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:	Carrick on Suir Camphill Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	26 June 2025
Centre ID:	OSV-0003608
Fieldwork ID:	MON-0047553

About the designated centre

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

Carrick on Suir Camphill Community, located in a town, provides long-term residential care to 16 both male and female residents over the age of 18 with intellectual disabilities, autism and physical support needs who require medium levels of support. The centre comprises six units in total combining a mixture of residential houses and individual semi-independent supported houses. All residents have their own bedrooms and facilities throughout the units which make up this centre include kitchens, sitting rooms, dining rooms and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (social care staff) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
Thursday 26 June 2025	12:00hrs to 16:30hrs	Marie Byrne	Lead
Friday 27 June 2025	09:00hrs to 13:10hrs	Marie Byrne	Lead
Thursday 26 June 2025	17:30hrs to 19:30hrs	Marie Byrne	Lead
Thursday 26 June 2025	20:30hrs to 22:00hrs	Marie Byrne	Lead
Thursday 26 June 2025	12:00hrs to 16:30hrs	Conor Brady	Support
Friday 27 June 2025	09:00hrs to 13:10hrs	Conor Brady	Support
Thursday 26 June 2025	17:30hrs to 19:30hrs	Conor Brady	Support
Thursday 26 June 2025	20:30hrs to 22:00hrs	Conor Brady	Support

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 completed by two inspectors over two days. Overall, the findings of this inspection were that residents were in receipt of a good quality service; however, improvements were required in relation to governance and management and this will be discussed further in the report.

In Carrick on Suir Camphill Community care and support is provided for up to 16 residents with an intellectual disability. The centre comprises two houses and three single occupancy units on a campus and three additional houses in housing estates close to the campus. Inspectors had the opportunity to meet with 10 of the 13 residents who lived in this centre over the course of the inspection. Two residents were not home when inspectors visited their homes. In addition, one resident was in the process of being discharged from the centre and had not been present in the centre for a number of months. Inspectors spent time over the course of the inspection engaging with residents and observing aspects of their day including them taking part in the upkeep of their home, spending time with their peers and staff and engaging in activities of their choosing. Inspectors also spoke with 12 staff over the two days of the inspection including three members of the local management team. This included meeting staff who were on day duty and those on sleepover shifts. Documentation was also reviewed about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

Residents had a variety of communication support needs and used speech, sign language, vocalisations, facial expressions, and body language to communicate. Some residents told inspectors what it was like to live in the centre, others used sign language and inspectors used observations, discussions with staff and a review of documentation to capture to lived experience of the remaining residents.

On arrival to the campus on the first day, there were no residents at home. Inspectors were informed that a number of residents were gone to visit another Camphill community and were planning to go shopping on the way home, one resident gone to work, one resident visiting their family and two residents gone out for lunch. Over the course of the first day of the inspection, inspectors completed a walk around each of the five premises on the campus and reviewed documentation in an office base.

Later in the afternoon, inspectors had an opportunity to meet residents and staff as they returned from their planned activities. Residents spoke about their day, including visiting family members, having lunch, shopping, their birthday plans, working on a local farm, working in a local pub, training for the Special Olympics,

playing sports, taking part in an acting group, watching movies, and going to the cinema. A number of residents also spoke about their healthcare and the steps they were taking to stay healthy. They also spoke about supports available from staff, should they require it.

Residents spoke with inspectors about their goals and talents. For example, one resident spoke about passing their driving test and another residents spoke about their recent art exhibition. A number of residents showed inspectors around their home and one resident proudly showed an inspector a colourful mural they had painted during the COVID-19 pandemic. A number of premises works had been completed or were ongoing at the time of the inspection. For example, paths were being laid during the inspection and windows and doors were due to be replaced just after the inspection. The provider had recognised that one premises was not meeting one resident's needs, particularly relating to accessibility. Plans were progressing to support them to move; however, due to the protracted nature of sourcing and completing works to another premises, the residents' transition plan had paused. This will be discussed further under Regulation 23: Governance and Management.

A number of residents spoke about how important it was to them to take part in the upkeep of their home and the grounds. One resident told an inspector they were not happy about the lip on the exit door from their kitchen. They said there was a risk that they or one of their peers could trip over it. Staff informed the inspector that the door was due to be replaced after the paths were laid outside. Three residents spoke about who they would go to if they had any worries or concerns.

Inspectors returned to the centre to meet residents and observe evening routines. Some residents were engaging in activities of their choosing and some residents were getting ready to go to bed. Residents were observed choosing when they wished to go to bed and those who required staff support, received this support as requested. Some residents spoke with inspectors about the events of the day and their plans for the following day.

On the second day of inspection, inspectors again visited residents in their homes on the campus, spoke to staff and observed residents' morning and lunchtime routines. A number of residents went to day services or work, while others engaged in activities of their choosing at home or in their community. After visiting the residents and the houses on the campus, inspectors visited the three houses in the community a short distance from the campus. Two residents were not there when inspectors visited their home, and one resident was home and relaxing as they had a long day travelling and shopping the day before. They were planning to go out for coffee after inspectors visited.

Throughout the inspection, inspectors observed a warm, friendly and welcoming atmosphere in the centre. Staff were observed to respect residents' privacy in their homes. They were observed to knock on residents' doors before entering, to speak with inspectors using person-first language and to focus on residents' strengths, talents. They also spoke about the ways in which residents contributed to their home and their community. They were observed to be very familiar with residents'

communication styles and preferences. They were available to residents should they require support and were observed spending time with them.

Overall, inspectors found that improvements were required in governance and management arrangements to ensure that residents continued to enjoy a good quality of care and a safe service.

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

Overall, inspectors found that improvements were required to governance and management, particularly relating to oversight by the provider and lines of accountability and authority.

The local management team consisted of a person in charge and they were supported by a house co-ordinator. The person in charge had just resigned and was in the process of inducting the person who had just been successful at interview for the person in charge post. There had been recent changes in the senior management of the service and the person in charge told inspectors they were reporting directly to the Chief Executive Officer at the time of this inspection.

Inspectors found that staff had access to training and refresher training in line with the organisation's policy. They had also completed training in line with residents' assessed needs, such as epilepsy and diabetes awareness training. Information was shared with the staff team at handovers and staff meetings to ensure that all staff were kept informed of residents' current care and support needs, their wishes and goals, and any control measures in place to keep them safe.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably qualified and experienced. They were supported in their role by a house co-ordinator. They demonstrated a good knowledge of residents' care and support needs and residents and staff were very complimentary towards them. As previously mentioned, this person in charge had resigned their post and was in the process of inducting the person who had just been successful at interview for the person in charge post.

Judgment: Compliant

Regulation 15: Staffing

The centre was fully staffed in line with the statement of purpose at the time of the inspection. Inspectors reviewed planned and actual rosters from March to May 2025. These demonstrated that all the required shifts were covered by regular staff and relief staff. There was no use of agency staff in this centre. They demonstrated that consideration was given to meeting residents individual needs and preferences and presenting risks. For example, for residents who required 1:1 staffing supports, split shifts were occurring when needed.

Inspectors reviewed a sample of five staff files and the file of the one live in volunteer (co-worker). These files contained the information required by the regulations. This included Garda Síochána (police) vetting, reference checks and valid identification for staff.

Inspectors also reviewed a sample of staff meeting minutes. Discussions were held around maintaining a safe environment for residents, ensuring residents were satisfied with: care and support in the centre; presenting and potential risks; complaints; compliments; incidents and accidents and safeguarding. Inspectors also reviewed a sample of staff probation and induction records which demonstrated that staff were in receipt of a thorough induction to the centre.

Judgment: Compliant

Regulation 23: Governance and management

Due to recent changes in senior management in the centre, inspectors found that lines of authority and accountability were not clearly defined. As previously mentioned, inspectors were informed that the person in charge was reporting directly to the provider's Chief Executive Officer on the day of the inspection. The organisation structure in the centre's statement of purpose stated that the person in charge reported to an area manager who in turn reported to an interim head of service. Inspectors were informed, that interviews were scheduled for these posts; however, the current structure did not provide assurances that there was adequate oversight and monitoring of this centre by the provider.

Based on a review of rosters and discussions with residents and staff it was clear that the person in charge and house co-ordinator were present in the centre on a regular basis; however, this was not clear for senior managers. Records reviewed demonstrated the local management team were identifying and following up on concerns relating to staff knowledge and performance, and completing the steps required by them in a timely manner. This included implementing additional control measures to safeguard residents; however, once escalated in line with the providers policies and procedures, there were considerable delays in responding and taking

action. Inspectors requested updates in relation to a number of notifications submitted to the Chief Inspector and corresponding investigations, and documentation received demonstrated considerable delays.

The provider's systems to monitor the quality and safety of service provided for residents included; unannounced provider visits every six months, area specific audits, and an annual review. Inspectors reviewed a summary of the latest six-monthly review. However, the full review and action plans had not yet been made available to the person in charge, and therefore they could not complete the required actions. This was indicative of a lack of connection between provider management and local management.

Inspectors were informed that a resident was due to transition out of centre, as parts of their home were not accessible or meeting their needs. However, initial discussions had been held been held with the resident and their representative approximately two years before this inspection but no transition has occurred. This again is indicative of a lack of senior management input to support the centre's local management and to drive and implement the necessary changes, programmes, projects and transitions within the centre.

Judgment: Not compliant

Quality and safety

Inspectors found that every effort was being made in this centre to ensure that residents were in receipt of good quality and safe service. Work was ongoing to ensure that residents' homes were well maintained. Residents were regularly engaging in activities they found meaningful. They were supported to communicate their wishes and preferences.

As previously discussed, the provider had completed significant internal premises works since the last inspection and works were ongoing to the grounds at the time of the inspection. In addition, funding had been secured to complete more premises works after the inspection. Issues relating to the accessibility of one resident's home was captured under Regulation 23: Governance and Management.

Residents had support and risk management plans which had considered their safety and safeguarding. Restrictive practices were reviewed regularly to ensure they were the least restrictive for the shortest duration. Where possible, they were reduced or eliminated. Residents' rights were recognised and promoted and they were supported to engage in shared decision-making about their care and support.

Regulation 26: Risk management procedures

Inspectors found that the provider had systems in place for the identification, assessment and management of risks in the centre, including a system of responding to emergencies. For example, a number of residents did not have direct staff supports during the night but had access to an alarm to alert staff in a nearby house if they required support.

Inspectors reviewed the centre-specific risk register and a sample of general and individual risk assessments. These outlined control measures which mitigated against risks in the centre. Risks and incidents were discussed at staff meetings to ensure staff were knowledgeable about risks and the controls in place to address these risks.

Residents were supported by staff to understand how to reduce the risk of harm and maintain their health and wellbeing. Staff who spoke with inspectors were aware of presenting risks, and the control measures in place to mitigate these risks.

Judgment: Compliant

Regulation 8: Protection

The provider developed and made available policies and procedures to ensure residents were safeguarded from abuse. Residents were supported to safeguard their finances. For example, assessments were completed in relation to the levels of support they required (if any) and money management plans were developed around budgeting and saving. Residents were supported by staff to complete regular balance checks of their income and expenditure.

Inspectors reviewed a sample of records relating to allegations of abuse. This included preliminary screenings, interim or full safeguarding plans and any correspondence from the Health Service Executive Safeguarding and Protection Team. Inspectors found that the required actions had been taken and the necessary safeguarding measure were being implemented. For example, staffing supports were in place, risk assessments had been developed, and support plans had been and updated as required.

Inspectors reviewed a complicated safeguarding matter whereby a resident had put themselves at risk online and this incident was found to have been followed up and the resident was well supported by staff and their family. Inspectors reviewed a sample of resident finances and found residents monies and balances were correct, receipts were present for vouched purchases and residents monies were safe, secure and accessible to the residents.

100% of staff had completed safeguarding training and staff who spoke with inspectors were aware of their roles and responsibilities should there be an allegation or suspicion of abuse.

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	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Carrick on Suir Camphill Community OSV-0003608

Inspection ID: MON-0047553

Date of inspection: 27/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Regulation 23(1)(a)

• There is a Person in Charge and a Team Lead in place in the community.
• An Area Services Manager has been recruited and commenced in the role on 05.08.2025. Org. Chart Attached.
• All staff in Carrick were informed of the new ASM and updated lines of authority at a staff meeting on 29/07/2025. This meeting was followed up with an email that contained details of the new organization chart.
• First site visit to Carrick is scheduled for Tuesday, 2 September 2025.
• An introductory meeting was held with the PIC on week commencing 05.08.2025 to begin induction and the ASM has been supporting the community daily through Microsoft Teams calls.
• From 2 September, ASM will be present on site every fortnight and will check in via Microsoft Teams daily or as required.
• The ASM will conduct a full audit of the Carrick Designated Centre. This will be completed by Monday 13.10.2025.
• A Quality Enhancement Plan (QEP) will be developed based on the audit, to be completed by 7th November 2025.
• 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. Interviews are scheduled for this position on 28.08.2025.
• Registered provider has reviewed the Statement of Purpose to reflect operational changes which will also reflect the Head of Services once the role has been fulfilled.

Regulation 23(1)(b)

• The Person in Charge will report to a designated and operational Area Services Manager who commenced on 05/08/2025, whereby monthly management meetings will commence.

• The Person in Charge is supported by:
o Area Services Manager
o The National Safeguarding Lead
o The Compliance, Safeguarding and Risk Manager
o The Risk and Compliance Officer to ensure quality care is provided to the community.
• The registered provider has updated structure diagrams whereby the Person in Charge has distributed to all staff via email and discussed via a staff meeting.

Regulation 23(1)(c)

• The Person in Charge will continue with local management and oversight by completion of all quality assurance audits, conduct team meetings and community management meetings each month.
• Supervision will be carried out by the ASM for the PiC, this will be completed by 02.09.2025.
• The PiC and the Team Lead will complete supervision of staff by 01.09.2025.
• The ASM, National Safeguarding Lead, Medication CSO, and Behavioral CSO will attend the monthly Community Management Meeting (CMM), scheduled for the second Monday of each month. The first will be on 08/09/2025.
• ASM will hold weekly regional meetings with PICs, with the first one held on 18/08/2025.
• ASM will also attend the weekly Senior Management Team meetings, starting Friday, 29th August 2025.
• The Compliance Officer will conduct a full Provider Audit on or before 01/10/2025.
• The Clinical Support Officer for Medication is scheduled to complete the annual medication audit on 24.09.2025.
• The Behavioral CSO visits the site monthly, or more frequently if needed. They attend team meetings each month where there are behaviors that challenge and provide 1:1 staff debriefs after incidents. They are available Monday to Friday, 09:00–17:00, by Teams or mobile. The staff team utilize this support regularly and there is a good relationship built between the team and CSO.
• The Health and Safety Officer is due to carry out a full audit (date to be confirmed).
• A review of Safeguarding was completed by the PiC and the National Safeguarding Lead was completed on 29.07.2025.
• The SOP was reviewed on 19/08/2025 by the National Operations Support Officer and the PIC. The current management structure is as follows:
Board → CEO → Head of Services Vacant (Interviews Thursday 28th August 2025) → ASM → PIC → Team Leader → House Coordinators x2 (Offering two positions currently) → Social Care Team
• The Compliance, Safeguarding and Risk Manager is due to review Operational Risk Register with PIC before 30/09/2025
• ASM was inducted into the incident management system 19/08/2025 and will begin reviewing incidents in real time.
• One full-time Social Care Worker role has been filled internally. They commenced the role on 18.08.2025.

• HR are actively engaging with recruitment agencies to source two SCA candidates. One interview is scheduled for 25.08.2025.
• All agency staff have completed mandatory training as per CCoI policies and are fully inducted, with access to all required systems to ensure safe and effective care.
• Supervision for agency staff is in place, aligned with CCoI's supervision policy to ensure ongoing professional oversight. This is reviewed by the Compliance officer during review of staff files.
• Rosters continue to be reviewed daily to ensure adequate, qualified, and experienced staff are available to meet residents' assessed needs.
• An on-call roster is in place to support staff outside regular working hours.
Camphill Communities of Ireland (CCoI) remains fully committed to upholding the highest standards of governance, leadership, and accountability across all designated centres. The actions outlined above reflect a targeted and strategic approach to strengthening local and national oversight, ensuring that services are both compliant with Regulation 23 and responsive to the evolving needs of residents.

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2025
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	13/10/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	01/09/2025

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	01/10/2025