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:	Dunshane Camphill Communities of Ireland
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	03 April 2025
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0046276

About the designated centre

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

Dunshane Camphill Communities of Ireland is a designated centre that provides 24-hours a day, seven days a week care and support for up to 17 residents in a rural location in Co. Kildare. The designated centre consists of eight residential buildings situated on over 20 acres of farming land in a campus style setting. The centre also provides day activation services from 9am to 5pm Monday to Friday, on site. Some residents participate in these day activities, such as baking, cooking, pottery, basketry, and farming within the grounds of the designated centre or are supported in other interests in the community. The site also contains extensive gardens, walk ways, forest trails, farm land and fields. The centre can accommodate residents, aged 18 and over with intellectual disabilities. Residents are supported by a team of social care workers, assistant support workers and voluntary workers. In line with the co-living model of care residents share communal living spaces with the volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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 3 April 2025	10:50hrs to 18:15hrs	Erin Clarke	Lead
Friday 4 April 2025	10:30hrs to 13:00hrs	Erin Clarke	Lead
Thursday 3 April 2025	10:15hrs to 18:15hrs	Karen Leen	Lead
Friday 4 April 2025	10:30hrs to 13:00hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This was a focused, risk-based inspection carried out by two inspectors over a two-day period. The purpose of the inspection was to assess the provider's progress in addressing areas of concern identified during the previous safeguarding inspection conducted in October 2024. At that time, the provider had been afforded additional time to address significant issues relating to staffing, governance, and the protection of residents.

This follow-up inspection found repeated non-compliance under these regulatory areas, in addition to newly identified failures in the process of assessment of residents' need. The overall findings highlighted that the provider remained unable to consistently meet the assessed needs of all residents. In some instances, the extent of residents' current needs was unclear, due to the absence of formalised and up-to-date assessments of need. This lack of clarity limited the provider's ability to deliver safe and appropriate care and impacted residents' experiences of daily life in the centre.

Safeguarding risks remained present, and the incompatibility of residents due to their current needs continued to affect the living experience for some individuals. Although some local improvements had taken place since the last inspection, the pace and impact of these changes were not sufficient to fully address the serious concerns previously identified.

The first day of inspection focused on engagement with the management team to review areas of risk, actions taken to stabilise the service, and the provider's overarching plans to decongregate the centre and move towards compliance. Inspectors were informed that four residents were due to be discharged from the centre due to the provider's inability to meet their needs; however, at the time of inspection, only one transition had been formalised.

The second day was spent visiting each house on the campus to meet with residents and staff, and concluded by meeting with management to follow up on outstanding documentation requests. On the days of the inspection, 17 residents were living in the centre. Over the course of the two days, inspectors had the opportunity to meet and engage with 16 residents across eight different houses located on the campus. Inspectors spoke with the interim person in charge, the interim person participating in management, a team leader, two permanent staff members, and four agency staff. During the inspection, inspectors also observed two agency staff being inducted into the designated centre by permanent staff. The provider had undertaken a number of recruitment campaigns and interviews in an attempt to secure permanent staff, but ongoing recruitment challenges were highlighted.

Residents were seen engaging in a range of daily routines and activities, both on and off the campus. The centre provides access to a variety of workshops including weaving, pottery, basketry, cooking, baking, and arts and crafts, along with

opportunities to care for animals on the farm or participate in gardening. Inspectors observed and interacted with several residents during these activities and in their homes.

One resident proudly gave the inspector a tour of their home and spoke enthusiastically about upcoming Easter celebrations and plans to visit family. Staff were observed following the resident's support plan, responding with clear and reassuring communication. Another resident was seen completing a puzzle in their living room and, with support from staff, indicated a preference not to engage further. Staff respected this, and their understanding of the resident's needs was evident. Throughout the inspection, staff demonstrated a good level of familiarity with residents' communication preferences and were seen providing support that was both respectful and responsive.

During the walkaround, inspectors were informed of several planned moves and changes within the centre, including the closure of certain houses and the registration of new premises. These changes were being proposed in response to both physical premises issues and the need for more appropriate resident groupings, including single-occupancy arrangements for individuals with higher support needs. However, past transitions were reported to have led to resident dissatisfaction with their new environments, and had also contributed to an over-reliance on agency staffing in some areas. The current management team acknowledged that evidence of planning and rationale for prior transitions was not available for review, making it difficult to evaluate the basis for those decisions or the outcomes for residents.

Inspectors observed that while some residents were settled and enjoying daily routines, others were having a very different experience. In one house, a resident who had come out to meet the inspectors returned immediately to their bedroom after a peer expressed discomfort at the visit. In this same house, residents were not freely accessing the living room and were instead spending time watching television in their bedrooms.

Alongside the provider's ongoing difficulties in securing permanent staff, inspectors noted that the complexity of residents' changing needs was outpacing the service's current capacity. Formal assessments of need had not been completed or updated in line with these changes, further impacting the centre's ability to plan and deliver safe and effective care.

Inspectors were also made aware that one resident had not left the centre in over 16 months. While the complexity of the resident's needs was acknowledged through a notice of discharge to the funder, it was evident that the centre did not have the capacity or appropriate resources in place to effectively support meaningful engagement and promote the resident's wellbeing.

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

Capacity and capability

Overall, while there was evidence of efforts to strengthen governance and stabilise staffing, the inspection found that significant challenges remained in fully resourcing the centre to deliver consistent, person-centred, and safe supports to all residents.

Since the previous inspection, there had been changes to the management structure. An interim person participating in management (director of services) had been appointed, along with an interim person in charge who also held responsibility for another large designated centre. Inspectors found that these managers were present in the centre on a regular basis and had taken steps within their remit to stabilise the centre and escalate risks appropriately within the provider's governance systems.

At the previous inspection, two residents had transitioned to single occupancy arrangements through an application to vary process, which had initially led to positive outcomes in terms of reduced safeguarding incidents. However, during this inspection, the interim management team advised inspectors that they did not stand over these prior transitions and had limited information regarding how these decisions had been made. They were now undertaking a centre-wide review of resident living arrangements.

However, despite these efforts, the interim nature of the leadership team, combined with the breadth of their governance responsibilities and the absence of other key roles within the centre's management structure, significantly impacted the centre's overall capacity. This lack of consistent, dedicated leadership at local level was evident in the slow pace of progress in addressing known issues, and in the inability to respond effectively to the complex and evolving needs of all residents.

While the provider had taken steps to maintain service delivery through the deployment of agency staff, the scale of the staffing shortfall was not being addressed by recruitment efforts undertaken to date. These pressures were further compounded by registration and transfer decisions made without sufficient strategic oversight, placing additional strain on an already overstretched workforce and undermining the centre's capacity to provide safe, consistent, and person-centred care.

Regulation 14: Persons in charge

The provider had appointed an interim person in charge for the centre in November 2024. The appointed person met the requirements of Regulation 14 in relation to relevant management experience and qualifications while the permanent post remained under recruitment.

Throughout the inspection, the interim person in charge demonstrated a comprehensive understanding of the service, as well as clear knowledge of residents' individual needs, preferences, and support arrangements. Their presence and familiarity with both residents and operational challenges contributed positively to the governance and oversight of the centre during this period of transition.

Judgment: Compliant

Regulation 15: Staffing

The centre was operating significantly below its required staffing capacity due to staff departures and the creation of additional staffing demands following the transition of some residents to single occupancy arrangements on the campus. When comparing agency usage between the October 2024 inspection and the current inspection, inspectors found that agency use had tripled, with the centre now operating with a staffing deficit of 27 posts against a required complement of 43.

It was found that earlier moves to single occupancy homes in 2024 had not been matched with an increase in staffing resources, despite the additional support needs such arrangements required. This demonstrated a lack of planning at the leadership level to ensure that such transitions were sustainable. At the time of inspection, one apartment was being staffed entirely by agency personnel, raising concerns about consistency of support, continuity of care, and the centre's overall ability to maintain safe and effective service delivery.

Judgment: Not compliant

Regulation 23: Governance and management

The inspection found that the designated centre was not adequately resourced to ensure the effective delivery of care and support in line with its statement of purpose, and that leadership decisions had contributed to further staffing deficits. Inspectors found that vacancies at key management levels had placed additional pressure on the leadership team, with members of the broader provider management structure stepping in to sustain day-to-day governance. For example, the Head of Services was providing direct support to the interim person in charge due to the vacant Area Service Manager position.

In addition to direct care staffing shortfalls, there were vacancies for a team leader and three house coordinator roles, all of which are critical to the daily operational oversight of the designated centre. The absence of these posts placed further strain on management capacity and limited the centre's ability to provide consistent

leadership and oversight.

The provider's six-monthly audits continued to identify significant areas for improvement, including in the areas of assessment of need, safeguarding and protection, staffing resources, and the review and upkeep of documentation. However, inspectors found that actions arising from audits and internal reviews were not being completed or resulting in the required improvements. At the time of this inspection, 62 of 93 actions from the most recent six-monthly audit in January 2025 remained outstanding. These findings were consistent with the issues identified during the previous inspection in October 2024.

These concerns were brought to the attention of the management team during the inspection. Notwithstanding efforts made by the current leadership team, the stretched management capacity continued to affect the service's ability to respond effectively to audit findings and to drive the necessary improvements required to meet regulatory standards.

Judgment: Not compliant

Quality and safety

The inspection found that while there were some improvements in certain operational areas, significant challenges remained in delivering consistent, safe, and person-centred care to all residents. Inspectors found that for some residents, their assessed needs could not be fully met within the current environment, and this had a direct impact on their quality of life and that of their peers. The centre continued to experience environmental limitations, staffing deficits, and compatibility issues, all of which impacted the delivery of safe and effective supports.

Moreover, formalised assessments of need were not routinely completed or used to inform decisions relating to internal transfers or discharge from the service, which further limited the provider's ability to plan care in line with residents' evolving needs.

Staff spoken with during the inspection demonstrated a good understanding of safeguarding practices and were knowledgeable about the current safeguarding plans in place. All staff had completed training in safeguarding vulnerable adults, and safeguarding measures were being implemented in daily practice. While progress had been made in stabilising the environment and supporting residents through familiar staffing, the inspection found that safeguarding risks remained due to the continued environmental incompatibilities and the unmet assessed needs of some residents.

Regulation 5: Individual assessment and personal plan

Following a number of assaults on staff, a statutory agency conducted a workplace safety inspection of the centre in December 2024. Since that time, inspectors found that the frequency of incidents had reduced, supported by improvements to support structures, and increased consistency in staff approaches to managing behaviours of concern.

Inspectors reviewed the provider's response to the statutory agency's findings in February 2025 and noted that the majority of required actions had been completed. However, one critical action remained outstanding, the review and updating of individual needs assessments. These assessments are required to be reviewed annually or following significant changes in need. It was found that, for residents who had experienced notable changes, assessments had not been updated since July 2023. This issue was brought to the attention of the management team and they had flagged it for action in the provider's six-monthly audit, with a due date for completion noted as February 2025.

Inspectors were further informed that, in February 2025, the funder of services had been issued 90-day discharge notices for four residents, citing the provider's ongoing inability to meet their assessed needs within the designated centre. Inspectors found that clear assessments of resident's current needs had not been adequately completed to inform this decision**.** In some cases, the complexity of these presenting needs was also impacting the freedom of movement and enjoyment of shared living spaces for other residents and these required clearer assessment.

Of the residents affected, only one resident had a formalised transition plan to move to another designated centre operated by the provider. The remaining three residents required external placements, but suitable alternative services had not yet been identified or confirmed. This presented ongoing risks both to the individuals concerned and to the overall quality of life and compatibility for all residents living in the centre.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had implemented a range of systems underpinned by written policies and procedures to promote the safety and wellbeing of residents. However, inspectors found that for four residents, the environment was no longer suitable to meet their assessed needs, and this was contributing to compatibility concerns between residents.

Inspectors acknowledged that the provider had identified the limitations of the

environment and had initiated referrals through external stakeholders to secure more appropriate placements for the four residents. At the time of inspection, a transition plan had been formalised for one resident, with a new home identified under the provider's governance. However, three residents remained on review lists awaiting the identification and confirmation of alternative placements better suited to their needs.

The provider had also identified safeguarding concerns in one house within the centre and had prioritised a permanent staff team to work specifically with residents in that location. Incident data was being monitored and trended, and the provider had recorded a reduction in safeguarding incidents over the preceding three months. Inspectors observed that peer-to-peer incidents had decreased where residents were supported by familiar and consistent staff. However, incidents continued to occur, and the environment itself remained a contributing factor.

Judgment: Substantially 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	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Dunshane Camphill Communities of Ireland OSV-0003616

Inspection ID: MON-0046276

Date of inspection: 04/04/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The vacant position of Team Leader has been filled by a staff member who has a sound knowledge of the service as they had previously worked there for a number of years. • One House Co Ordinator position has been filled by an agency staff member who also has a sound knowledge of the service and is familiar with the residents' needs. • CCoI continue to work with agencies in a bid to source suitably qualified and skilled staff to reduce our reliance on agencies. • 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 • Camphill Dunshane utilise a cohort of agency staff who are familiar with the residents' needs • 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. • The WTE required for the community has decreased by two WTE following the successful discharge of one resident into the care of suitable care provider. • This figure will further decrease following a number of planned discharges from the service.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:

Since the inspection 3rd & 4th April 2025 the Person in Charge has departed the role and the Interim Head of Services has taken on the role of Person in Charge on an interim basis.
• CCoI continue to work with agencies in a bid to source suitably qualified Person in Charge for the service.
• There are two full time Team Leaders in place, who have designated responsibilities each day to ensure oversight in each house. Both Team Leaders meet with the HoS/PIC who provides guidance and support for the community.
• The HoS/PIC is present in the at least three days per week. They are also available for support via teams, phone and email for support when they are not on site.
• Meetings are held daily where updates are provided and discussed with actions agreed.
• Weekly house meetings are occurring with all aspects of the service is discussed with residents.
• Monthly House Team Meetings are occurring where all items associated with the house and residents' welfare are discussed.
• The new compliance, safeguarding and risk manager has scheduled the completion of a provider audit and will monitor the completion of all actions identified in consultation with the HoS/PIC.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• A full review of all Assessments of Needs has been completed with a priority placed on the residents identified for discharge or transition within the organisation.
• All supporting documentation which provides guidance to staff and identify individual resident's need are also currently being reviewed.
• CCoI continues to engage with the funder to progress transitions and discharges from the services to ensure all residents are supported in environments appropriate to their needs.
• One resident has successfully transferred to an alternative care provider where their assessed needs will be met in this environment.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• A number of assessments have been carried out by other service providers to identify a suitable placement for one resident. These assessments concluded on 21st May 2025.Confirmation from the funder of the identified most suitable placement will be informed to CCoI and a transition process will continue with the resident involving all relevant stakeholders associated with the resident's care. In the interim period, additional staff continue to be in place to support all residents where required. Meetings have been scheduled with the funder and representatives of a number of other residents to review the suitability of their placements and an agreed plan to commence transitions to transfer to identified alternative providers implemented.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/07/2025
Regulation 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	31/07/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/07/2025

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	31/05/2025
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	31/07/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/06/2025