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:	Camphill Community Grangebeg
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	25 June 2025
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0047546

About the designated centre

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

Grangebeg Camphill Community is a residential service for up to 12 men and women over the age of 18 with intellectual disabilities. According to the centre's statement of purpose people live, learn and work with others in healthy social relationships based on mutual care respect and responsibility. The designated centre consists of two, two-storey premises on a campus. Each of the houses have a number of private and communal spaces. Residents have access to gardens and plenty of outdoor spaces and the centre is based on a farm, which is situated in a rural part of Co. Kildare. Support is provided 24 hours a day, seven days a week by a team comprised of a person in charge, social care workers, social care assistants, and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Wednesday 25 June 2025	15:10hrs to 19:00hrs	Erin Clarke	Lead
Thursday 26 June 2025	10:30hrs to 18:00hrs	Erin Clarke	Lead
Wednesday 25 June 2025	15:10hrs to 19:00hrs	Tanya Brady	Lead
Thursday 26 June 2025	10:30hrs to 18:00hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to provide assurance that safe and good quality care was being provided to residents in this centre. The inspection was carried out as part of a wider regulatory programme of inspections of centres operated by this provider in response to information received by the Chief Inspector of Social Services. The inspection was conducted by two inspectors over the course of two days. The first day was unannounced and commenced in the afternoon to allow inspectors to observe daily routines and evening-time activities. Inspectors returned the following morning to continue the assessment and engage further with residents and staff.

In total, inspectors met with eight staff members and 11 residents during the inspection. They also met with the interim person in charge and the interim head of services, both of whom held broader governance responsibilities across the provider's services. At the time of inspection, both individuals had submitted their resignations, which were due to take effect shortly thereafter. The inspection focused on five key regulations, all of which were found to be non-compliant. Significant improvements were required to ensure that residents' care, safety, and quality of life were prioritised.

Inspectors identified several serious risks within the centre, including inadequate staffing levels, residents' incompatibility, and substandard maintenance and hygiene standards in the premises. The provider was not appropriately managing these risks and was directly impacting residents' safety, wellbeing, and daily-lived experiences.

Camphill Community Grangebeg is a designated centre registered to accommodate up to 12 residents and is made up of two large two-storey houses, each home to six individuals. The centre is located in a rural setting in County Kildare and operates within a wider congregated campus that includes a working farm, a day service facility, and an office building.

On the days of inspection, one resident was absent, having been admitted to an acute healthcare setting for several months. Inspectors found that there were no clear systems or governance arrangements in place to ensure the resident continued to receive appropriate support or information during their absence. This was attributed to the high turnover in management and the resulting lack of consistency and oversight within the centre. Staff and the person in charge were unclear about the provider's responsibilities regarding the resident's ongoing care, safeguarding of their possessions and responsibilities including the status of any planned transition or discharge arrangements.

Inspectors met and engaged with the remaining 11 residents over the course of the two-day inspection. While some residents were observed to be active and involved in community-based activities, others shared concerns with inspectors about their living arrangements and the adequacy of support they received. One resident

disclosed a safeguarding concern directly to inspectors. Other residents in the second home visited were less engaged in their home and in their community with inspectors finding poor premises and living arrangements in place to keep residents safe. Inspectors found that poor living conditions and inadequate environmental arrangements were contributing to this disengagement and affecting residents' quality of life.

Residents who spoke with inspectors clearly expressed their desire to be actively involved in decision-making within their home. They also demonstrated a strong awareness of the ongoing changes in management and the high turnover of leadership in the centre. Some residents said they would not know who to approach with concerns once the current interim managers had left. Such was the level of distress experienced that one resident sought out and requested to speak with an inspector during a separate inspection of another centre operated by the same provider. The resident stated that it was unfair to themselves, their peers, and the staff that their concerns were not being acknowledged or addressed.

Inspectors conducted multiple walk-through of both houses over the two-day inspection and found that the centre had not been adequately resourced to maintain the premises to a standard that was clean, safe, or homely. Several areas were found to be in poor condition, with the standard of upkeep falling below what would be expected in a residential setting. In particular, the condition of residents' bathrooms was noted to be extremely poor, posing a potential risk in terms of infection prevention and control. Inspectors documented these concerns with photographic evidence.

Residents who spoke with inspectors voiced their dissatisfaction with the state of their living environment. One resident described it as "like a building site," expressing a desire for it to be painted, adding, "I don't like living in it." Another resident shared that they were "upset they had to lock it", referring to the restriction placed on access to a bathroom due to its deteriorated condition. Inspectors were informed that this bathroom had become so unfit for use that the person in charge had to implement a restrictive practice, temporarily preventing residents from using it until repairs could be completed.

Residents also took the opportunity to share aspects of the centre and their lives they were proud of and happy with. One resident, who had recently started paid employment, spoke with pride about the positive impact this had on their life. They gave inspectors a tour of the poly tunnel, which they enjoyed spending time in. Several residents invited inspectors to view their homes, highlighting personal spaces that reflected their interests and individuality. One house had two small seating areas that allowed residents to watch television alone or spend time away from larger communal spaces. One resident proudly displayed their sporting medals, while another had certificates of achievement from completed courses hanging on their bedroom wall.

In another house however, one resident was observed watching television in their bedroom, as inspectors were informed that they did not enjoy the high noise levels in the communal areas and were therefore spending more time in their room to

avoid the disruption. They showed the inspectors the home improvement magazines they regularly purchased, along with photos of animals they liked. A different resident shared with inspectors a selection of dresses they had bought for previous family events and birthdays. These interactions reflected efforts by residents and staff in personalising resident spaces and maintain routines despite broader issues within the centre.

In one house, a resident was relaxing in a downstairs living room, surrounded by personal items and things of interest. They were supported on a one-to-one basis by a long-standing staff member who demonstrated detailed knowledge of the resident's needs and interests. The resident appeared happy and at ease in their environment, expressing affection for staff and satisfaction with their daily activities. In the second house, which was a mirror image of the first, this same room was not in use and full of debris. Residents who used to spend time there no longer could access these rooms and instead were forced to spend time in noisier communal areas where inspectors observed peer to peer incidents.

Over the course of this inspection, the inspectors noted that the environment was extremely loud for protracted periods of time with some residents engaging in long periods of loud vocalisations. Inspectors observed that other residents chose not to spend time in their living areas with one resident in their bedroom alone which staff stated was to get away from the noise.

Inspectors were informed by staff that the absence of a consistent, full-time person in charge was having a noticeable impact on residents. Residents were accustomed to being actively involved in the day-to-day running of the centre, and staff noted that this level of engagement had diminished due to ongoing management changes. Two residents spoke directly with inspectors, expressing that it was "unfair" that they did not have stable management structures in place to support them or ensure their concerns were heard and addressed.

Staff and management spoken with throughout the inspection demonstrated a clear commitment to improving the lives of residents living in the centre, having identified and raised concerns, particularly about the environmental issues present, on multiple occasions. Despite these concerns being recorded over a number of years the environmental issues had continued to deteriorate.

Residents also described a range of meaningful activities they were involved in, including choir, farm work, cookery courses, sports, and computer-based interests. In one house, a resident was observed in the main living area watching television. They spoke openly with the inspector about situations in the house that caused them discomfort, such as another resident entering their personal space, which they said "irritated" them. The resident stated that staff were aware of their preferences and actively supported them to feel safe.

While the inspectors acknowledged that the provider was aware of some of the identified issues on inspection. Their response to the identified issues was not timely nor effective considering the serious implications of the identified risks. The provider's systems in place were found to be neither robust nor consistently

implemented to ensure residents' safety at all times. Inspectors ultimately found that residents' rights were not being consistently upheld. Fundamental rights, such as privacy, dignity, and the right to live in a safe, clean, and supportive home, were frequently compromised due to a lack of oversight, inadequate responsiveness to known risks, and concerns regarding the provider's capacity to deliver a safe and rights-based service.

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

Capacity and capability

This inspection found widespread non-compliance across all five regulations reviewed. Serious concerns were identified regarding the condition of the premises, safeguarding practices, risk management, the protection of residents' rights, and the overall effectiveness of governance systems. While inspectors acknowledged that the provider was aware of some of these issues, the response to date had not been timely or effective, given the severity of the risks. The governance and management arrangements in place were not robust or consistently implemented to ensure the safety, quality of care, or wellbeing of residents.

At the time of inspection, the centre was not operating in line with the staffing requirements outlined in its statement of purpose or its organisational structure. The team leader post, a key component of the centre's leadership structure, had been vacant for over a year, and it was unclear whether this position remained sanctioned by the provider. Furthermore, the centre was undergoing a period of considerable transition, with the imminent departure of the area service manager, the interim head of services, and the person in charge.

This inspection formed part of a broader programme of regulatory monitoring, prompted by multiple pieces of unsolicited information received by the Chief Inspector and by poor compliance findings in other designated centres operated by the same provider. Inspectors found that the governance and management systems in place at this centre were ineffective in providing adequate oversight of the quality and safety of care. There were clear deficits in leadership, accountability, and oversight across several key areas.

The systems intended to safeguard residents and ensure their needs were met were found to be incomplete and ineffective. Inspectors found an absence of adequate risk management in decision-making processes, a lack of oversight of living conditions and staffing levels, and an overall failure to respond appropriately to known risks. In one example, a provider assurance report had been submitted in June 2024 following receipt of unsolicited concerns. However, at the time of this

inspection, there was no clarity among staff about the status of the actions outlined in that report or who was responsible for implementing them.

Staff informed inspectors that the absence of a consistent, full-time person in charge was having a negative impact on both staff and residents. Residents, who had previously been supported to play an active role in the running of their home, had seen this level of involvement diminish as a result of repeated management changes. Two residents spoke directly with inspectors about how "unfair" they felt the situation was, stating that the lack of stable leadership meant their concerns were not being listened to or addressed.

When inspectors spoke with staff, they expressed uncertainty regarding current reporting lines and were unsure who to escalate concerns to in the absence of the named managers. This lack of clarity in leadership and accountability posed a significant risk to the effective governance and safe operation of the centre.

Regulation 14: Persons in charge

Inspectors found that the regulatory requirement to have a full-time and suitably qualified person in charge had not been consistently met. There was a prolonged lack of stability in local management, resulting in significant gaps in leadership, oversight, accountability, and governance. The provider had not ensured that persons in charge were adequately supported to fulfil their responsibilities. In several instances, they were expected to take on multiple roles across different services, which was neither effective nor sustainable.

The person in charge at the time of inspection was the fifth individual to hold the role within an 18-month period. In the days following the inspection, they submitted formal notification of their resignation to the Chief Inspector, stating that the position was not tenable due to the inadequacy of the provider's governance arrangements. Both staff and residents told inspectors that the ongoing absence of consistent and structured leadership made it difficult to maintain continuity of care and created challenges in the daily operation of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The centre was operating below the staffing requirement as stated in the statement of purpose dated 14 May 2025. This stated that the staffing complement of whole time equivalent (WTE) staff was 23 plus a team leader position and person in charge. Inspectors found that these staffing levels were not based on current assessments of resident need. On the day of inspection there were 15 WTE staff identified as working in the centre. This also meant eight WTE vacancies, which was

a 53% vacancy rate, mainly in one house in addition to the vacant team leader role and the imminent departure of the person in charge.

There was a notable reliance on agency staff in one of the houses to ensure the roster was adequately resourced. While one house benefited from a relatively stable team, comprising long-standing staff members and a house coordinator, this level of continuity and consistency was not reflected in the second house visited during the inspection.

Inspectors reviewed the rosters for the current month and also for the previous month May 2025 and found that in one week within one house for example, that five agency staff covered six sleepover shifts and four day shifts. In the week of inspection in one house only two of the providers staff appeared on the roster and the rest of the shifts were covered by agency staff. This equated to between 125 - 200 hours of agency staff a fortnight in one house alone. This did not provide continuity of care for residents nor did it provide an assurance that resident needs were understood and met consistently.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the provider's oversight arrangements were not effective in consistently identifying risks, safety issues, or safeguarding concerns. Although systems and tools were available within the centre to support governance and risk management, they were not being utilised in a structured or meaningful way. The overarching systems of governance and management lacked coherence and accountability, and processes intended to ensure oversight were not being implemented effectively.

While some audits had been completed at both local and provider levels, these were not sufficient to detect or respond to key areas of concern, particularly in relation to the condition of the premises. For example, actions arising from premises audits had not been followed through or sanctioned for funding. One bathroom, in such a poor state of repair that it was deemed unusable, had been locked for a prolonged period of time. This restrictive measure was implemented due to the failure to maintain the bathroom to an acceptable standard, and no clear timeline for repair had been provided. This represented a restriction on residents' rights and was directly linked to insufficient resource allocation for the maintenance of the centre. In another house, inspectors found a second communal area and kitchen filled with broken furniture, debris, and visibly unclean conditions. These areas, which should have served as alternative living spaces for residents, were inaccessible. As a result, residents had reduced access to communal spaces, contributing to increased time spent alone in their bedrooms and, for some, social isolation.

Inspectors also identified poor planning and oversight regarding the transition of a resident who had been in an acute healthcare setting for several months. There was no evidence of a clear or coordinated plan to support or safeguard the resident during their absence or in preparation for their return or transition.

Since February 2024, the centre has experienced considerable management instability, with five persons in charge and four persons participating in management holding positions over a short period. In many instances, the person in charge role was temporarily held by a more senior manager on an interim basis, and several of those appointed were not based full-time in the centre. This inconsistent management presence undermined the provider's ability to lead and sustain meaningful change. This was further compounded by the imminent vacancies in both the head of services and area manager posts.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the governance and management systems in place were not consistent with a rights-based approach to care and support. There was a notable reliance on restrictive practices, such as limiting access to essential facilities, as a response to environmental deficits, insufficient staffing levels, and unmanaged behaviours of concern. These measures were reactive and did not reflect best practice in supporting residents' rights, autonomy, or wellbeing.

In relation to the safety and quality of care provided, inspectors found that the provider had failed to implement robust and comprehensive safeguards to mitigate risks of harm to residents. Significant concerns were identified in the management of behaviours of concern, including instances of residents displaying sexualised behaviours and or being exposed to faeces in communal areas. Up to the time of inspection, there was limited evidence of effective interventions or targeted actions being taken by the provider to address these risks.

In one example, a resident who was known to present with escalating behaviours of concern was not being adequately monitored. The monthly review documentation for this resident was notably limited, referencing only weekend home visits, while other residents had more comprehensive reviews. This inconsistency in monitoring posed a risk to the timely identification and management of emerging needs, particularly for residents with more complex behavioural profiles.

The overall environment in one of the houses was observed to be loud and over-stimulating for prolonged periods, with ongoing vocalisations from residents. Staff confirmed that the persistent noise levels had led some residents to retreat to their bedrooms for extended periods, seeking quiet and privacy. This environmental

stressor was not being actively addressed and contributed to reduced engagement and quality of life for some individuals living in the centre.

Regulation 26: Risk management procedures

The risk management procedures in place did not provide assurance that the centre was effectively responding to situations where residents' safety may be compromised. Inspectors found that the provider had not taken a proactive or preventative approach to addressing known risks, which limited the centre's ability to ensure a safe, supportive, and high-quality living environment for residents.

Ongoing issues relating to the maintenance and condition of the premises had not been addressed in a timely or sufficient manner. Additionally, behaviours of concern among residents had escalated over a prolonged period, without corresponding adjustments in staffing, resource allocation, or the provision of behaviour support planning. This reactive approach significantly impaired the delivery of appropriate and effective behavioural interventions.

High levels of management turnover further contributed to the archiving, loss, or incomplete transfer of key records, resulting in information gaps that affected the continuity and quality of care. Inspectors were not assured that the provider demonstrated sufficient urgency or accountability in identifying and addressing these risks, many of which posed a direct threat to residents' safety and wellbeing.

When inspectors met with the behaviour support specialist and requested documentation to guide staff practice, it was confirmed that ongoing changes in staff and management had undermined the implementation of support strategies. As a result, inspectors were not assured that governance systems were in place to support the regular review, embedding, and monitoring of behaviour support plans. The absence of consistent, evidence-based interventions left residents without the safeguards required to meet their assessed needs.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that significant changes in the management team, including the imminent departure of the area service manager, head of services, and person in charge, had negatively impacted safeguarding arrangements within the centre. At the time of inspection, there was no clearly defined safeguarding pathway in place for the following week, once key managers had exited their roles. Staff who spoke with inspectors were uncertain about the current safeguarding reporting structure or

escalation process, highlighting a breakdown in oversight, leadership, and communication.

During the course of the inspection, inspectors were either informed of or directly observed three separate safeguarding incidents. Some residents expressed discomfort and dissatisfaction with the behaviours of their co-residents, and inspectors noted that the management of behaviours of concern in one of the houses, accommodating six individuals, was particularly challenging due to the complexity of residents' needs and interpersonal dynamics.

Despite these concerns, there was no evidence that compatibility assessments had been completed to assess or mitigate interpersonal risk. In one of the houses, safeguarding risks were further exacerbated by a high reliance on agency staff, which limited continuity of care and further reduced effective oversight. As a result, inspectors were not assured that the provider had implemented appropriate and robust systems to ensure residents were adequately protected from the risk of harm.

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 8: Protection	Not compliant

Compliance Plan for Camphill Community Grangebeg OSV-0003621

Inspection ID: MON-0047546

Date of inspection: 26/06/2025

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: .• A suitably qualified and experienced Person in Charge commenced in their role on 11-08-2025. The PIC works onsite in the center Monday to Friday. • 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 Monday 29 September 2025. • The PIC is now supported by a newly appointed ASM who commenced on the 18-08-2025. An introductory meeting was held with the PIC and the ASM on 18-08-2025. A further meeting took place on the 20-08-2025 to address areas for improvement highlighted in the inspection reports. • The new ASM will conduct fortnightly visits to the center to include a walk around, conversations with residents, staff and PIC providing for increased onsite oversight. • Weekly governance meetings will be held with the PIC and ASM commencing 01-09-2025 until such time as all systems in this compliance plan have been actioned and implemented, after which meetings will move to fortnightly.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider is actively engaged in an ongoing recruitment campaign. • The PIC will liaise with the social media expert by 29-08-2025 to develop new ideas to increase engagement from potential candidates and ensure all social media outlets are	

being utilized effectively. A discussion will take place with residents as to whether they would like to be involved in social media recruitment videos by 10-09-2025.

• CCOI continue to reach out to local education facilitators and promote positions in local newspapers, colleges and radio stations for maximum exposure. In the interim, the Provider has ensured the staffing shortfall is being addressed through the use of approved overtime and the deployment of regular, trained agency personnel.

• 1 new staff member commenced their employment on 01-08-2025.

• An offer has been accepted by another candidate who is due to commence their employment by 10-09-2025.

• A review of the current WTE will be completed by the PIC and ASM by 30-09-2025 to ensure the supports in place are in line with resident identified needs.

• The team lead position has been successfully recruited for, and the role has been formally offered on 21.08.2025.

• All regular agency staff working in the Centre are being trained as per CCOI training requirements and are provided with access to CCOI systems. A full review of training is being conducted, and agency staff will be completing additional trainings as required. This review will be completed by 02-09-2025 by the community administrator for the centre.

• The supervision schedule has been reviewed to include regular agency staff. All staff due/overdue supervision will be provided with same by 15-10-2025.

• The maintenance role has now been accepted, and the new candidate is onboarding.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A full-time suitably qualified and experienced PIC has commenced and works onsite in the center. Commenced 11-08-2025.

• A full time and experienced ASM commenced in the center on 18-08-2025. The new ASM completed a meet and greet visit in the houses with the PIC on the 18-08-2025.

• The ASM will conduct weekly visits to the center, and in their absence will ensure a suitably qualified person attends onsite. This process commenced on 18-08-2025.

• The ASM will meet with the PIC again by the 29-08-2025 to discuss support arrangements for the PIC in their post.

• The team lead position has been successfully recruited for, and the role has been formally offered on 21.08.2025.

• A baseline regulatory audit (covering up to 30 regulations, including governance and management) will be undertaken in the center by the PIC and the ASM by 30-09-2025. This audit will provide for development of an overall center quality improvement plan by 30-10-2025. The audit and quality improvement plan will identify areas for improvement in the center, not just those highlighted in the inspection report, and actions to address those areas in a timely and efficient manner, thereby providing a path forward.

• An accessible complaints officer poster is now provided on display in the communal areas of the center to ensure residents understand who they can speak to should they have a concern.

• A recruitment campaign remains underway for frontline staff as detailed in the staffing plan above. Refer to staffing compliance plan.

• A review of the current WTE will be completed by the PIC and ASM by 30-09-2025 to ensure the supports in place are in line with resident identified needs.

• The supervision schedule has been reviewed, and regular agency staff are now included, ensuring they receive supervision as per CCOI policy. All staff due/overdue supervision will be provided with same by 15.10.2025.

• 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.

• All relevant information has now been formalized into an official transition planning document for one resident. Furthermore, a practical transition planning tool will be developed to guide the steps involved in transitioning a resident into/out of the center by 30-10-2025.

• The new PIC and ASM have both read the ADT policy.

• An ADT panel meeting will be held by 30-09-2025 to review the residents' discharge from the center and ensure all steps have been followed and formalized to conclusion.

• Weekly governance meetings will be held with the PIC and ASM commencing 01-09-2025 until such time as all systems in this compliance plan have been actioned and implemented, after which meetings will move to fortnightly.

• ASM will also attend the weekly Senior Management Team meetings, starting Friday, 22nd August 2025.

• 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 governance continuity.

• The Health and Safety Officer conducted a full health and safety audit on 25.05.2025. 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 10.12.25.

• A provider audit has been completed for the center by the Compliance Department and feedback from this audit is being provided to the PIC on 22.08.25. The PIC in consultation with their ASM will ensure all actions are closed in line with the action plan as outlined on the provider audit.

• A schedule is in place to ensure provider audits occur in line with Regulation 23.

· The Clinical Support Officer for Medication is scheduled to complete the annual medication audit by 22.08.2025

· The Behavioral CSO continues to visit 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 National Safeguarding Lead is working with the PIC to analyze safeguarding trends to support learning during team meetings and has completed a review of existing safeguarding plans.

· 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 x1 (position offered) → House Coordinator x2 → 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 trainings. The next meeting will take place on 10/09/2025.

· The PIC is new to the role and will be provided with formal supervision by the ASM 30-09-2025. The PIC will be supported with increased mentoring and support while they settle into the roles and responsibilities.

· A full review of the restrictive practices for the center by the PIC in conjunction with the restrictive practice panel occurred on 12.08.2025.

· Restrictive practices will be reviewed by PIC and CSO on a monthly basis going forward.

· ASM was inducted into the incident management system 19/08/2025 and will begin reviewing incidents in real time.

· 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 22-08-2025.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• 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 31.08.2025.

• The Compliance, Safeguarding and Risk Manager together with the PIC is completing a review of the operational risk register and associated risk assessments, this review is commencing on 22.08.25.

• Where behaviours of concern from residents' impact on other resident's, appropriate risk assessments will be developed to capture and monitor this risk. Information for this review will be gathered by staff knowledge of the residents, the baseline regulatory audit, the residents feedback document, compatibility assessments, SVP and incident management data. The review and development of appropriate risk assessments will be completed by the PIC and ASM by 30-09-2025.

• All staff have resumed use of the digital incident management system which will support timely reviews, and trend analysis by all relevant professionals/management. Both the new PIC and ASM have been provided with access to this system and have been inducted into the system.

• A new Clinical Support Officer (CSO) – Behavioural Support has been appointed and commenced on 05.08.2025 in CCOI. This results in each CSO being able to concentrate solely on their associated centres with their regions.

• Following the inspection, the Provider ensured a comprehensive review of the maintenance needs within the community and the progress on same is as follows;

o Water Softeners were installed throughout the community by the 25-07-2025.
o Professional Deep Clean of all bathrooms & toilets undertaken by the 29-07-2025.
o All bathroom floors re-painted by the 19-08-2025.
o Junk room cleared out by the 15-08-2025.
o The two cars on site have been removed on 24-07-2025.
o House 1 painting works are scheduled to commence on 15-09-2025.
o House 2 painting works commencing two weeks later. Estimated completion date of 10-10-2025.
o All rubbish under the bridge has been cleared and disposed of.

• The Provider has commissioned an external auditor to carry out a full health and safety audit in Grangebeg, which will include hazard identification. This is scheduled for 03.09.25.

• A baseline regulatory audit (covering 30 regulations, including protection) will be undertaken in the centre by the PIC and the ASM by 30-09-2025. This audit will provide for development of an overall centre quality improvement plan by 30-10-2025. The audit and quality improvement plan seeks to identify areas for improvement in the centre, not just those highlighted in the inspection report, and action and address those areas in a timely and efficient manner. This audit will cover up to 30 regulations, including but not limited to IPC, premises, protection, governance and management, staffing, persons in charge, and risk management. Additionally, the audit will be based on a walkabout of the centre, conversations with residents and staff, and a review of relevant documentation.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A review of all safeguarding plans/NF06s will be undertaken by the PIC with the support of the ASM by 12-09-2025 to ensure all actions have been implemented and the effectiveness of same has been assessed.

• A baseline regulatory audit (covering 30 regulations, including protection) will be undertaken in the center by the PIC and the ASM by 30-09-2025. This audit will provide for development of an overall center quality improvement plan by 30-10-2025.

• The PIC will ensure an accessible poster is readily available in communal areas of the designated center detailing who the designated officers are, along with the deputy designated officer by 29-08-2025 to contact in event of management absence. This updated information and the new poster will be discussed at the residents meeting by staff on 31-08-2025. Any resident who does not wish to attend the residents meeting will be informed individually of the change by 31-08-2025.

• The new ASM will complete the Designated Officer training on HSEland by 26-08-2025.

• The new ASM will attend a meeting with the safeguarding lead on 26-08-2025 for a full induction into the services process.

• The new ASM will attend the Designated Officer safeguarding training provided by CCOI on 28-08-2025.

• PIC is completing a refresher designated officer training on 28-08-2025.

• CCOI will provide safeguarding training to all outstanding staff by 29-08-2025.

• The PIC will ensure all staff have been asked to read and sign the CCOI safeguarding policy by 30-09-2025, regardless of whether previously completed or not.

• The new PIC and ASM have now read the CCOI safeguarding policy.

• Compatibility assessments will be completed for all residents by Coordinators by 15-09-2025

• The current arrangements for the resident who prefers quieter environments is currently under review with the PIC and the CSO to ensure appropriate strategies are in place to support the resident and furthermore to ensure the resident's will and preference in relation to where they spend their time is respected and documented. Compatibility assessment in progress for this individual by the coordinator, due for completion by 15-09-2025.

• A full review of existing behaviour support plans will be undertaken by the PIC to ascertain if all are in date, in line with incident management data, and relevant to the current situation and needs. The PIC has enlisted the support of the CSO in relation to any outstanding reviews, outstanding interventions, new behaviours, increases in behaviours, and requirement for new strategies should current strategies be identified as ineffective. This process has commenced.

• An accessible feedback document will be provided to each resident to ascertain their satisfaction level with their service and home by 30-11-2025 and gather any suggestions from them. This information will inform the annual review of care and supports for 2025. Safeguarding will form part of this document. In the interim, resident feedback will be gathered via the baseline audit which includes onsite interactions.

• Where behaviours of concern from residents' impact on other resident's, appropriate risk assessments will be developed to capture and monitor this risk by the PIC with the support of the ASM. Information for this review will be gathered by staff knowledge of the residents, the baseline regulatory audit, the residents feedback document, SVP and incident management data. The review and development of appropriate risk assessments will be completed by the PIC and ASM by 30-09-2025.

• A full review of all restrictive practices within the centre has been undertaken by the community admin and CSO in line with the organisation's current restrictive practice policy and national guidance. This occurred on Tuesday 12.08.25

• The Restrictive Practice Policy was reviewed on 18.08.25 and the Compliance, Safeguarding and Risk Manager is currently working with IT support to update the reporting flow on the system. The policy will be issued to staff when flow has been updated, and the policy has been signed off by the Provider. This will be completed no later than 10.09.25. Following the review of the policy, the Restrictive Practice Committee will convene by 30.09.25 and going forward will convene on a quarterly basis for review of all restrictive practices. In the event unplanned or emergency restrictive practices that require implementation, a process will be followed to ensure these are reviewed by the panel within a timeframe not exceeding 3 working days.

• Restrictive practices are now a standing agenda on staff team meetings and local governance meetings.

• The National Safeguarding Lead has reviewed all current safeguarding concerns and associated risk assessments. Immediate safeguarding plans have been updated to ensure robust protective measures are in place.

• The National Safeguarding Lead has submitted twelve notifications to the Safeguarding and Protection Team and the Chief Inspector following the HIQA inspection in relation concerns raised regarding the premises at the time of the inspection.

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	11/08/2025
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	15/10/2025

Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	15/10/2025
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	15/10/2025
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	18/08/2025
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	Not Compliant	Orange	30/10/2025

	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.	Not Compliant	Orange	15/10/2025
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	18/08/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Not Compliant	Orange	30/10/2025

	responding to emergencies.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/10/2025