



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

## Issued by the Chief Inspector

Name of designated centre:	The Bridge Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	01 December 2025
Centre ID:	OSV-0003605
Fieldwork ID:	MON-0048153

## About the designated centre

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

The Bridge Community is located in a small town in Co. Kildare and provides residential, day and transitional training services to a wide range of people. There are five residential houses, three located within the main site and two houses located in housing estates in the community. The local town offers an array of amenities such as shops, a supermarket, bank, post office, public library, and community health services. There are various recreational and other facilities and workshops on the main site to provide work and learning experiences for the residents and day attendees. Residential services are provided to people with mild to moderate intellectual disabilities, physical and sensory disabilities and also those on the autism spectrum. The designated centre has capacity to provide full-time residential services for a maximum of 16 adults, male and female, and to provide respite for one adult. Residents are supported by social care staff, care assistants and short-term co-workers (volunteers).

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	14
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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 1 December 2025	11:00hrs to 18:30hrs	Erin Clarke	Lead

## What residents told us and what inspectors observed

The purpose of this inspection was to assess the provider's application to renew the registration of the designated centre for a further three-year period and to assess the progress made by the provider in implementing organisational and centre-level improvements. Overall, the inspector found that outcomes for residents had improved, particularly in relation to safeguarding arrangements and governance and management systems. However, the inspector identified that further improvements were required to ensure that the centre was appropriately equipped and resourced to fully meet the assessed needs of residents.

The Bridge comprises five residential houses, three of which are located on the main campus and two in nearby community housing estates. The centre is within a short walking distance of the local town, is registered to accommodate 16 residents, and, at the time of the inspection, was home to 14 residents with 2 vacancies. The inspector met with the area service manager, team leader, and administrative support staff, and spoke with three staff members. The inspector also met with three residents from two houses on the campus.

Residents spoken with described positive relationships with staff and reported being involved in discussions about their day-to-day lives. Residents also spoke positively about recent opportunities to take holidays and participate in social and recreational activities. However, the inspector observed that staffing arrangements and access to multi-disciplinary supports impacted residents' ability to consistently engage in activities of their choosing and to have their assessed needs met in a timely manner.

During the inspection, the inspector observed that while residents were supported to access activities and community engagement, staffing arrangements did not consistently demonstrate how all residents could engage in activities of their choosing at all times. One resident had experienced a change in needs and had become increasingly reluctant to leave their home in recent months. This resident required the support of two staff members for increasing periods throughout the day, with observations and support required at intervals of no less than every two hours.

The resident experiencing self-chosen isolation was observed to take meals in their bedroom. This was discussed with the resident, who confirmed that this was their preference. However, the inspector considered that the increased care needs of this resident had a direct impact on staffing deployment and on the opportunities available to other residents within the house.

Since the previous inspection, residents had been supported to participate in a range of social and recreational activities, including holidays and short breaks. Two groups of residents travelled to Spain, one resident took a break in County Clare, another travelled to Kilkenny, and one resident expressed a wish to attend a show in

London. In line with residents' contracts of care, the inspector was informed that fundraising activities were undertaken to support residents to take holidays, as the costs associated with staff support during holidays were required to be met by residents. Examples of fundraising activities included the organisation of an on-site Christmas market and sponsored walks. One resident spoke with the inspector about participating in a 10km race and described being responsible for organising a raffle for an upcoming Christmas fair.

The inspector observed that some residents experienced limitations in how easily their changing needs could be responded to. For some residents, accessing healthcare supports or specialist services involved delays or depended on external arrangements, which affected how quickly their needs could be met. This meant that residents sometimes had to wait for supports or adapt their routines while decisions or funding arrangements were being progressed.

Overall, while residents were supported to live active lives and were treated with respect, the inspector found that delays in accessing specialist supports, equipment and environmental adaptations affected the day-to-day experience of some residents and limited the centre's ability to consistently respond to residents' changing needs.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

## Capacity and capability

The previous inspection in June 2025 was completed as part of a wider programme of inspections across designated centres operated by this provider, following information received by the Chief Inspector that raised concerns regarding the quality and safety of care being delivered. At that time, the provider's capacity and capability to deliver a safe and effective service in this centre was heavily reliant on the presence of a full-time, permanent person in charge, with limited wider governance support in place.

At the time of the current inspection, the inspector was informed that the person in charge was due to leave the organisation in the near future. Recruitment plans were in place, with four interviews scheduled during the inspection week. While this presented a potential risk to continuity, the inspector found that governance and management arrangements had strengthened since the previous inspection.

A new area services manager, who was also appointed as the person participating in management, and a new head of services had both commenced in October 2025. In addition, a team leader had been recruited within the previous two weeks, filling a

role that had been vacant for a prolonged period. These appointments had improved management presence and oversight within the centre.

The inspector met with the newly recruited team leader, who was completing their induction. The role was outlined as a split post, combining frontline support with administrative and supervisory responsibilities. The inspector found that this role was appropriately designed to support staff practice and day-to-day operational oversight, though the impact of the appointment was still in the early stages.

Staffing arrangements generally reflected residents' assessed needs; however, the inspector identified some challenges in relation to staffing numbers, deployment and continuity. The centre continued to experience vacancies across social care worker and healthcare assistant roles, and a reliance on agency staff. While rosters demonstrated that the majority of shifts were filled, this was often achieved through agency usage and staff covering additional shifts.

The inspector identified patterns of rostering that did not consistently demonstrate adequate rest periods between shifts, including staff working day duty followed by sleepover or waking night duty. These arrangements raised concerns about sustainability and staff wellbeing, and indicated that staffing deficits were affecting rostering arrangements.

### Registration Regulation 5: Application for registration or renewal of registration

The provider submitted an application to renew the registration of the designated centre within the required timeframe. The application was complete and accompanied by the required supporting documentation.

Judgment: Compliant

### Regulation 14: Persons in charge

The person in charge at the time of the inspection was employed on a full-time basis and had been working in the centre for a number of years. They were suitably qualified, experienced and competent to fulfil the role.

Effective arrangements were in place to ensure the continued operation and management of the centre during the absence of the person in charge. These arrangements had been initiated in advance by the person in charge prior to commencing leave and included clear delegation of responsibilities to staff and appropriate governance oversight at organisational level. The inspector was satisfied that these arrangements ensured continuity of management and oversight during this period.

Judgment: Compliant

### Regulation 15: Staffing

The inspector found there was generally sufficient staff on duty to meet residents' immediate care and support needs at the time of inspection; however, gaps were identified in staffing numbers and rostering arrangements. The centre continued to experience a number of vacant posts, including two social care worker vacancies and two healthcare assistant vacancies, equating to approximately four whole-time equivalent (WTE) posts. One vacancy had been unfilled for a prolonged period, extending beyond six months. It was confirmed that relief staffing posts, which had not previously been advertised, were now being actively recruited to build a relief panel for the centre.

The approved staffing complement had decreased from approximately 31.5 WTE to 28.5 WTE due to one resident discharge, resulting in a net reduction of two posts. While staff rosters demonstrated that the majority of required shifts were covered, this was achieved through agency staff, averaging approximately 400 hours per fortnight, and by residential and day staff covering additional shifts.

Deficits were identified in relation to staff deployment across day, night and sleepover duty. Rosters reviewed showed that some staff members were scheduled to work day shifts followed by sleepover or waking night duties, including instances where staff worked day duty and then remained on-site for night cover. This did not consistently demonstrate that staff were afforded adequate rest periods between shifts, nor that staffing deficits were sustainably addressed without reliance on extended working hours or temporary staffing arrangements.

Judgment: Substantially compliant

### Regulation 23: Governance and management

At the time of inspection, the person in charge was on a period of annual leave. Interim safeguarding and operational oversight arrangements were clearly outlined. Day-to-day responsibility had been delegated to senior staff within the centre, with governance oversight maintained at organisational level. No new admissions were planned during this period. Arrangements were in place to ensure residents continued to be supported to attend healthcare appointments as required.

The inspector was informed of recent changes to clinical oversight arrangements within the centre. An additional clinical support officer had been appointed, with defined caseloads allocated to support residents' assessed needs and provide guidance to staff. The provider advised that quality improvement systems within the

centre were due to be revised, with a new quality improvement plan scheduled for implementation from January 2026.

Judgment: Compliant

### Regulation 31: Notification of incidents

The inspector reviewed a sample of notifications submitted to the Chief Inspector and found that all required notifications had been submitted by the person in charge in accordance with regulatory requirements. Notifications reviewed were submitted within the prescribed timeframes and included the required information.

Records demonstrated that incidents and events occurring in the centre were clearly documented and appropriately categorised. Notifications reflected a range of incidents, including safeguarding concerns, incidents of behaviours of concern, accidents, and other notifiable events.

Judgment: Compliant

### Regulation 4: Written policies and procedures

A system was in place to ensure that Schedule 5 policies were reviewed in accordance with regulatory requirements, at a minimum interval of three years. Policies were available to staff, and there was evidence that staff had read and signed to confirm their understanding. The inspector reviewed a sample of 11 policies and found that all were in date.

Judgment: Compliant

### Quality and safety

Overall, the inspector found that systems were in place to support the quality and safety of care delivered to residents. The provider had arrangements to identify, assess and manage risks, respond to incidents, and implement safeguarding measures in line with residents' assessed needs. Improvements were evident in safeguarding practices, incident oversight and the implementation of positive behavioural support arrangements.

However, while residents were protected from immediate harm, the inspector identified that the provider did not consistently demonstrate the capacity to meet residents' assessed and emerging needs in a timely and equitable manner. In particular, gaps were identified in how healthcare supports, environmental adaptations, and specialist interventions were accessed and implemented, with reliance on external funding, waiting lists, or resident-led financing in some cases. As a result, further improvement was required to ensure that the centre could meet the needs of residents.

While the centre benefited from the involvement of behavioural and clinical support officers, the inspector found that residents' emerging needs required input from a wider range of healthcare professionals. In the cases reviewed, access to some of these supports was dependent on residents meeting the cost themselves or on prolonged waiting lists and outstanding business cases. As a result, it was not demonstrated that the provider could consistently meet each resident's individual assessed needs in a timely and equitable manner.

### Regulation 26: Risk management procedures

The inspector reviewed a sample of incidents that had occurred in the centre, along with associated individual risk assessments. These included risks relating to epilepsy, falls, behaviours of concern, and medicine-related errors. Risk assessments were found to be individualised, regularly reviewed and informed by learning from incidents.

Following a choking incident in the centre, appropriate measures had been implemented to mitigate the risk of recurrence. These measures included consultation with relevant healthcare professionals, review and updating of risk assessments, and the provision of additional training to staff in first aid and other life-saving interventions. Records demonstrated that staff had received relevant training and that learning from the incident had been incorporated into ongoing risk management practices.

The inspector was informed that incidents were reviewed by area service management, with clear systems in place for oversight, sign-off and follow-up. This ensured that risks were identified, monitored and responded to in a timely manner. Overall, the provider had systems in place to identify, assess, manage and review risks, supporting the safety and welfare of residents.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of three residents' assessments of need and personal plans. While assessments were in place and reviewed within required timeframes, gaps were identified in how residents' assessed needs were being met in practice.

Records of assisted decision-making assessments and documented conversations demonstrated that residents were consulted regarding aspects of their care and support, including discussions about healthcare interventions and associated costs, such as dietetic reviews. However, it was not clear how the centre could fully meet residents' assessed needs where access to required healthcare supports was dependent on residents funding the cost themselves. In one case, a dietetic review was required at a cost of €160, while the resident's remaining weekly allowance was €124. It was not demonstrated how the resident could reasonably fund this support or how the provider would ensure the need was met. While rationale for resident expenditure was recorded, this was not clearly linked to the resident's contract of care or how essential healthcare needs would be prioritised.

In another file reviewed, an assessment relating to the use of bedrails identified that responsibility for informing the public health nurse of any changes that could impact their use rested with the resident. It was not clear how this responsibility was determined, nor how the resident was supported to manage ongoing requirements such as monitoring measurements or recognising when reassessment was required.

The inspector reviewed records relating to one resident for whom an urgent referral had been made to the funder in April 2025 to review their living environment. The provider had identified that the resident was at risk due to the need to navigate stairs in the context of diabetes-related health concerns and an increased risk of falls. An occupational therapy review had recommended a downstairs bedroom and an enlarged bathroom; however, no update was available at the time of inspection regarding progress or interim measures to mitigate the identified risk.

Further examples observed included a resident who had an approved business case for an adapted shower and wheelchair since the previous inspection; however, it was not clear when these adaptations would be installed. While an interim wheelchair had been provided, it could not be safely accommodated on the centre's transport. Another resident was awaiting access to private counselling services, and a further resident remained on a waiting list for psychology supports. Documentation reviewed by the inspector indicated that the costs associated with accessing these services were to be borne by residents. Consequently, the reliance on residents to fund essential assessments and supports limited the provider's ability to consistently meet residents' assessed needs, as required under Regulation 5.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that residents' intimate care plans contained a good level of detail to ensure residents received care in line with their assessed needs and personal preferences. Care plans outlined desired outcomes for residents and included guidance for staff on preferred approaches, items and supports to promote comfort, dignity and positive engagement.

The safeguarding policy had been revised in January 2025 and was available to staff in the centre. Staff spoken with were familiar with safeguarding procedures and their responsibilities in responding to concerns.

Since the previous inspection, the number of safeguarding incidents between residents had reduced. This reduction was attributed to improved implementation of positive behavioural support plans and greater consistency in staff practice. Records reviewed demonstrated that safeguarding concerns were identified, responded to and monitored appropriately, with measures in place to protect residents from harm and support their ongoing safety.

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
<b>Capacity and capability</b>	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
<b>Quality and safety</b>	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

# Compliance Plan for The Bridge Community OSV-0003605

Inspection ID: MON-0048153

Date of inspection: 01/12/2025

## 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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> <li>• The role that had remained vacant for over 6mts was a Team Leader role, that role is filled as of 17/11/26. The person in post remains in post and performing their role to a very high standard.</li> <li>• The provider held an open day in the designated centre on 24/01/26, with one offer in process.</li> <li>• The local management team has a strong working relationship with the agencies we use, the needs of the centre are in the main provided by a cohort of agency staff who are not transient but have a built knowledge of the centre over the course of years.</li> <li>• A review of the rosters was completed after inspection and rosters were amended. When reviewed, the staff that were seen to be on waking nights were on sleep nights, rosters were modified to ensure clarity. ]</li> </ul>	
Regulation 5: Individual assessment and personal plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <ul style="list-style-type: none"> <li>• Since inspection there has been one instance of MDT support being required that could not be met via the community primary care system promptly due to waiting lists, in this instance camphill communities met the cost. Going forward where an MDT need cannot be met via the community primary care system the Area Service's Manager will be notified and escalation to the HSE Disability Manager will occur</li> <li>• In the instance of the dietetic review the resident had been referred via the community primary care system but chose to pay privately due to the size of the waiting list. Staff assisted this resident through an assisted decision making meeting. This resident is not currently incurring dietetic costs.</li> <li>• In the instance of the use of bedrails identified, the resident uses these via choice as they find them a comfort, the use of the bedrails were reviewed by the public health nurse in 2022, she agreed on assessment that there use was of value to the resident.</li> </ul>	

The use of the bedrails are logged as a restriction and monitored quarterly as a restriction, a central component of their use continues to be personal choice.

- Specific to the requests in April 2025 for the funder to review the living arrangements of one resident residing upstairs, the risk for this resident is epilepsy. The Area Service's Manager has liaised with the disability manager to flag the case, this occurred 12/02/26. The area Services Manager will begin the process with an internal case review to identify the actions required internally e.g. referral to Kildare CoCo. That internal review will be conducted no later than 31/03/26. A business case will be submitted by the Area Services Manager that will be costed around a ground floor solution with 1:1 staffing. To mitigate the risk we will continue to provide 1:1 support, at all times the resident is accompanied, there is a risk assessment in place for stair use that guides staff will be in front or behind when the resident uses the stairs.
- Since inspection a shower has been adapted including the provision of a shower chair the provider has covered these costs. Since inspection a wheel chair identified in the inspection report has been replaced that can be safely accommodated in the centre's transport, the cost of this change was covered by the provider.
- The ASM with the local management team will review the status of residents on waiting lists or using private service provision, where appropriate escalation to the Disability Manager will occur. The review will be carried out no later than 31/02/26. ]

## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	13/02/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2026