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 of Ireland Greenacres
Name of provider:	Camphill Communities of Ireland
Address of centre:	Dublin 14
Type of inspection:	Unannounced
Date of inspection:	11 November 2025
Centre ID:	OSV-0003623
Fieldwork ID:	MON-0048152

About the designated centre

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

Greenacres provides residential care for up to four adults with an intellectual disability who require low to medium supports. The centre is comprised of two buildings located in a suburb in South Co. Dublin. The first property is made up of a seven bedroom house and a stand alone building which is used as a social hub in the back garden. The house is home to up to three residents and has a kitchen and dining room, and a sitting room and each resident has an en-suite bathroom. The second property is a spacious apartment for one resident. It consists of a kitchen-dining room, two bedrooms, one of which had an en-suite bathroom, a laundry room, and a main bathroom. There was also an outdoor balcony and a shared facilities such as a gym and conference facilities which the resident could use if they wished to. Both premises are close to a variety of public transport links. There are shopping centres, pubs and local shops within close proximity of the centre. Residents have the opportunity to attend day services or avail of training, employment or volunteer work in their local community. Residents are supported 24 hours a day, seven days a week by social care workers and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Tuesday 11 November 2025	11:00hrs to 18:00hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This unannounced, risk-based focused inspection was carried out to assess the provider's progress in addressing the findings from the previous inspection of 07 July 2025. At that time, inspectors identified concerns regarding the wider governance of the centre and the provider's capacity to effectively oversee the quality and safety of the service. These concerns were linked to the imminent departure of key leadership roles, including the area service manager and the interim head of service, which posed a risk to continuity and oversight within the centre.

The provider had recently recruited into key leadership roles in the weeks preceding the inspection. While these appointments were a positive development, the inspector found that effective oversight had not been maintained during the recruitment and onboarding period, and governance arrangements were not sufficiently robust to ensure continuity of oversight while these roles were being established.

The centre comprises two premises. The first is a house located in a suburban area of South County Dublin, registered to accommodate three residents, with one vacancy at the time of inspection. The second premises is an apartment for a single resident. Based on the concerns found on the previous inspection, the inspector focused on one house within the centre. On arrival to the centre, the inspector was greeted by an agency staff member who had worked in the centre on a regular basis and was familiar to residents.

The inspector briefly met with one resident who was relaxing in the sitting room, watching television, and was supported by one member of staff. The resident appeared comfortable in their surroundings. The inspector also spoke with a second resident who spoke positively about their achievements since the previous inspection. They described ongoing work on a computer-based project, outlined what they enjoyed learning, and spoke with enthusiasm about a new course they were due to commence.

The inspector did not have an opportunity to meet with family members during the inspection. However, the inspector was informed that concerns had been raised by families through a family forum, primarily relating to the level of communication from the provider. The inspector was advised that the person in charge was actively working to address these concerns at the time of inspection.

The purpose of this inspection was to follow up on the provider's compliance plan in response to the concerns identified at the previous inspection. Overall, the inspector found that while the provider had reinstated monthly clinical review structures following the previous inspection, these measures had not resulted in effective clinical oversight. The healthcare management concerns identified at the July 2025

inspection remained unresolved at the time of this inspection which were having a negative impact on a resident's access to activities and dignity.

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 significant deficits remained in governance and management arrangements, staffing levels, and operational oversight, which collectively limited the provider's ability to ensure the quality and safety of care.

While the provider had taken steps to strengthen governance arrangements since the July 2025 inspection, including the recent appointment of senior management roles and reinstating review structures, the inspector found that these measures had not yet resulted in effective oversight or measurable improvement in practice.

The inspector found that the governance structure of the centre had recently been strengthened with the appointment of two senior management roles, including a Head of Service and an Area Service Manager, in the weeks preceding the inspection. As both individuals were newly appointed they were still in the process of completing their probationary periods and learning about their key responsibilities and duties associated with their roles.

The provider submitted a compliance plan on 20 August 2025, setting out assurances regarding how they would respond to the July inspection findings. A central focus of these assurances related to clinical governance. The inspector found that the actions outlined in the provider's compliance plan had not been implemented in a manner that ensured effective clinical governance. While monthly management and clinical review meetings had recommenced, these were conducted remotely and did not demonstrate that identified healthcare concerns were being effectively monitored, reviewed, or addressed. Healthcare management issues identified during the July 2025 inspection remained evident at the time of this inspection, indicating that actions taken had not translated into effective practice at centre level.

Regulation 14: Persons in charge

The person in charge, who had commenced in post shortly before the July 2025 inspection, held a broader governance remit extending beyond the designated centre, including responsibility for day services and supported living arrangements.

The inspector found that the person in charge was not present in the centre on a regular basis, which limited their capacity to provide consistent operational oversight.

The inspector found that staffing shortages within a day service operated by the provider were impacting on the designated centre. In particular, the person in charge was primarily based in the day service building due to their dual remit of day and residential services, which limited their visibility and availability within the designated centre on a regular basis. Staff spoken with were not aware when the person in charge would be working in the centre. In addition, the team leader, was also required to provide cover within the day service one day each week, which further reduced operational oversight within the designated centre.

In addition, the inspector identified unclear role delineation between the person in charge and the team lead. This lack of clarity resulted in delays in progressing required actions and, during the inspection, contributed to occasions where staff were unable to provide clear or accurate information in response to requests for documentation and evidence.

Judgment: Not compliant

Regulation 15: Staffing

The inspector found that staffing vacancies in the centre had increased since the previous inspection. In July 2025 two staffing vacancies had been identified; however, at the time of this inspection, four vacancies were present.

In line with the centre's statement of purpose, a staffing complement of 8.4 whole-time equivalent (WTEs) staff was required to safely operate the service and meet residents' assessed needs. On the day of inspection, 4.5 WTE were in place. While the provider reported that three staff were in the process of onboarding, these staff were not available at the time of inspection.

The inspector also found that the skill mix within the centre was not sufficient to support effective oversight and monitoring of residents' health and support needs. This deficit impacted the service's ability to respond in a timely and consistent manner to changes in residents' wellbeing, as outlined under Regulation 6: Healthcare.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that governance and management arrangements did not ensure effective oversight of the quality and safety of care in the centre.

As part of the provider's compliance plan, arrangements were put in place to reinstate monthly clinical reviews of medicine management and residents' care. The inspector reviewed two monthly management meeting records and found that, although monthly reviews had recommenced, these were conducted remotely and had not resulted in demonstrable improvements in practice. Significant concerns regarding the management and oversight of a resident's healthcare needs remained during this inspection.

A six-monthly unannounced audit was completed in August 2025 by a representative of the provider. The audit identified deficits in relation to personal planning, completion of annual reviews, goal setting, and the absence of some healthcare action plans. While these issues were identified within the audit, the inspector found that the associated regulation had subsequently been recorded as compliant. The inspector was unable to determine how compliance had been achieved, as the identified deficits remained outstanding at the time of inspection. For example when the completed actions were requested during the inspection they were not available for review.

Due to the repeated findings identified on this inspection in relation to clinical oversight, and the provider's failure to achieve compliance through the implementation of their submitted compliance plan, a regulatory decision was taken to issue a warning letter to the provider to set out the provider's obligations to take immediate and effective action to address the non-compliances.

Judgment: Not compliant

Quality and safety

This inspection examined the quality and safety of care provided to residents, with a particular focus on healthcare management, assessment and planning, and risk management. Overall, the inspector found that quality and safety were compromised due to ongoing failures in clinical oversight, ineffective implementation of healthcare guidance, and weaknesses in assessment, review and risk management processes.

The inspector found that the healthcare needs of one resident with fluctuating medical presentations were not being assessed, planned for, or reviewed in line with the resident's needs or the requirements of the regulations. Significant gaps in clinical oversight, poor-quality health plans, inconsistent implementation of medical advice, and the absence of structured clinical review contributed to an ongoing risk to the resident's health, wellbeing, and participation in daily life.

As previously identified, assessments of need and associated support plans had not been reviewed or updated to reflect changes in circumstances. The inspector found that these documents remained unchanged since the previous inspection, despite evidence of evolving healthcare needs. This limited staff understanding and reduced assurance that care was being delivered in a planned, responsive, and evidence-informed manner.

Regulation 26: Risk management procedures

The inspector found that individual resident risk assessments had last been reviewed in January 2025 and had not been updated to reflect the risks identified during this inspection or those previously identified at the July 2025 inspection. As a result, the risk management documentation did not accurately reflect current risks or provide staff with clear guidance on how to manage emerging or ongoing concerns. In particular, risks in relation to mobility, bowel dysfunction, medicine administration, and other health related-concerns were not accurately assessed, reviewed or aligned with residents' current needs, reducing assurances that risks were being effectively managed in practice.

The inspector also found that risk assessments were not in place for some restrictive practices used within the centre, nor had these practices been approved through the provider's restrictive practices committee. As a result, the associated risks had not been formally identified, assessed, or reviewed in line with the provider's own governance requirements.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector was informed that discussions regarding one resident's future care arrangements and support needs were taking place with family members on the day of inspection. These discussions referenced emerging mobility needs alongside existing healthcare requirements. Records reviewed showed that, as early as June 2025, consideration had been given to potential transitions to alternative care settings and associated funding arrangements. However, the inspector found that these discussions were not supported by an up-to-date assessment of need, nor had they been reviewed or overseen through the provider's Admissions, Transfers and Discharges (ATD) committee.

The absence of a structured assessment and governance oversight meant that discussions regarding potential changes in care arrangements were not underpinned by documented evidence or multidisciplinary input. This reflected an ongoing concern regarding the provider's management of transfers, both within and external

to the designated centre, and limited assurance that decisions would be informed, planned and person-centred.

The inspector found that one needs assessment had not been reviewed or updated to reflect changes in needs or circumstances, despite changes being identified in areas including healthcare, mobility, communication, and daily living supports. As a result, the assessment did not accurately reflect the resident's current support requirements. In another instance, there was no evidence that an annual review of the resident's personal plan had taken place, as required by the regulations or goal planning taken place with the resident.

Judgment: Not compliant

Regulation 6: Health care

As part of their compliance plan following the previous inspection, the provider had reinstated monthly clinical review arrangements. The inspector found that while these reviews had recommenced, they were conducted remotely and did not result in effective clinical oversight. There was no structured review of healthcare documentation, and the records examined during this inspection remained unchanged since July 2025.

The inspector's review of health observation records and medicine administration records found that advice given was not implemented consistently in practice. Multiple occasions were identified where medicine continued to be administered during periods when it should have been withheld in line with the recorded guidance. As a result a resident was experiencing side effects of a medicine that was impacting on the resident's ability to attend activities in the community. The inspector also found that the actions taken, such as a medical review, did not result in improved health outcomes. There was no evidence of escalation for further clinical advice, or reassessment when the initial intervention did not achieve the intended effect. As a result, staff were continuing to support the resident without clear or effective clinical direction.

In addition, the inspector identified deficits in the management of another identified health concern for a resident. Records showed that a healthcare assessment earlier in 2025 identified the need for ongoing monitoring and lifestyle-based management, with follow-up review recommended within a defined timeframe. Although healthcare professionals had advised specific dietary and lifestyle adjustments to support the resident's wellbeing, these recommendations were not included in the healthcare plan. There was no structured monitoring to support their implementation, nor evidence that staff were guided in how to apply these recommendations in daily practice. While records indicated that further investigations had taken place, the inspector was not provided with evidence that

results had been reviewed, recorded, or used to inform ongoing care, and the current status of this health concern was therefore unclear.
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
Regulation 6: Health care	Not compliant

Compliance Plan for Camphill Community of Ireland Greenacres OSV-0003623

Inspection ID: MON-0048152

Date of inspection: 11/11/2025

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: • Since inspection the provider has significantly enhanced both the supports and governance oversight provided to the PIC. The provider as of the 9th of October 2025 has an 'Area Service's Manager' in post with line management responsibility to the PIC. • The PIC has significantly enhanced her governance presence within the designated centre, the roster is now amended to ensure either the PIC or Team Leader are present and this will be spread over 5 working days and this is being done with a 3/2 rotation with the PIC being present 3 days one week and the Team Lead 2 days with that split rotating. • There is now in place a governance presence recording sheet to be signed by any member of staff of Camphill with a governance responsibility. • The designated centre Team Leader is currently on annual leave, a meeting has been arranged for 20/01/25 to be attended by the PIC, Team Leader and Area Service Manager the purpose of the meeting is to discuss role delineation. • With the aim of providing greater support to the PIC the Area Service's Manager is implementing a 'buddy system', the PIC will receive input and support from another PIC starting with a day visit on 19/01/26.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The WTE has improved since inspection, on the day of inspection the WTE in situ was 4.5 today 13/01/25 it is 5.6 with two additional WTE's recruited with roles accepted and awaiting the completion of due diligence after which the WTE will stand at 7.6, one of	

these roles is Social Care.
• The provider is currently seeking the recruitment of one additional Team Leader who when recruited will be allocated to the Day Service managed by the PIC, this will dilute the governance load of the designated centre.
• A revised induction programme for new and agency staff has been implemented to ensure familiarity with resident needs, documentation standards, escalation pathways and clinical supports.
• Specific to skill mix within the centre and its ability to sufficiently support effective oversight of residents health and support needs. The provider has successfully recruited an additional 'Clinical Support Officer'. At the time of inspection there had been 1 'Clinical Support Officer'.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Monthly clinical reviews are no longer remotely done, since inspection the 'Clinical Support Officer has been in the designated centre 4 times. With the onboarding of a second 'clinical Support Officer' now complete, on site visits will be a minimum of monthly and likely to be more frequent, since inspection the Clinical Support officer has been on site 4 times.
• Part of the emphasis of the Clinical Support Officer when they are present will be to enhance practice by supporting staff in groups around care plan orientation, the Clinical Support Officer will be attending the designated centre for this purpose on 02/02/26 and 16/02/26.
• Specific to the referenced six monthly provider unannounced audit, one annual review meeting occurred on 18/12/25. For remaining reviews the PIC has liaised with families and stakeholders and remaining reviews will be completed on or before 02/03/26.
• Since inspection, clinical care plans referenced by the inspector in both report and feedback have been reviewed and amended by the 'Clinical Support Officer' this has been done in consultation with the PIC and relevant GP.
• Specific to assessment of needs, it is decided to renew them and on 20/01/26 a full day meeting of care team/ local governance and Area Service's Manager is scheduled to review and update all assessment of 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:
• Since inspection all individual resident risk assessments have been reviewed and updated to reflect the risks identified on the day of inspection 11/11/25.
• On 11/12/25 the providers restrictive practices committee met and reviewed and approved the designated centre restrictive practices.

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:
• Specific to the future care needs of one resident cited, there are no plans for this resident to move. The discussions with family were an early discussion around monitoring for changes to mobility. On 13/01/26 a fire evacuation drill was conducted with this resident and they demonstrated a very good awareness coupled with an ability to mobilise independently and at a pace that allowed for safe evacuation. The PIC has further engaged with the residents GP who has stated that at this time he believes the designated centre meets his mobility and health needs. There will be ongoing assessment of the designated centre's ability to meet the residents care needs and in this regard we have requested that the GP make a referral for a geriatric assessment, the GP was in agreement referral being made 13/01/26.
• It has been decided to renew all residents assessments of need drawing upon the care knowledge of the wider care team. On 20/01/26 a full day meeting with the care team/ local management and Area Services Manager will occur with the purpose of reviewing all assessments of needs.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• The Clinical Support Officer attended the designated centre since inspection 4 times and all health care related plans have been reviewed, renewed or amended in conjunction with the GP and PIC.
• Medication regimes where appropriate have been reviewed by a GP.
• The format of recording the administration of PRN medication have been changed to provide clearer guidance with a weekly sign off to indicate the PIC has reviewed practice.
• As referenced in the inspection report 11/11/25 there was concern around the status of clinical investigation, specifically the status of a residents bloods analysis. The GP's review of bloods is he is satisfied with bloods results and has not amended the

prescription.
• The PIC now has a significantly enhanced on site presence to monitor and support staff in the implementation of health related care plans, the PIC's presence is recorded via an on site governance record.
• The 'Clinical Support Officer' will when on location spend time with care staff around care plan orientation with sessions planned for 02/02/26 and 16/02/26.

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	28/02/2026
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	28/02/2026

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	28/02/2026
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	28/02/2026
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 responding to emergencies.	Not Compliant	Orange	28/02/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health	Not Compliant	Orange	28/02/2026

	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.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	28/02/2026
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	28/02/2026
Regulation 06(1)	The registered provider shall provide appropriate health care for each	Not Compliant	Orange	28/02/2026

	resident, having regard to that resident's personal plan.			