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

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| Name of designated centre: | Camphill Community Grangemockler |
| Name of provider: | Camphill Communities of Ireland |
| Address of centre: | Tipperary |
| Type of inspection: | Unannounced |
| Date of inspection: | 26 June 2025 |
| Centre ID: | OSV-0003622 |
| Fieldwork ID: | MON-0047554 |

## About the designated centre

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

Camphill Community Grangemockler is a designated centre operated by Camphill Communities of Ireland. The centre provides a community residential service for up to 17 adults, male and female, with disabilities. The centre consists of four large separate houses all within short walking distance to each other. One of the houses had an adjacent flat which was home to one resident. These houses are located in a rural area on the site of a farm and are in close proximity to a small village and some towns in Co. Tipperary. Each resident had their own bedroom and facilities within the centre include sitting rooms, kitchens, dining rooms, utility rooms and staff offices. In line with the provider's the model of care, residents are supported by paid staff and at times by volunteers. The staff team are supported by the person in charge.

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

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| 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 |
|---|---|---|---|
| Thursday 26 June 2025 | 12:20hrs to 17:30hrs | Conan O'Hara | Lead |
| Friday 27 June 2025 | 09:30hrs to 13:00hrs | Conan O'Hara | Lead |
| Thursday 26 June 2025 | 19:30hrs to 21:00hrs | Conan O'Hara | Lead |
| Thursday 26 June 2025 | 12:20hrs to 17:30hrs | Linda Dowling | Support |
| Friday 27 June 2025 | 09:30hrs to 13:00hrs | Linda Dowling | Support |
| Thursday 26 June 2025 | 19:30hrs to 21:00hrs | Linda Dowling | Support |

## What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to provide assurance that safe and good quality care was being provided to residents in this centre. The inspection was carried out as part of a wider regulatory programme of inspections of centres operated by this provider in response to information received by the Chief Inspector of Social Services. The inspection was completed by two inspectors over two days.

The inspectors had the opportunity to meet with the 16 residents who lived in this centre over the course of the inspection. The inspectors spent time over the course of the inspection engaging with residents, spoke with 16 staff members including the management team, carried out a walk through of each premises, observing care practices, observing daily routines and the activities in the centre as well as reviewing documentation.

As noted the centre consists of four large separate houses all within short walking distance to each other. One of the house had an adjacent flat which was home to one resident.

On arrival to the first unit which was home to four residents, the inspectors met with the first resident who was tidying the service vehicle. They welcomed the inspectors and spoke of two upcoming plans for holidays. The resident stayed in the adjacent flat and showed the inspectors their flat. The inspectors meet with two other residents in the kitchen as they were having a cup of tea. The two residents also showed the inspectors their bedrooms. They had returned from accessing the community in the morning and one resident noted that they were volunteering in a local cafe in the afternoon. The inspectors met with the fourth resident in the sitting room in their preferred seat after returning from the community and was watching TV.

The first unit was a large two-storey building with an adjacent flat. The two-storey building comprised of three individual residents' bedrooms, sitting room, dining room, kitchen laundry room, boot room, office and shared bathroom. The adjacent flat comprised of an en-suite bedroom. The inspectors found that the unit was decorated in a homely manner with pictures and residents' belongings.

The inspectors then visited the second unit which was home to four residents. The inspectors met with the four residents in the house. The first resident told the inspectors they were back from attending the gym and were having lunch. The second resident was sitting at their preferred table in the kitchen engaged in their routine of deciding videos and films to watch. They resident had recently moved to a bigger room in the house and was in the processing of moving their possessions to the new room. They told the inspectors they were happy in the new room. A third resident spoken with had returned from a walk and was deciding on what to do for the afternoon. The fourth resident was out of the house in the morning but met with

inspectors in the evening and noted upcoming plans for holidays.

The second unit was a large two-storey detached house which comprised of four residents' bedrooms, kitchen, dining room, living room, utility room, boot room, office and external laundry. However, broken blinds were observed in the sitting room. This had been self-identifed by the provider and plans in place to address same.

In the afternoon, the inspectors visited the third unit which was home to four residents. The inspectors were informed that one resident had left to attend their day service and the three other residents had gone into a restaurant to celebrate a birthday. The inspectors met with the four residents later in the evening. The first resident spoke of where they were form and how they had celebrated their birthday. They were then observed on the phone to a family member. A second resident met the inspector briefly and appeared comfortable in their home before returning to their bedroom. Two of the other residents were observed spending time outside of the centre and discussing holiday plans with staff. Overall, positive interactions observed between staff team and residents.

The third unit was a large two-storey house. It comprised of four individual residents' bedrooms, sitting room, dining room, kitchen, utility, boot room and office.

Later in the afternoon, the inspectors visited the fourth unit which was home to four residents. One resident eagerly showed the inspectors around their house and identified their bedroom, they showed the inspectors all their belongings and where they store they items of value. Another resident came up the stairs and showed the inspectors their bedroom and fixed the sheets on their bed. One resident was observed to come into the kitchen and feed their cat. At one stage three residents were sitting in the sitting room watching a programme and relaxing all residents appeared comfortable in each others presence and with staff interactions.

The fourth unit was a large two-storey house. It comprised of four individual residents' bedrooms, kitchen/dining room, sitting room, utility, office, boot room, office space and shared bathrooms. The inspectors observed an area of damp in the hallway and were informed that the source of dampness had been recently addressed.

The inspectors returned in the evening to meet residents and observe evening routines. Overall, residents were settling in for the night and were observed watching TV, speaking of the days events and some residents were preparing to go to bed or had already decided to go to bed.

On the second day of inspection, the inspectors reviewed supporting documentation in the office and returned to visit one house. Two of the residents were in the office supporting the staff with cleaning and paperwork.

Overall, residents appeared content and comfortable in their homes. Residents were observed to be active in the community. The majority of the staff team spoken with reported that they were supported to. Some staff members highlighted concerns

regarding the governance and management and the staffing arrangements of the centre. The inspectors found that improvements were required in staffing and governance and management arrangements.

The next two sections of the report present the findings of this inspection in relation to the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

## Capacity and capability

Overall, this inspection found that the governance and management structure in place required improvement to ensure there were clear lines of authority and accountability were managing this centre. In addition, the inspectors found that the staffing arrangements required improvement.

There was a local management structure and system in place. The centre was managed by a full-time, suitably qualified and experienced person in charge who was supported in their role by a team leader and house coordinator. There was evidence of regular quality assurance audits taking place. However, there had been recent changes in the senior management of the service which meant the lines of authority and accountability were unclear on the day of the inspection.

The staffing arrangements required improvement to ensure appropriate staffing levels at all times and that consistent care and support was provided to residents. A review of a two months of rosters demonstrated that there was a high reliance on agency staffing to maintain the staffing complement. At times the staffing levels fell below the planned staffing complement. While, the inspectors were informed of efforts to increase staffing levels and improve consistency of staffing, however the actions taken had yet to effectively and sustainability resolve the staffing issues. Staffing arrangements were also found as an area for improvement on previous inspections.

## Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably qualified and experienced. The person in charge was also responsible for one other designated centre. The inspectors were informed that this was a temporary arrangement until September 2025 when the staff member returned from approved leave. The person in charge was supported in their role in this centre by a team leader and house co-ordinator. The person in charge demonstrated a very good knowledge of the residents supported in the centre.

Judgment: Compliant

## Regulation 15: Staffing

The inspectors found that the staff team were observed to be striving to provide care in line with residents' assessed needs. However, the staffing arrangements required improvement. This was also found as an area for improvement on previous inspections.

The person in charge maintained an up-to-date staffing roster. The inspectors reviewed a sample of the roster for all houses for May and June 2025. There was an established staff team in place which ensured continuity of care and support to the residents. In the first unit and adjacent flat, two staff during the day to support four residents and one sleep over staff at night. In the second unit, the four residents were supported by two staff during the day and two sleep over staff at night. In the third unit, there was two staff during the day to support four residents. At night the residents were supported by a sleep over staff and a waking night staff. In relation to the fourth unit, four residents were supported by two staff during the day and by a waking night and sleepover staff at night.

However, the inspectors found that there was a high reliance on agency staffing to maintain the staffing complement. For example, in June 2025, 67 out of 224, almost 30% of shifts were covered by agency staff. The assessed number of staff required was stated as 31 whole time equivalent (WTE). At the time of the inspection the centre was operating with 12 WTE vacancies. A review of the rosters demonstrated that the staffing complement was maintained by the person in charge, team leader, staff team and agency staff. On 23 occasions in the two month period the staffing levels fell below the planned staffing complement**.** While the reduced staffing levels were in line with minimum safe staffing levels for this centre, the staffing arrangements required further review to ensure the planned staffing complement levels was maintained.

There was evidence of efforts to increase the consistency of staffing by identifying key agency staff to provide long-term cover for the vacancies and ongoing recruitment to fill the vacancies. The actions taken had yet to effectively and sustainability resolve the staffing issues.

In addition, it was not demonstrable that the staffing levels were in line with the changing and assessed needs of the residents. For example, additional staffing for one resident was required in line with recommendations from clinicians and an internal application had been completed seeking additional staffing supports for another resident, neither had come into effect at the time of inspection.

Judgment: Not compliant

## Regulation 23: Governance and management

The management structure of the centre required improvement to ensure lines of authority and accountability were clearly defined.

The centre was managed by a suitably qualified and experienced person in charge. The person in charge was was responsible for this designated centre and one other designated centre operated by the provider. They were supported in their role in this centre by a team leader and house coordinator. There were on-call arrangements in place to support the staff team outside of regular working hours.

There was evidence of quality assurance audits including the annual review and six-monthly provider visits. These audits identified areas for improvement and developed actions plans to address same. In addition, local audits had been completed in medication, restrictive practices and IPC.

However, there had been recent changes in the senior management of the service which meant the lines of authority and accountability were unclear on the day of the inspection. For example, according to the statement of purpose the person in charge reported to the area manager, who in turn reported to the head of service. The head of service then reported to the Chief Executive Officer (CEO). On the day of the inspection, the roles of the area manager and head of service were vacant. While inspectors reviewed evidence of emerging structures to manage with the changes, the management systems in place did not ensure sustainable, consistent and effective monitoring. This issue was ongoing at the time of the inspection with inspectors informed of a number of managers that were handing in their resignations in this providers services.

Judgment: Not compliant

## Quality and safety

Overall, the centre was striving to provide person-centred care and support to residents in a safe homely environment.

There were systems in place to identify, manage and review risks in the centre. The inspectors reviewed the risk register and personal support plans for specific care and support needs. The inspectors found the personal plans and corresponding risk assessments to be up to date and to suitably guide the staff team in supporting the residents.

There were systems in place to keep residents safe. For example, the staff team had been supported to complete training in safeguarding. Incidents and accidents occurring in the centre were reviewed and responded to by the local management

team as appropriate. Residents reported being happy in the centre and were observed appearing comfortable in their home.

## Regulation 26: Risk management procedures

The provider had systems in place to identify and manage risk. The inspectors reviewed the risk register and found that general and individual risk assessments were in place. The risk assessments for two houses were found to be up to date and the person in charge was actively reviewing the remaining two houses as they were at their due date. Risk assessments were found to reflect the control measures seen to be in place on the day of inspection. For example, one resident who lives in the adjacent flat had a call bell that they used to contact staff when they required support. When the inspectors returned to the house in the late evening the staff member was seen to be carrying the receiver for this bell at all times. Risk assessments were in place for identified risks such as swallow care, dementia, medication, behaviour, use of agency, volunteers, use of gardening equipment and keeping pets.

The person in charge and the staff spoken with on the day of inspection were aware of this risks present in the centre and the control measures in place to mitigate the risk. Staff spoke about the use of call bells as mentioned above, incident accident forms and safeguarding with ease demonstrating good knowledge and understanding of the processes to follow.

The person in charge also had an oversight of the farm risk assessments to ensure they aliened with the risk assessments in place for the designated centre.

Judgment: Compliant

## Regulation 8: Protection

There were systems in place to keep the residents safe. All staff had up-to-date training in safeguarding and demonstrated a knowledge of the residents' needs and what to do in the event of a concern. The inspectors reviewed a sample of incidents and accidents occurring in the centre over the last six months and found that there were appropriately reviewed and managed. Residents appeared content and comfortable in their home and in the presence of the staff team and management.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| **Quality and safety** | |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Camphill Community Grangemockler OSV-0003622

## Inspection ID: MON-0047554

## Date of inspection: 27/06/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>Following the recent inspection, the following actions have been taken to address staffing requirements and ensure compliance with regulatory standards:<br>• A full-time Person in Charge (PIC) is currently in post and actively fulfilling their statutory duties under the Health Act 2007.<br>• The PIC on maternity leave from another community is due to return on 11/09/2025, concluding the current dual PIC arrangement across the two communities.<br>• Two full-time Social Care Workers and one part-time Social Care Worker have been successfully recruited:<br>o One full-time SCW commenced employment on 31/07/2025.<br>o The second full-time SCW and the part-time SCW will commence once onboarding and Garda vetting are completed.<br>• One relief Social Care Assistant has also been recruited; their start date will be confirmed upon completion of onboarding.<br>• One other full-time Social Care Worker was offered a position but declined during the onboarding stage.<br>• Following a meeting with the PIC on 11/08/2025:<br>o HR administrators re-engaged with recruitment agencies.<br>o Updated job descriptions for vacant posts were shared.<br>o Relevant CVs were requested and are awaited for review.<br>• Local outreach is being conducted to attract qualified candidates:<br>o In partnership with educational institutions.<br>o Advertising in local newspapers, colleges, and radio stations.<br>o Ads will run throughout September.<br>• A consistent cohort of agency staff continues to support the Grangemockler Community.<br>• All agency staff:<br>o Have completed mandatory training as per CCoI policies (confirmed 21/08/2025).<br>o Are fully inducted and have access to required systems, including emails and online portals. | |

o Receive supervision aligned with CCoI's supervision policy.
o Have no outstanding inductions (confirmed by PIC and Admin on 21/08/2025; monitored by Compliance Officer during audits)
• Rosters are reviewed daily to ensure adequate, suitably 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 staff on 06/08/2025.
• All needs assessments are being reviewed and will be completed by 31/08/2025.
o A DSAMT (Disability Services Additional Measures Tool) was submitted to the funder on 19/08/2025 for additional supports. The PIC will follow up weekly for an update.

CCoI remains committed to ensuring safe, person-centred, and consistent care through the ongoing recruitment and development of a skilled workforce.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A new Area Service Manager commenced in post on 5th August 2025, providing enhanced oversight and leadership at regional level.
• Area Service Manager has engaged in daily check ins via phone and teams with PIC
• First site visit to Grangemockler is scheduled for 02/09/2025.
• An introductory meeting was held with the PIC on 07/08/2025 to begin induction and agree on a short-term plan.
• From 26/08/2025 ASM will be present on site every week and will check in via teams daily.
• ASM held an introductory meeting with the PIC on 07/08/2025 to begin induction and agree on a short-term plan.
• ASM will hold weekly regional meetings with PICs, with the first one completed on 19/08/2025
• ASM will also attend the weekly Senior Management Team meetings, starting Friday, 22nd August 2025.
• All staff in Grangemockler were notified of the new ASM and updated authority lines via email on 07/08/2025.
• The ASM, National Safeguarding Lead, Medication CSO, and Behavioral CSO will attend the monthly Community Management Meeting (CMM), scheduled for the second Monday of each month. The first will be on 08/09/2025.
• The Head of Services position is currently vacant, with interviews scheduled for 28/08/2025.
• In the interim, the CEO is covering Head of Services responsibilities to ensure governance continuity.
• The current management structure is:

Board → CEO → Head of Services (Vacant) → ASM → PIC → Team Leader → House Coordinators (1 of 2 positions vacant) → Social Care Team
• Supervision for PIC with ASM is scheduled for 21/08/2025.
• The Learning and Development Officer provide monthly support to PICs and Admins for training planning and compliance (next meeting: 10/09/2025).
• The Health and Safety Officer are due to carry out a full audit as per schedule in November 2025. The last one was completed 19/06/2025 actions are currently being completed and will be closed off before 31/10/2025.
• The Compliance Officer conducted a full audit of the designated Centre on 17/07/202 actions are currently being completed and will be closed off before 31/11/2025. The timeline for this has been extended due to planned maintenance works which have been booked.
• The Clinical Support Officer for Medication is scheduled to complete the annual medication audit on 28/08/2025 and 29/08/2025.
• Behavioral CSO Commenced on 05/08/2025, first site visit on 12/08/2025. They will attend meetings as needed, will have live incident/accident report notifications and will attend site bi-weekly unless there is a need for more frequent visits. They are available Monday to Friday, 09:00–17:00, by Teams or mobile.
• SOP reviewed on 12/08/2025 by National Operations Support Officer and PIC.
• Risk register was reviewed on 19/06/2025; all actions have been closed.
• Restrictive Practices review by PIC and CSO scheduled for 03/09/2025. No new RPs for panel review; RP panel has reconvened.
• ASM was inducted into the incident management system on 07/08/2025 and is now reviewing incidents in real time.
• Camphill Communities of Ireland (CCoI) remains committed to strong governance, leadership, and accountability across all designated centres, with a strategic focus on compliance with Regulation 23 and responsiveness to evolving resident needs.
· Supervision for PIC with ASM has been scheduled for 21/08/2025
· 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.
· A review of the risk register took place on 19/06/2025. All actions from this are closed out.
· Restrictive practices will be reviewed by PIC and CSO on 03/09/2025 there is no new RP's for panel review. Panel has now reconvened.
· ASM was inducted into the incident management system 07/08/2025 and has begun reviewing incidents in real time.
· Camphill Communities of Ireland (CCoI) remains fully committed to upholding the highest standards of governance, leadership, and accountability across all designated centres. The actions outlined above reflect a targeted and strategic approach to strengthening local and national oversight, ensuring that services are both compliant with Regulation 23 and responsive to the evolving needs of residents.

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 15(1) | The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. | Not Compliant | Orange | 31/12/2025 |
| 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 | 31/10/2025 |