage on 12 June 2025, the original prescription had not been archived, posing a potential risk for medicine error due to conflicting guidance available to staff.

The inspection also identified an absence of a defined management structure within the centre. Due to recent changes in local management, staff were unclear about lines of accountability, for instance, who to contact if a staff member was absent at short notice. Furthermore, there were gaps in clinical governance arrangements. The role of the clinical support officer, responsible for supporting staff in areas such as medication management and resident reviews, had been vacant for several months. As outlined in the centre's statement of purpose, clinical and care interventions were to be reviewed monthly by the clinical support officer; however, these reviews had not taken place. Although support plans were in place, inspectors noted that one resident's plan lacked specific clinical guidance, with staff instructed only to contact the GP when needed.

In addition, inspectors reviewed the placement of one resident living in a single-occupancy accommodation. The resident expressed satisfaction with their living arrangement, and documentation supported positive outcomes since the transition from group living. However, inspectors were concerned about the security of tenure. The placement, which was originally established for safeguarding purposes, was not permanently funded and was being maintained through risk-based funding. At the time of inspection, there were no formal updates available regarding long-term funding or the sustainability of the placement.

Judgment: Not compliant

Quality and safety

Overall, the centre was striving to provide person-centred care and support to residents in a safe homely environment.

The inspectors reviewed safeguarding arrangements, resident compatibility, and potential risks within the centre. These were found to be low in presentation, supported by individual living environments and positive risk-taking practices, including one resident leading an independent lifestyle. Inspectors were informed that a placement review was being considered for another resident due to their increasing support needs associated with ageing.

Regulation 26: Risk management procedures

The inspectors reviewed a sample of reports related to adverse events, incidents and accidents which had occurred in the designated centre. These records clearly described the nature of the incidents, the actions taken to de-escalate incidents and keep residents and staff safe, and actions and learning required following the events. Where relevant, information taken from adverse incidents was used to update risk assessments and residents' care and support plans.

The previous person in charge maintained a risk register, which rated and set out control measures to mitigate risks related to the service and the service users. The inspectors found that the person in charge, the team lead, and the support staff had identified relevant support needs of each individual and had implemented appropriate risk assessments and control measures. Furthermore, inspectors found that support staff were working with residents to ensure that they could participate fully in activities of their choosing and were not risk-averse in promoting safety measures to support each individual.

Judgment: Compliant

Regulation 8: Protection

Staff spoken with demonstrated a clear understanding of their safeguarding responsibilities and reporting procedures. Inspectors reviewed residents' files and found that intimate care plans were up-to-date and provided clear and respectful guidance for staff. These plans outlined how to support residents in a manner that promoted dignity, personal choice, and individual preferences during the provision of personal care.

The centre was home to three residents, and the living arrangements of the two houses were configured in a manner that promoted each resident's safety, wellbeing, and comfort. There were no safeguarding concerns reported or observed

by inspectors at the time of the inspection. Previous safeguarding concerns relating to compatibility in the centre had been addressed by the provider.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Community of Ireland Greenacres OSV-0003623

Inspection ID: MON-0045438

Date of inspection: 07/07/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Consistent agency staff are scheduled in advance to ensure continuity of care and familiarity with residents. Recruitment for permanent staff is ongoing and has been escalated to the provider for resolution. The PIC, appointed on 30 June 2025, is actively stabilising staffing arrangements and maintaining clear communication lines. Target: All vacancies to be filled and staffing fully compliant by 30 November 2025. • Onboarding: One candidate has been interviewed and offered a position as SCA. • A recruitment drive is underway nationally to recruit sufficient core staff. We continue to reach out to local education facilitators and promote positions in local newspapers, colleges and radio stations for maximum exposure. • There are interviews scheduled for week commencing 18.08.2025. • In the interim, the staffing shortfall is being addressed through the use of approved overtime and the deployment of regular, trained agency personnel. • Greenacres Community in Camphill utilise a cohort of agency staff who are familiar with the residents' needs and consistent on the roster where possible. • All staff currently utilised via agency have been trained as per CCOI training requirements. • All staff currently recruited via agency have access to CCOI systems and are inducted fully to meet the needs of all community members. • All agency staff receive supervision in line with CCOI policy • All rosters are reviewed on a daily basis to ensure adequate suitably skilled cover is in place to support each resident. Safeguarding, Governance and Oversight CCOI are committed to safeguarding the rights and wellbeing of all residents. The following safeguarding structures are in place: The Person in Charge (PIC) will ensure that all safeguarding concerns are promptly reported and appropriately notified to the Health Information and Quality Authority	

(HIQA) and the Safeguarding and Protection Team (SPT), in full compliance with statutory requirements. The PIC will prioritise the immediate safety of all residents and will implement appropriate safeguarding measures as required. This includes immediate protective actions, interim control measures, and longer-term safeguarding strategies, as identified through risk assessment and multidisciplinary review.

- Regular safeguarding training for all staff, including CMSNs, aligned with the National Standards for Adult Safeguarding.
- Robust incident reporting and review procedures, ensuring transparency and timely action.
- Open communication culture, encouraging staff and residents to raise concerns safely.
- Ongoing supervision and support for CMSNs to ensure safeguarding practices are embedded in daily care.

Regulation 23: Governance and management

Not Compliant

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

Head of Services Interview on 28.08.2025

Area Services Manager Commencing on or before 06.10.2025

Person in Charge (PIC) In place

Team Lead In place

Designated Safeguarding Officer In place

Compliance and Safeguarding Risk Manager In place

Quality and Compliance Officer In place

National Safeguarding Lead In place

Clinical Support Officer In place- commenced on 13.05.2025

Second Behavioural Support Officer In place – commenced on 05.08.2025

- The Person in Charge is supported by:
 - o The National Safeguarding Lead
 - o The Compliance, Safeguarding and Risk Manager
 - o The Quality and Compliance Officer
 - o The Health and Safety Officer
 - o Clinical Support Officers
- to ensure quality care is provided to the community.

- The National Safeguarding Lead will be notified of all safeguarding incidents to ensure appropriate oversight and to facilitate joint review with the Person in Charge (PIC). This process will ensure that all statutory notifications to HIQA and SPT are submitted in full compliance with regulatory timeframes.

- The Chief Executive Officer is currently fulfilling all Head of Service functions on an

interim basis, ensuring continuity of leadership and operational oversight until a successful appointment is made to the role.

- Out of hours escalation and Oversight

Camphill Communities of Ireland (CCoI) has had a Person-in-Charge (PIC) On-Call Roster in place for a number of years, providing consistent and reliable managerial oversight outside of standard business hours. This system operates across both the North and South regions, ensuring that staff have access to senior managerial support at all times for the escalation of incidents, safeguarding concerns, or urgent operational matters. The on-call rota is maintained and monitored to ensure full regional coverage and continuity of governance across all services.

- Staff Training – All staff will be attending suicide prevention training imminently.

- CCoI has been in ongoing communication with the HSE CHO7 regarding the tenure of the residence. The most recent email correspondence was dated 04.06.2025. A face-to-face meeting was held in Grangebeg on 13.08.2025, during which CCoI confirmed that they would follow up on securing sustained funding for the tenure.

- The outdated prescription identified during inspection was removed immediately. The PIC has support from the clinical CSO to ensure medicine management compliance.

- As agreed at our meeting in July 2025, the Clinical Support Officer will attend scheduled monthly meetings with the Greenacres Team.

- Greenacres Community appointed two staff to be trained as in-house Trainee Medication Assessors. The training will take place on week commencing 25.08.2025.

- Trainee Assessors support medication compliance by completing structured training and supervised assessments to ensure they can competently evaluate staff administering medication. Further internal Medication Management Audits will be carried out by PIC to ensure full compliance and are scheduled monthly going forward.

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.	Substantially Compliant	Yellow	30/11/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/09/2025
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	31/07/2025

	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.			
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