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 Callan
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	14 July 2025
Centre ID:	OSV-0003607
Fieldwork ID:	MON-0047558

About the designated centre

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

Camphill Community Callan consists of two residential units and five individual units for single residents located in a small town. Overall this designated centre provides a residential service for up to 12 residents, both male and female, over the age of 18 with intellectual disabilities, Autism and those with physical and sensory disabilities including epilepsy. In line with the provider's model of care, residents are supported by a mix of paid staff and volunteers. The centre does not accept emergency admissions.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 14 July 2025	08:50hrs to 17:30hrs	Marie Byrne	Lead
Monday 14 July 2025	08:50hrs to 17:30hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by two inspectors of social services over one day. The purpose of the inspection was to provide assurance that safe and good quality care was being provided to residents in this centre. It 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.

From what residents told them and what inspectors observed, it was evident that residents were in receipt of a good quality of care and support in this centre. This inspection had some positive findings, with the majority of regulations reviewed found compliant. However, the findings of the inspection were that the provider did not have effective governance and management systems in place and this will be discussed under Regulation 23: Governance and Management.

In Camphill Community Callan residential care is provided for up to twelve adults with an intellectual disability. The designated centre comprises seven premises in a town Co. Kilkenny. There are five single occupancy homes, a large apartment with three resident bedrooms and a large house with four resident bedrooms.

During the inspection, the inspectors of social services had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting seven residents, eight staff, and the person in charge. Inspectors completed a walk around the premises and documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre. Over the course of the inspection, inspectors reviewed morning, midday and evening routines.

In line with the findings of the previous inspection in this centre in May 2025 residents were busy and had things to look forward to. A number of residents were self-employed, working as artists in a local studio, attending day services, volunteering, and taking part in education.

Residents told inspectors they were happy and felt safe. Examples of what they said included, "I am happy here and I am very busy", "I love it here", "I have a lot of friends here". Residents spoke about developing and maintaining their independence and choosing how and where they spent their time. Some of residents' favourite activities included, swimming, going out for drinks and meals, spending time on a farm, taking part in the upkeep of their homes and gardens, shopping, and going to the gym and using the pool and Jacuzzi. Four residents had just returned from foreign holidays and one resident spoke about their plans to go on a foreign holiday later in the year. Another resident spoke about their plans to go away with their peers to a house in the country later in the summer.

Each of the premised appeared homely and comfortable. There were numerous communal areas where residents could choose to spend their time. There was a maintenance list in place and a maintenance worker had just been employed by the provider to work in this centre three days per week. A flat roof was due to be replace and a resident's bedroom was due to be painted just after the inspection. Inspectors were informed funding for these works had been approved by the provider.

Throughout the inspection, residents appeared to be very comfortable with the staff supporting them. Warm, kind, and caring interactions were observed between residents and staff. Staff were observed to be aware of residents' support needs and their communication preferences.

In summary, residents were being supported to a engage in a activities of their choosing at home and in their local community. Improvements were required to governance and management and examples of this will be discussed later in the report.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

Inspectors found that improvements were required to governance and management, particularly relating to oversight and monitoring. In addition, lines of authority and accountability were not as described in the centre's statement of purpose due to staff vacancies at management level.

The local management team consisted of the person in charge and three house co-ordinators. Due to the vacancies at senior management level, the person in charge was reporting directly to the Chief Executive Officer (CEO). This arrangement did not ensure clear managerial supports, supervision and oversight.

The centre was not fully resourced as staffing numbers were not in line with the centre's statement of purpose. However, interviews had just been held and new staff were on boarding. Efforts were being made to ensure continuity and consistency of care while vacancies were being filled.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge who had the qualifications, skills and experience to fulfill the requirements of the regulations. Schedule 2

documentation for the person in charge was reviewed in advance of the inspection. They had the required qualifications and experience to meet the requirements for this regulation.

They were also identified as person in charge of another large designated centre operated by the provider close to this one. The person in charge continued to be present in the centre regularly and to had systems to ensure their oversight and monitoring in this centre.

Judgment: Compliant

Regulation 15: Staffing

There were five whole time equivalent (WTE) vacancies at the time of the last inspection in May 2025. Since then the provider had successfully recruited to fill one vacancy and had completed a number of successful interviews and offered a number of positions. As a result, if all positions offered were accepted one whole time equivalent vacancy would remain which was a house co-ordinator post.

One house co-ordinator had commenced in post since the last inspection which meant three of the four required house-cordinators were in post at the time of this inspection. The current vacancies were not found to be impacting on continuity of care and support for residents as regular staff were completing additional hours; however, a number of staff told inspectors this was not sustainable. Relief or regular agency staff were also completing shifts. For example, in a sample of rosters for two months reviewed, regular staff, one relief staff and three regular agency staff had completed the required shifts.

A number of residents were complimentary towards staff, co-workers and the local management team describing them as "kind", "helpful", "friendly" and "easy to get on with".

A review of a sample of three staff files and one co-worker's (live-in volunteer) were completed and they contained the information required under Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the designated centre was not adequately resourced. The statement of purpose outlined that the person in charge reported to the area manager, who in turn reported to the head of service, who reported to the CEO. On

the day of the inspection, the roles of area manager and head of service were vacant and the person in charge was reporting directly to the CEO.

Overall, inspectors found that improvements were required to governance and management. In addition to the resource issues described above, gaps were found in the provider's oversight and monitoring such as,

- The latest management meeting for this centre had not been attended by a member of the provider's senior management team,
- Restrictive practices not being reviewed in line with the provider's policy as due to personnel changes and vacancies the meeting could not occur, and,
- Incidents were not being reviewed by a member of the senior management team. For example, 24 incidents that occurred in May 2025 had not been reviewed by a senior level manager.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that residents were supported to lead busy and active lives. They were regularly taking part in work, day services, education and activities they enjoyed at home and in their local community. Their independence was supported and encouraged and they were making choices and decisions in their day-to-day lives.

Residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. There was a system for responding to emergencies and to ensure the vehicles were serviced and maintained.

Residents were also protected by the safeguarding and protection policies, procedures and practices in the centre. Staff had completed safeguarding training. Those who spoke with inspectors were knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse.

Regulation 26: Risk management procedures

The inspectors reviewed the risk management policy and the safety statement in place. The provider's risk management policy, dated May 2024, met regulatory requirements. The risk register, general and residents' individual risk assessments were found to be reflective of the presenting risks and incidents occurring in the centre. They were also up-to-date and regularly reviewed. For example, the inspectors reviewed 21 individual risk assessments which assessed and managed risks around, healthcare needs, fire safety, manual handling, safeguarding and self-

injurious behaviour. All risk assessments had been reviewed in April or May of this year.

Inspectors reviewed the systems to record incidents, accidents and near misses and a sample incident reports since the last inspection. They found that incidents were been reviewed and followed up on by the local management team; however they were not being reviewed by the provider's senior management team and this was captured under Regulation 23: Governance and Management. Trending of incidents was completed by the local management team, and learning as a result of reviewing incidents was used to update the required risk assessments and shared with the staff team in the sample of staff meeting minutes reviewed.

There were systems to respond to emergencies and to ensure the six vehicles were roadworthy and suitably equipped.

Judgment: Compliant

Regulation 8: Protection

The provider's safeguarding policy clearly detailed staff roles and responsibilities should there be an allegation or suspicion of abuse. Staff had completed safeguarding training and as previously mentioned, those who spoke with inspectors were aware of their roles and responsibilities. They named the different types and indicators of abuse and how they would respond in line with the provider's and national policy. They were each aware of who the designated officer was for this centre and who to go to if their absence.

There had been four allegations or suspicions of abuse since the last inspection in May 2025. From reviewing documentation relating to these and through discussions with staff, inspectors found that staff had followed the provider's and national policy. For example, all incidents had been reported to the National Safeguarding Team as required.

As a proactive measure, the local management team had recently reviewed compatibility to explore any potential or actual safeguarding risks and each residents' wishes and preferences relating to living accommodation. They were in the process of supporting residents to explore their options, including supporting them to access the support of independent advocates, as required.

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	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 Callan OSV-0003607

Inspection ID: MON-0047558

Date of inspection: 14/07/2025

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Following the recent inspection, the following actions have been taken to address requirements and ensure compliance with regulatory standards:

· A new Area Service Manager (ASM) started on 18th August 2025, providing regional oversight and leadership.
· First site visit to Callan is scheduled for Thursday, 21st August 2025.
· An introductory meeting was held with the PIC on 19/08/2025 to begin induction and agree on a short-term plan.
· From 21st August, ASM will be present on site every week and will check in via teams daily.
· The ASM will conduct a full audit of the Callan Designated Centre. This will involve more frequent site visits initially.
· A Quality Enhancement Plan (QEP) will be developed based on the audit, to be completed by 31st October 2025.
· All staff in Callan were informed of the new ASM and updated lines of authority via email on 18/08/2025.
· 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.
· ASM will hold weekly regional meetings with PICs, with the first one planned for 02/09/2025
· ASM will also attend the weekly Senior Management Team meetings, starting Friday, 22nd August 2025.
· A full-time Person in Charge (PIC) is currently in the post and actively fulfilling their statutory duties under the Health Act 2007.
· The PIC on maternity leave is due to return on 11/09/2025. This will end the current dual PIC arrangement across the two communities.

· The Head of Services position is currently vacant and being advertised through a national recruitment process.
· In the meantime, the CEO is covering the responsibilities of the Head of Services to maintain governance continuity.
· The Health and Safety Officer is due to carry out a full audit (date to be confirmed).
· The Compliance Officer will conduct a full Provider Audit on or before 31/08/2025.
· The Clinical Support Officer for Medication is scheduled to complete the annual medication audit on 25/08/2025 and 27/08/2025.
· The Behavioral CSO visits 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. To be completed and ready for shared learning for September's staff meetings beginning 15/09/2025
· The SOP was reviewed on 19/08/2025 by the National Operations Support Officer and the PIC. The current management structure is as follows:
Board → CEO → Head of Services Vacant (Interviews Thursday 28th August 2025) → ASM → PIC → Team Leader (Vacant in Recruitment Process) → House Coordinators (x3) → Social Care Team
· The Team Leader role has been advertised both internally and externally. Ads have been purchased for KCLR radio, Kilkenny People newspaper, and Jobs.ie.
· The ads were purchased on 19/08/2025 and are scheduled to run during the week beginning 25/08/2025.
· 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.
· The Compliance, Safeguarding and Risk Manager is due to review Operational Risk Register with PIC before 30/09/2025
· Supervision for PIC with ASM has been scheduled for week beginning 25/08/2025
· Restrictive practices will be reviewed by PIC and CSO on 26/08/2025 there is no new RP's for panel review. Panel has now reconvened.
· ASM was inducted into the incident management system 19/08/2025 and will begin reviewing incidents in real time.
· One full-time Social Care Worker has been successfully recruited and will commence employment on Monday, 25th August.
· One full-time Social Care Assistant has also been recruited; their start date will be confirmed upon completion of onboarding.
· 2 other Full-Time staff were interviewed and offered Social Care worker positions however declined during offer/onboarding stage.
· Following a meeting with the Person in Charge (PIC) on 19/08/2025, HR administrators re-engaged with recruitment agencies, shared updated job descriptions for vacant posts, and requested relevant CVs. CV review meeting with PIC is scheduled for 20/08/2025.
· All agency staff have completed mandatory training as per CCoI policies and are fully inducted, with access to all required systems to ensure safe and effective care. As confirmed by PIC and Admin on 19/08/2025, there are currently no outstanding staff inductions. This is reviewed by the Compliance officer during review of staff files.
· Supervision for agency staff is in place, aligned with CCoI's supervision policy to ensure

ongoing professional oversight. This is reviewed by the Compliance officer during review of staff files.
· Rosters continue to be reviewed daily to ensure adequate, qualified, and experienced staff are available to meet residents' assessed needs.
· An on-call roster is in place to support staff outside regular working hours.
· The SOP for On-Call, outlining the roles and responsibilities of the PIC, ASM, CEO, and Head of Services, was shared with the staff team on 06/08/2025.
Camphill Communities of Ireland (CCoI) remains fully committed to upholding the highest standards of governance, leadership, and accountability across all designated centres. The actions outlined above reflect a targeted and strategic approach to strengthening local and national oversight, ensuring that services are both compliant with Regulation 23 and responsive to the evolving needs of residents.

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 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	30/10/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/10/2025