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:	30 June 2025
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0047547

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:	16

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 30 June 2025	11:00hrs to 19:15hrs	Tanya Brady	Lead
Monday 30 June 2025	11:00hrs to 19:15hrs	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 the Chief Inspector of Social Services. There were five regulations reviewed on this inspection and inspectors found all five were not compliant.

Inspectors arrived mid morning to this centre and spent time there until early evening. Inspectors found there were 16 residents living in this centre in seven premises. Since the previous inspection completed in April 2025 one resident had transitioned to live in another setting and a second resident was in the middle of a planned move to another centre operated by the provider. Two other possible transitions had not progressed as stated,which was part of the provider's response to the inspection findings in April 2024.

Inspectors visited all premises that comprise this designated centre and found that while some rooms were homely and comfortable, large parts of the premises were in a poor condition with risks for resident safety as a result. This included evidence of leaks, broken and discarded furniture in and around homes, broken window restrictors on first floor windows, uneven paths and areas around homes overgrown and rubbish not collected or lying where discarded outside resident windows.

Inspectors met 10 residents over the course of inspection. Inspectors were concerned with the levels of consultation regarding residents' moves, transitions, compatibility impact and continuity of care for residents in this centre. One resident spoken with stated they were happy with their service (as they had recently moved to better accommodation - but also had to move again to accommodate another resident which was not ideal), Another resident presented as agitated regarding staff changes. One resident was observed to spend large periods of time in bed (due to reported behaviours of concern) and and the majority of other residents did not communicate verbally and were not supported by staff familiar with their communication needs at the time of the inspection.

Residents in the centre communicated using a variety of methods of communication including speech, eye contact, body language, sign language vocalisations, gestures and behaviour. Inspectors were informed by staff that for some residents, it was of significant importance for them to have staff who knew them and their communication signals well to best interpret those communication attempts and to respond appropriately.

Inspectors found that this was not possible due to the provider's staffing deficits and reliance on agency staff as outlined later in the report. Other residents had complex health care needs or presented with behaviour that challenges and staffing deficits

also prevented the receipt of high quality continuity of care and support for residents.

Capacity and capability

The purpose of the current inspection was to provide assurance that safe and good quality care was being provided to residents in this centre. In response to previous inspections and regulatory actions taken, the provider had submitted written assurances to the Chief Inspector, that outlined the actions they would take to come back into compliance. These submitted plans formed lines of enquiry within this current inspection.

Inspectors found during this inspection that the provider had failed to address the actions identified by them in their submitted responses to the Chief Inspector. While the provider had completed the transition of one resident and was in process of a second transition there remained a lack of comprehensive assessment to underpin the rationale for resident transitions both externally and internally. Inspectors acknowledge that in one location there had been a reduction in peer to peer safeguarding as an outcome of one transition. However, this had not been reviewed formally in a manner that could inform planning for required resources currently within that home.

Regulation 14: Persons in charge

Inspectors found arrangements in place regarding the regulatory requirement to have a full time and competent person in charge in place were not adhered to. There was no consistency or continuity of local management in this centre which left clear gaps in terms of leadership, governance, oversight and accountability.

Person's in charge were required to hold multiple roles which did not work and was not effective. There had been another change to the person in charge since the April 2025 inspections and the current person in charge was resigning in the days following inspection stating the post was not tenable due to inadequacies in the providers governance structures.

Staff informed inspectors that the lack of structured and consistent management made it very difficult to work in this centre. Staff who spoke to inspectors highlighted that they were unclear who to raise concerns with in the provider's management structure.

Judgment: Not compliant

Regulation 15: Staffing

The last inspection of this centre completed in April 2025 found that agency use had tripled, with the centre then operating with a staffing deficit of 27 posts against a required complement of 43 whole time equivalent staff (WTE). Despite the assurances given by the provider to the Chief inspector and the actions stated by them for completion the required complement of staffing had not been reviewed nor was it based on assessments of resident needs.

The provider was unsure as to their staffing needs and when asked by inspectors provided conflicting information in this regard. For example, previous submitted provider assurances, compliance plan responses, warning letter responses and the centres statement of purpose (a document that outlines the staffing in the centre) all had different information. Local management provided inspectors a current figure of 40 WTE which was stated to be based on current staffing levels rather than on required or assessed levels. On this inspection the current staff team was stated as 17 WTE with a number of other staff identified as 'onboarding' however, they were not in post on the day of inspection. This was an increase in the staffing deficit since the previous inspection.

The inspectors met and spoke with staff and co-workers (volunteers who lived and worked in the centre) as part of this inspection. Staff spoken with and observations made by inspectors in addition to documentation reviewed all demonstrated that the level of vacancies in this centre negatively impacted on the consistency of care and support for residents. For example, residents with complex support needs were being exclusively staffed by agency staff as the providers own staff were reportedly refusing to work with them (due to incidents/staff getting hurt). There was not appropriate oversight of these agency staff in terms of supervision, training and ensuring appropriate skills, experience and expertise to work with complex residents. For example, on the day of inspection the manager did not know the names of agency staff on shift who when questioned by inspectors had very limited knowledge of residents needs and were lone working. Inspectors were shown a system for the tracking of agency staff with the intent of providing supervision. However, not all staff who were on the roster were on this list and those that were had not been consistently provided with guidance or support.

Other staff spoken with expressed concerns as to the running of the centre and described a poor culture that was not based on residents needs with limited communication or guidance on how to support residents. Other staff spoken with had recently been recently promoted to new roles and stated they were still learning and only on their first few shifts. Overall inspectors found that staff were endeavouring to carry out their duties in the absence of written guidance and management support and oversight but were severely hampered in doing so.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors were not assured by the governance arrangements found to be in place during this inspection. The provider's strategic and operational decision making and overall management and resourcing of this designated centre was not effective nor driving improvement for residents.

Findings of the last inspection were that the governance and management of this centre was poor. This inspection found that the provider had not ensured appropriate actions had been taken in line with the compliance plan response from the inspection completed on 3 April 2025, nor in line with their submitted response to a warning letter issued to the provider on 2 May 2025.

The number of changes in the management team since the last inspection had also contributed to the lack of implementation of systems and to the poor systems of oversight in place to ensure support provided to residents was consistently and effectively monitored. This centre has had four persons in charge in a one year period, in addition to a series of individuals performing multiple roles throughout this time.

The current person in charge informed inspectors they had resigned their position and were finishing in the days following inspection with no replacement identified. Manager and staff retention has been an ongoing problem in this centre resulting in poor continuity of leadership, governance, accountability and oversight.

The impact of this was seen in a number of areas reviewed including, but not limited to;

- Non-implementation of previous assurances and compliance plans submitted to the Chief Inspector
- Non-implementation of assurance following a warning letter issued by the Chief Inspector of Social Services
- Lack of comprehensive assessment of residents' needs
- Lack of comprehensive assessment of the required staffing provision/required whole time equivalency (WTE) to safely staff the centre
- Poor admission/discharge procedures and implementation
- Poor decision making regarding the internal transfer of residents- Inappropriate use, supervision and oversight of agency staff

Overall inspectors were not assured that the provider was equipped to drive improvement in this centre. This preliminary feedback was given to the Chief Executive Officer (CEO) following this inspection and no further assurances were received.

Judgment: Not compliant

Quality and safety

The findings of the current inspection did not provide assurances that residents in this centre were in receipt of a high quality, safe services.

No improvements were noted from the previous inspection such as, no environmental enhancements, no reviews of restrictive practices, there was an increase in the reliance on agency staff. However, concerns remained in relation to safeguarding and the compatibility of residents in the centre.

In addition, assessment of needs were not effective in identifying residents needs or the level of staffing supports required to deliver care in a safe and effective manner. This will be discussed further under Regulation 5: Individualised Assessment and Personal Plan.

Regulation 26: Risk management procedures

Inspectors were not satisfied with the standard of risk management and oversight in this centre. This did not adequately safeguard or protect residents. Inspectors reviewed the current centre risk register in addition to the provider's overarching risk mechanisms and individual residents' risk assessments and found that these failed to adequately or accurately identify risks that were observed on one day of inspection.

Inspectors reviewed the centre's risk register and noted 17 recorded risks. These risks areas included; accidental injury to residents, residents going missing, risk of falling/harm, risk of behaviours of concern, staff injuries and risk of insufficient resources to support residents. Inspectors observed six overdue actions pertaining to risks logged on the risk register. These included risks pertaining to resident incompatibility, property/maintenance risks, and medication error risks involving resident's medication.

In information submitted by the provider to the Chief Inspector, they stated that they were actively working towards the discharge of a number of residents due to their inability to meet these residents' needs. As outlined also under Regulation 5 the lack of comprehensive assessments of residents' needs did not underpin decision making or assessment of risks. Inspectors were informed that these decisions on discharge were primarily based on the severity of these residents' behaviours of concern. Staff reportedly refused to work with residents who were in turn were being exclusively staffed by agency staff. This arrangement was reviewed by inspectors and posed a number of risks in terms of the provision and continuity of

safe and quality care to these residents which was of concern. In particular as not all of these risks had been identified or recorded by the provider.

The condition of this premises was highlighted earlier in this report however, the environmental risks observed on walking around the centre by inspectors was concerning. This designated centre is very large and has substantive grounds. Environmental risks observed and not identified nor managed by the provider posed risks of falls for residents with poor mobility, infection prevention and control or injury risks based on the rubbish and debris observed and health risks based on the condition of some living environments.

Inspectors found for instance:

- Some buildings in a very poor/dilapidated state of repair
- Uneven pathways/surfaces
- Unfinished maintenance works outside residents homes
- Broken furniture left on corridors outside residents bedrooms
- Filled skips/rubbish/waste that needed removal
- Rubbish thrown out bathroom window (pile of rubbish observed)
- A resident's bedroom with a leak/considerable leak stained ceiling
- A resident's window with a broken window safety restrictor (first floor)
- Overgrown gardens/trees/bushes that where surrounding residents houses and in some cases impeding fire escapes.
- Unfinished/uncovered drainage vents/pipes (external)
- Build-up of leaves outside residents homes access/exits
- Full gutters/weeds/moss all over residents houses roof/gutters.
- Large areas of farm land, a farm, barns, farm sheds, tools, machinery that could pose risk if residents were unsupervised (which was observed).

In addition to environmental and support risks stated, the inspectors also observed clinical risk for a number of residents on the day of inspection.

For one resident the management of their elimination care planning and catheter care was extremely poor. Inspectors observed a catheter hanging from the bottom of a resident's trousers whereby the resident was observed emptying this on the ground as they walked around the designated centre grounds with staff. In consulting this resident’s care plan, the inspectors found there was ‘guidance’ that was dated ‘2023’ and not an individualised elimination care plan to guide staff. This guidance noted the catheter should be secured with straps above the resident’s knee and the resident should be supported to empty/eliminate with privacy/dignity. The resident was observed later in the evening with a full catheter bag hanging from the bottom of their trousers that was dragging on the ground behind them as they walked.

Another resident was supported by ambulance from the designated due to prolonged seizure activity on the day of inspection. In discussing this resident with the staff member scheduled to work with them, they had very little knowledge or understanding of the resident's needs nor were they aware the resident had been

taken by ambulance to hospital and did not know where the resident was as they sat in the empty house at the start of their shift.

Another staff member spoken with, who was lone working and caring for another resident demonstrated a very limited understanding/ knowledge of this resident's complex assessed needs.

Overall inspectors were not satisfied with the management of a number of risks identified on this inspection nor the providers demonstrable ability to manage these risks.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Overall, inspectors were not assured that residents' needs were being appropriately assessed and reviewed as required to reflect current, changing and emerging needs.

As previously mentioned, as part of the compliance plan response and the response to the warning letter the provider had committed to completing assessment of needs for each of the residents within the centre. Inspectors reviewed the documentation in place and did not find evidence of updated assessments and were consequently not assured that residents' needs had been appropriately assessed. For example, on review of one assessment of need on file, it failed to identify the details in management of a resident's behaviour that challenges. The provider in response to a complaint about this resident's care stated in documents reviewed by inspectors that they had not completed needs assessments or reviews as required and inspectors found that no plans were in place to arrange such a review.

The provider's stated action of assessment and identification of residents' assessed support needs to inform planning for resources/staffing remained incomplete. This did not provide assurance that the supports in place were as required for residents. This inconsistency or potential lack of knowledge regarding residents' needs remained a serious issue which was having a direct negative impact on the lived experience of residents.

As previously mentioned, the inspectors reviewed numerous documents completed by the provider that indicated that two residents required an alternative service. For both no clear assessments of need underpinned this decision. For one resident while the provider stated that they were planning on discharge, no actual decisions or actions had been taken. Although some meetings had taken place and inspectors reviewed minutes of these they had not been escalated through the appropriate management channels, and were not submitted to the relevant funder. When the inspectors requested further information in relation to decisions taken to improve the residents service such as reducing agency staff use, the management team were unable to provide any assurances that progress in this matter was underway.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Dunshane Camphill Communities of Ireland OSV-0003616

Inspection ID: MON-0047547

Date of inspection: 30/06/2025

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 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
Appointment of a permanent experienced Person in Charge will ensure consistency and continuity of local management in the centre. (Effective 25 August 2025)

• A newly appointed, suitably qualified, and experienced Person in Charge will formally commence in post on 25 August 2025.
• As the PIC is new to the role they will be supported with increased mentoring and support while they settle into the roles and responsibilities. This guidance will be provided by the CEO and supported by the two current Team Leaders. The CEO has met the incoming PIC in Dunshane on 25.08.25 to commence induction.
• The Head of Property will conduct weekly visits to the centre to include a walkaround of the premises, conversations with staff and centre management for increased onsite oversight. This commenced on 25.08.2025 and will continue until the commencement of the Area Service Manager.
• Weekly governance meetings will be held with the PIC and CEO commencing on 01.09.2025 until such time that all systems in this compliance plan have been actioned and implemented, after which meetings will move to fortnightly and will be conducted with the new ASM following their commencement.
• A new Area Services Manager has been appointed and will commence in their role on 06.10.25.
• An introductory meeting will be held with the PIC and the ASM on 06.10.2025.

• A further meeting will be scheduled on the 16.10.25 to determine the progress of the quality enhancement plan considering the areas for improvement highlighted in the inspection report.
• The new ASM will conduct weekly visits to the centre to include a walkaround, conversations with residents, staff and PIC providing for increased onsite oversight.

These visits will commence on 20.10.25.
• A system has been agreed whereby the PIC will attend board meetings to provide information on the operations and needs of the center. The first meeting is scheduled for 29.09.2025.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Update re staffing on 25.08.2025:

• House Coordinator x1 commenced on 25.08.2025
• Social Care Worker x1 commenced on 25.08.2025
• Social Care Worker x1 commencing on 28.08.2025.

Camphill Communities of Ireland (CCoI) recognises the critical importance of ensuring that each designated centre is resourced with the appropriate number and skill mix of staff to meet the assessed needs of residents, in line with Regulation 15 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

A full review of staffing levels in Dunshane Community has been completed, and an evidence-informed workforce plan has been developed to ensure safe and person-centred care delivery.

Corrective and Preventative Actions Undertaken Since Inspection:

1. Full Review of Staffing Needs and Workforce Planning
Upon review of the Service User Information Tool (SUIT) for Dunshane Community the Whole Time Equivalent (WTE) staffing requirement for the centre to operate safely and in full compliance with Regulation 15 has been identified as:

Person in Charge 1 WTE
Team Lead 2 WTE
House Co-ordinators/SCW/SCA 33.2 WTE
TOTAL 36.2 WTE

This overall requirement is expected to reduce by 2.0 WTE in the coming 2–3 weeks, following the planned/documented transition of a CMSN to another service provider. This change will be reflected in the next staffing review and workforce planning update, and a new Statement of Purpose will be provided to HIQA.

2. Current Staffing Position and Progress Since Inspection

As of the most recent payroll data review (August 2025), Dunshane Community has 21.49 WTE staff in place across relevant roles.

Since the date of the most recent HIQA inspection, significant progress has been made to strengthen the workforce:

• 6.25 WTE staff have been successfully recruited and are currently in the onboarding process.
• A further 2.5 WTE have been offered positions and are pending formal acceptance and contract finalisation.
• Projected Total Post-Onboarding WTE: 30.24
• Remaining Staffing Deficit: 5.96 WTE

3. Interim Measures and Mitigation of Risk

Pending the full recruitment of the outstanding 6.56 WTE, CCoI has implemented a range of proactive interim measures to ensure service continuity and mitigate any risk to residents:

• Deployment of trained and familiar agency staff from reputable recruitment agencies.
• Regular use of overtime from existing core staff, ensuring continuity of care and familiarity with residents' needs.
• Active monitoring of staffing rosters by local and regional management to ensure that planned and actual staffing levels remain aligned to residents' needs and regulatory expectations.

4. Ongoing Recruitment Strategy

CCoI continues to prioritise recruitment through:

• Direct recruitment campaigns on national and international platforms.
• Partnerships with specialist recruitment agencies to source suitable candidates.
• Close collaboration with the national Human Resources department to expedite interview and onboarding processes.

A focused action plan is in place to fully close the staffing gap, with regular reporting to senior management and the Board.

In conclusion, while a staffing shortfall currently exists, measurable progress has been achieved since inspection, and robust interim arrangements are in place to ensure continuity and safety of care.

CCoI remains fully committed to achieving full compliance with Regulation 15 and will continue to review and update the workforce plan to reflect changing needs and regulatory expectations. Ongoing internal audits and oversight mechanisms are in place to ensure the effectiveness of staffing arrangements and their impact on residents' outcomes.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A range of targeted actions have been implemented to strengthen leadership, clarify oversight structures, and ensure that transitions and internal service arrangements are managed in a transparent, policy-led, and resident-focused manner.

Strengthening of Centre-Level Leadership

Head of Service Interview on 28.08.2025
Area Services Manager Commencing on or before 06.10.2025
Person in Charge (PIC) Commenced on 25.08.2025
Team Lead x2 In place
House Coordinators In place (x1 commencing on 25.08.2025)
Designated Safeguarding Officer In place
Compliance and Safeguarding Risk Manager In place
Quality and Compliance Officer In place
National Safeguarding Lead In place

• A comprehensive assessment of all residents' needs has commenced and will be completed by 29.09.2025.
• The ADT panel meetings recommenced on 24.07.2025. CCOI are confirming that all current and future transitions, admissions and discharges will comply with the policy and procedure and will be recorded through the ADT panel meetings.
· The CEO (until the commencement of the ASM), National Safeguarding Lead, Medication CSO, and Behavioral CSO together with the centre management will attend the monthly Community Management Meeting (CMM), scheduled for the last Wednesday of every month. The July meeting took place on 30.07.2025.

· ASM when they commence on 06.10.25 will attend the weekly Senior Management Team meetings.

· The Head of Services position is currently vacant, and interviews are scheduled for 28.08.2025. In the meantime, the CEO is covering the responsibilities of the Head of Services to maintain continuity of governance.

· The Health and Safety Officer carried out a full audit on 30.07.2025. The PIC and ASM will disseminate the findings from this audit and ensure actions are closed off by 30.11.25. The Health and Safety Officer will conduct a further hazard identification audit by 15.12.25.

· An external Health & Safety officer will complete a full review on 01.09.2025 – 02.09.2025.

· The Quality and Compliance Officer has completed a provider audit which commenced

on 25/07/2025. Feedback will be provided to the new person in charge on 01.09.25. The PIC in consultation with their CEO will ensure all actions are closed in line with the action plan as outlined on the provider audit.

· The Clinical Support Officer for Medication is scheduled to complete the annual medication audit on 06.10.2025 – 07.10.2025.

· The Behavioral CSO visits the site at least bi-weekly. They attend team meetings as necessary when there are behaviours of concern to discuss. They are available Monday to Friday, 09:00–17:30, by Teams or mobile. The staff team utilize this support regularly.
· The National Safeguarding Lead is providing additional applied safeguarding training to all staff and regular agency staff on 22.08.2025 and 29.08.2025.

· 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 (Commencing on 06.10.2025) → PIC (Commenced on 25.08.2025→ Team Leaders x2 → House Coordinators x3 (Additional House Coordinator onboarding on 25.08.2025) → Social Care Team

· The Learning and Development Officer holds monthly meetings to support PICs and Admins in fulfilling training obligations for staff teams, supporting booking and planning of training. The next meeting will take place on 10/09/2025.

· The Compliance, Safeguarding and Risk Manager is due to review Operational Risk Register with PIC on 08.09.2025

· Restrictive practice reviews will be completed by the RP panel on 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. The schedule will be reviewed by the PIC on a monthly basis, commencing on 15.09.25 and subsequently by the Quality & Compliance Officer during provider audits.

· 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.

· The SOP for On-Call, outlining the roles and responsibilities of the PIC, ASM, CEO, and Head of Services, was shared with the staff team on 08.07.2025 and subsequently on 22.08.25.
An accessible letter will be provided to each resident by the House Co-Ordinator's by 29-08-2025 to inform them of the new management people in place and their contact details.

An ADT panel meeting will be held by 30-09-2025 to review the residents' discharge from the centre and ensure all steps have been followed and formalized to conclusion.
· The Head of Property will conduct weekly visits to the centre to include a walkaround of the premises, conversations with staff and centre management for increased onsite oversight. This commenced on 25.08.2025 and will continue until the commencement of the Area Service Manager.

· Weekly governance meetings will be held with the PIC and CEO commencing on 01.09.2025 until such time that all systems in this compliance plan have been actioned and implemented, after which meetings will move to fortnightly and will be conducted with the new ASM following their commencement.

· A new Area Services Manager has been appointed and will commence in their role on 06.10.25.

· An introductory meeting will be held with the PIC and the ASM on 06.10.2025.
· A further meeting will be scheduled for the 16.10.25 to determine the progress of the quality enhancement plan considering the areas for improvement highlighted in the inspection report.

· The new ASM will conduct weekly visits to the centre to include a walkaround, conversations with residents, staff and PIC providing for increased onsite oversight. These visits will commence on 20.10.25.

· A system has been agreed whereby the PIC will attend board meetings to provide information on the operations and needs of the center. The first meeting is scheduled for 29.09.2025.

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.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Corrective and Preventative Actions Undertaken since inspection:
• Risk Assessments
Dunshane Centre Risk Assessments:

The Provider has initiated a comprehensive review of the centre's risk

assessments which will be completed by the PIC in consultation with the Compliance, Safeguarding and Risk Manager, by 20.09.2025.
The Health and Safety Officer completed a review of the operational risk register and associated risk assessments, concluding on 07.08.25. The Compliance, Safeguarding and Risk Manager will subsequently review the above together with the PIC by 30.09.25.
The reviewed assessments are aligned with CCoI's Risk Management Framework and are now being monitored on an ongoing basis by both local management and the national Compliance & Risk function to ensure continued relevance and responsiveness.
• CMSN Risk Assessments:
A focused review of individual risk assessments for CMSNs is currently underway. This process is being led by centre management with input from clinical support and behaviour specialists where appropriate.
The objective of this review is to:
• Ensure that all individual risks are accurately identified and assessed.
• Confirm that all control measures are person-specific, effective, and proportionate.
• Integrate clinical guidance (e.g., Behaviour Support Plans) into the risk management process.
• Ensure risk documentation aligns with each CMSN's current presentation, needs, and support arrangements.
This work will be completed on 29/08/2025, after which all CMSN risk assessments will be subject to regular multidisciplinary review and governance oversight.
• Strengthened Supports
This individual's needs, CCoI has established a dedicated, consistent staffing team to support the CMSN on a full-time basis. This approach reduces environmental and interpersonal risk factors, strengthens therapeutic relationships, and ensures stability in the support environment.
To further mitigate risks associated with behaviour and support planning:
• The assigned team has completed focused training delivered by CCoI's Clinical Support Officer, covering the CMSN's Behaviour Support Plan (BSP) and related supports on: 21/07/25 and 30/07/25. All attending staff signed an attendance record and confirmed that they understood the guidance and its application to the individual's care.
• Ongoing clinical oversight is in place to monitor the effectiveness of the BSP and to provide staff with real-time support, review, and coaching as needed.
• The BSP is subject to regular multidisciplinary review to ensure it remains appropriate, effective, and reflective of the individual's evolving needs.
• Ongoing Governance and Monitoring
All risk management procedures in Dunshane Community are overseen by local management and are subject to regular review by the National Compliance, Safeguarding & Risk function. Risk assessments for high-needs CMSNs are reviewed monthly or more frequently as required, and any significant risks are escalated to the Senior Management Team (SMT) for strategic oversight.
• Premises Works
We acknowledge the concerns raised in the inspection report regarding the condition and safety of the premises. The following corrective actions have been taken or are scheduled to ensure full compliance with regulatory standards and the ongoing safety and wellbeing of residents:
• Uneven Pathways and Surfaces
o All existing defective pathways and paving works are scheduled to commence Thursday, 14th August 2025.

o Work will begin on pathway reconstruction on Monday, 18th August 2025.
• Unfinished Maintenance Works Outside Residents' Homes
o All tools and materials were removed from the area on 08.08.2025. The affected area has been cordoned off and marked as restricted access pending completion of outstanding works.
o Works to be completed by 20/08/2025
• Broken Furniture in Corridors Outside Residents' Bedrooms
o All broken furniture has been removed and properly disposed of. Ongoing monitoring is in place to prevent recurrence.

• Accumulated Rubbish and Waste, Including Filled Skips
o All waste and skips have been cleared and replaced as required. Waste management procedures have been reviewed and strengthened.

• Rubbish Discarded from Bathroom Window
o The area has been cleaned, and a designated bin has been placed nearby. A window mesh has been ordered and will be installed by 16th August 2025 to prevent further issues.

• Leak and Water Damage in Resident's Bedroom
o A qualified contractor has assessed the damage. The repair quote has been approved, and works are scheduled to commence on 18th August 2025.

• Broken Window Safety Restrictor (First Floor)
o The window restrictor has been replaced and inspected. The repair is now complete and compliant with safety standards.

• Overgrown Gardens, Trees, and Bushes Impeding Access and Fire Escapes
o Overgrown foliage has been cut back and heavy landscaping works are ongoing. Landscaping waste is scheduled for removal by 15th August 2025.
o Stump and tree removal works have been booked with a professional tree surgeon to commence on 14th August 2025.

• Unfinished or Uncovered Drainage Vents and External Pipes
o Works are currently in progress and scheduled for completion by 18th August 2025. The affected areas have been covered pending completion of outstanding work.

• Build-up of Leaves Around Resident Access and Exit Points
o Leaves have been cleared, and a preventative maintenance schedule has been implemented to ensure regular clearing and monitoring.

• Blocked Gutters and Moss/Weeds on Roofs and Gutters
o All affected areas have been cleaned, and an ongoing gutter maintenance plan is now in place to ensure future compliance.

• Unsecured Farm Areas, Tools, Machinery, and Outbuildings
o Access to farm buildings and equipment has been restricted through the erection of secure gates and fencing. All tools and machinery have been relocated to locked storage areas. New safety signage has been installed to reinforce restricted access areas.

Completed on 29.07.2025

• The Provider has commissioned an external auditor to carry out a full health and safety audit in Dunshane, which will include hazard identification. This is scheduled for 01.09.25 – 02.09.25.

• Clinical Risks
Following the inspection, the existing elimination and catheter care guidance document, originally dated 2023, was reviewed in full by CCoI's Clinical Support Officer on 27.07.2025. The purpose of this review was to ensure that the guidance accurately reflects current best practices, clinical standards, and the individual needs of the CMSN in question.

This revised guidance includes:
o Clear instructions on catheter positioning, securing mechanisms (e.g., appropriate use of leg straps), and hygiene protocols.
o Defined procedures for maintaining dignity and privacy during elimination, including supervision requirements and environmental supports.
o Risk mitigation strategies to prevent infection, leakage, or environmental exposure.

On 1st August 2025, a staff meeting was held with all staff members currently supporting the CMSN. This session was led by the Clinical Support Officer and included:

o A structured walk-through of the updated elimination and catheter care guidance document.
o Visual demonstrations and practical discussion to reinforce proper application of catheter care procedures.
o Opportunities for staff to raise questions, clarify responsibilities, and confirm understanding.

All attending staff signed an attendance record and confirmed that they understood the guidance and its application to the individual's care.

An individualised elimination and catheter care plan has now been developed for the CMSN, incorporating the following elements:

o Specific routines and supports required for elimination.
o Clinical oversight protocols.
o Detailed guidance on how dignity and privacy are to be upheld in both routine and unplanned care situations.
o Monitoring and review schedules to ensure ongoing suitability of care.

This care plan is now integrated into the CMSN's overall personal plan and will be subject to monthly review by the Person in Charge, with input from clinical supports as required.

• Lone Working and Knowledge of CMSNs Assessed Needs

We acknowledge the concern raised during the inspection regarding a staff lone working.

As part of its ongoing commitment to employee safety, Camphill Communities of Ireland has engaged with an external provider specializing in lone worker safety solutions. Following consultation and evaluation, a system has been selected that offers comprehensive support for lone workers across all relevant sites. These will be rolled out by 30.09.2025.

The selected system includes personal safety devices that can be assigned to identified lone workers.
These devices are equipped with the following features:
o Upon activation of the SOS signal, the system utilizes GPS technology to determine and transmit the user's location
o Emergency alert functionality to summon assistance or emergency services
o Automated escalation protocols to notify designated personnel in the event of an incident
o Emergency call monitoring and response are managed by the external service provider to ensuretimely and effective intervention.
o Maintenance and testing of these devices are carried out by an external service provider to ensure optimal system functionality and reliabilit

As part of CCoI's commitment to continuous quality improvement and person-centred care, we have initiated a comprehensive review and update of all CMSNs, Behaviour Support Plans (BSPs), and associated support documentation across the service to be completed by 01/10/2025.

As part of our ongoing review of CMSN files and individual support documentation, all staff will be required to review, familiarise themselves with, and formally acknowledge the assessed needs and support requirements of each resident they support. This will be completed by 01.11.2025

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:
Camphill Communities of Ireland (CCoI) acknowledges the findings of the most recent inspection report and accepts that the assessment of residents' needs in Dunshane Community did not, at the time of inspection, adequately reflect the current, changing, and emerging needs of all individuals.

CCoI is committed to ensuring that all residents have comprehensive, up-to-date assessments of need in place, and that these are reviewed regularly to inform appropriate care planning, support delivery, risk management, and resource allocation.

Corrective and Preventative Actions Undertaken since inspection:

1. Immediate Actions Taken Post-Inspection

Following the inspection, and in alignment with previous commitments in the compliance plan and warning letter response, the following immediate actions were undertaken:

• Comprehensive review of all assessment of needs documentation across the designated centre was initiated.
• Priority was given to individuals identified by inspectors as having behavioural support needs or where gaps in assessment were clearly identified.
• In cases where significant gaps were identified (including the CMSN referenced in the inspection report), clinical and operational teams were mobilised to begin immediate updates of needs assessments, with a specific focus on behaviours that challenge, safeguarding risks, and environmental supports.

2. Clarification and Correction of Miscommunication
It is acknowledged that, during the inspection, inaccurate information was shared with inspectors regarding the discharge plans of one CMSN. CCoI confirms that this individual is not scheduled for discharge, and there are no current plans for their transition from the service. This error was a result of internal communication breakdowns which have since been addressed through a formal review and the implementation of stricter communication protocols.

Further, as part of our internal review, CCoI has confirmed that no discharges or service transitions will be progressed without a comprehensive, multidisciplinary assessment of need and consultation with the Senior Management Team and relevant HSE funders.

3. Current Progress on Assessment of Needs
All centre-wide risk assessments have been reviewed in full.

Assessment of Needs for CMSNs are currently undergoing an in-depth, multidisciplinary review to ensure they accurately reflect the current and emerging needs of residents, including behavioural support requirements and environmental considerations.

Dedicated clinical and behavioural supports are involved in this process to ensure that needs assessments are comprehensive, person-centred, and actionable.
For the CMSN referenced in the inspection report, a dedicated, consistent staffing team is now in place, all of whom have received training from CCoI's Clinical Support Officer on the resident's Behaviour Support Plan (BSP) and associated care strategies.

This review process is being overseen by the national Compliance, Safeguarding & Risk function and will be completed in full by 29/08/2025.

4. Governance and Resource Planning
In addition to the above, CCoI has taken systemic action to strengthen the governance structures required to support robust and responsive needs assessments:

• The appointment of a permanent Person in Charge (commencing 25 August 2025) will bring consistent leadership and oversight to Dunshane.
• Two Team Leads are currently in place and supporting the day-to-day coordination of

assessments, staff deployment, and resident support planning.
• CCoI has significantly invested in national support functions, including Human Resources, Clinical Supports, and Risk and Compliance, which now provide stronger oversight and operational support for individual assessments and related service decisions.

5. Management of Transitions and Discharges
All discharges and transitions from Dunshane Community to date have been fully aligned with CCoI's Admissions, Transfers, and Discharges (ATD) Policy, and have been undertaken in full consultation with the HSE and relevant stakeholders. Each decision has been clinically and ethically reviewed to ensure it is in the best interests of the individual and consistent with their assessed needs.

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	25/08/2025
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	30/09/2025

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	30/09/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
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.	Not Compliant	Orange	29/08/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Orange	29/08/2025

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	29/08/2025
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	30/09/2025