Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Dunshane Camphill Communities of Ireland
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	08 December 2025
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0049057

About the designated centre

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

Dunshane Camphill Communities of Ireland is a designated centre that provides 24-hours a day, seven days a week care and support for up to 18 residents in a rural location in Co. Kildare. The designated centre consists of seven residential buildings situated on over 20 acres of farming land in a campus-style setting. The centre also provides day activation services from 9am to 5pm Monday to Friday, on site. Some residents participate in these day activities, such as baking, cooking, pottery, basketry, and farming within the grounds of the designated centre or are supported in other interests in the community. The site also contains extensive gardens, walk ways, forest trails, farm land and fields. The centre can accommodate residents, aged 18 and over with intellectual disabilities. Residents are supported by a team of social care workers, assistant support workers and voluntary workers. In line with the co-living model of care residents share communal living spaces with the volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 8 December 2025	09:45hrs to 18:50hrs	Erin Clarke	Lead
Monday 8 December 2025	09:45hrs to 18:50hrs	Karen Leen	Lead
Monday 8 December 2025	09:45hrs to 18:50hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

In October 2025, the registered provider was issued with a Section 51 Notice of Decision to cancel the registration of this designated centre. In accordance with the Health Act 2007 (as amended), the provider exercised their right of appeal. While this legal process is ongoing, the provider remains responsible for the operation of the designated centre and for meeting all statutory obligations under the Health Act 2007 (as amended).

This unannounced inspection was carried out by three inspectors on one day to ensure that residents were safe and well cared for and that appropriate action was being taken by the provider to move back into compliance with the regulations. The inspectors utilised the provider's comprehensive response to the compliance plan request, which had been submitted to the Chief Inspector of Social Services following the inspection of 25 September 2025 and which identified actions taken since that time.

Inspectors informed their judgments through observations, conversations with management and staff, and a review of documentation about how care and support is provided to residents and documentation which reflected actions taken since the previous inspection, completed 25 September 2025. Overall, findings of this inspection demonstrated that the provider, while making changes to their overall systems for oversight, had yet to implement actions in a way that drove change. As such the provider had failed to move into compliance and was not delivering safe levels of care to all residents.

It was of particular concern to inspectors that the provider's local arrangements for oversight were not identifying matters that had the potential for serious health and safety impact to residents. As a result of findings on the day of inspection, two urgent actions were issued verbally during the inspection and followed by an urgent request for written assurances the day after the inspection under Regulation 6 (Healthcare) and Regulation 28 (Fire Precautions).

During this inspection inspectors had the opportunity to meet or observe eight residents, six staff members, a team leader, the nominated person in charge, safeguarding, the risk and compliance manager, area service manager and head of services. Some core staff spoken to talked of changes that had occurred since the last inspection, however, one staff member stated that they did not seem to have to complete as many checks as previously and another staff member was unclear on the location of recording sheets for daily observations.

On the day of inspection, the team leader on duty confirmed that three staff had called in sick that morning and reported a high level of staff sickness overall. The team leader also advised that they were required to cover a shift in one house,

having initially been rostered to work from the office. All staff who spoke with inspectors identified staffing levels as the most significant risk within the centre.

On arrival at one house in the designated centre, inspectors were greeted by staff and escorted through a corridor leading to the main sitting room. Accessible information was displayed for residents, including information on the complaints process and the management team. Inspectors found that this information did not reflect the current person in charge as appointed by the provider. Inspectors also requested the agency induction pack for the centre, which was provided by the provider nominated person in charge. This document was found to be outdated and did not reflect the current management structure, including the person in charge put forward for appointment in November 2025. Inspectors were informed that this was the most up-to-date version in use.

In this house, inspectors met three residents. One resident was relaxing in the sitting room, while two residents were resting in their bedrooms, but were met later in the day. Inspectors observed residents moving freely within their homes, supported by staff in their daily routines. Inspectors also observed residents being supported by staff to prepare for an outing, including a drive and lunch, and noted respectful interactions between staff and residents during this time.

Inspectors reviewed the support plan for one resident who required daily catheter care. While the support plan stated that the highest standards of hygiene must be maintained, inspectors found that staff did not have access to appropriate personal protective equipment (PPE) to carry out the procedure safely and hygienically. In addition, the storage arrangements for the required equipment were visibly unclean and did not meet appropriate hygiene standards. These findings are discussed further under Regulation 6: Health Care.

In another of the houses one inspector met with three residents. One resident was spoken with briefly at their front door and they preferred the inspector not enter which was respected. This resident was being supported by a staff member who introduced themselves to the nominated person in charge stating that they had not met them previously in person. Two residents in another of the residences were out when the inspector arrived to their home, one entrance door into this home was locked with no key available in the key box, however, another entrance door opposite residents' bedrooms was unlocked and internally the staff office was also unlocked and open which was in direct contravention of the provider's newly devised SOP for locking premises. The inspector in asking about this was told by the nominated person in charge that the door was left open to allow maintenance and workmen access the building.

Inspectors observed residents in another home being supported to leave their home and go to their laundry which was in a separate building and later leaving to go out. Inspectors observed that one resident who had the potential to independently navigate around their home externally was not afforded the opportunity to do so unsupported due to the handrails not having been installed around the newly laid ramps and pathways.

Resident compatibility remained an ongoing concern. Records reviewed in November noted that one resident had experienced a recent reduction in incidents, which was attributed to another resident being away from the house for a number of weeks, suggesting that compatibility issues may have been a contributing factor to previous behaviours of concern.

The provider had assured the Chief Inspector in its compliance plan that no internal transfers would occur until all relevant assessments had been completed and that residents and families had been informed that all proposed transfers were paused pending completion of these assessments.

Despite the provider's assurances, inspectors found evidence that discussions regarding transfers were ongoing over a prolonged period and that residents' expectations were being set in relation to future moves that had not yet been approved. Minutes of a community management meeting held on 5 November 2025 recorded that one resident was described as being very eager to begin the moving process and had been informed that the move would take place after Christmas. The same meeting recorded that another resident was looking forward to moving to their apartment.

This indicated that residents were being given information about anticipated moves and timeframes in advance of the completion of required assessments or the receipt of any formal approval. Inspectors found that this had an adverse impact on residents, as discussions about moving had been ongoing for over a year. In October 2025, it was reported that one resident experienced a particularly difficult period marked by heightened anxiety, and this anxiety was attributed to the proposed move.

Inspectors found that repeated changes in leadership, insufficient staffing capacity and ineffective governance systems continued to impact the provider's ability to deliver safe, consistent and high-quality care. Despite actions being proposed following previous inspections, the provider had not demonstrated the capacity or capability to see these actions through to completion or to embed sustainable improvements.

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 while some changes to provider level systems had been made since the last inspection, these had not been effective at centre level and improvements were also not apparent at centre level. Improvement was required in relation to governance and management within the centre which is an area where

the provider has failed to achieve compliance since October 2024. As found on three previous inspections in 2025 ineffective oversight and an inability to respond to residents' assessed needs in particular at a centre level continues to have a significant impact on their quality of life.

Since the previous inspection, there had been significant changes within the governance structure of the centre. A new area service manager commenced on 09 October 2025, and a head of service commenced on 13 October 2025, both replacing the previously nominated person participating in management (PPIM). In addition, the newly appointed person in charge appointed 25 August 2025 was removed from post and replaced by a residential services manager, who commenced with the provider on 30 October 2025 covering the residential services manager position and the nominated person in charge position.

The provider failed to ensure a consistent local management structure present in the centre. There continued to be changes at person in charge and house coordinator level which impacted on the ability of the provider to implement their quality improvement programme, to address centre level deficits and to drive potential quality initiatives. Inspectors found that the provider had not ensured a suitably qualified and competent person in charge was in place.

Inspectors found that the provider continued to operate with a significant staffing deficit, persistent vacancies and high turnover. Staffing levels were below those required to meet residents' assessed needs, and reliance on agency staff remained high. The reduced number of house coordinators further limited oversight and consistency of care. These deficits impacted the provider's ability to respond safely to residents' needs.

Inspectors found that governance and management arrangements did not provide effective oversight of the quality and safety of care. Management systems, audits and walk-throughs were in place but were not effective in identifying risks or driving improvement. Incident review, staff supervision and follow-through on actions were inconsistent. As a result, the provider did not demonstrate effective governance at centre level.

Regulation 14: Persons in charge

It is a requirement for a designated centre to have a registered person in charge. It is also the responsibility of the registered provider to ensure that all persons in charge appointed meet the requirements of the Regulations. Regulation 14 places obligation on the provider to ensure that the person in charge has appropriate qualifications, experience, and competence to fulfil the role. Inspectors found that this requirement on the day of inspection had not been met in this centre.

Since the previous inspection on 25 September 2025, the person in charge who had been appointed on 25 August was removed from post on 25 November 2025 by the provider and this change was notified to the Chief Inspector via the notifications

procedure. The replacement to the role was also notified on that date. The nomination was for the residential services manager, who was newly appointed to that role on 25 October 2025.

Following review of all prescribed information submitted by the provider and discussions with the nominated person in charge on the day of inspection, inspectors found that the individual did not meet the minimum requirements of the Regulations to hold the role of person in charge. As a result, inspectors informed the area services manager and National head of services on the day of inspection and the provider on the day following the inspection that they were required to nominate an alternative person in charge. The area services manager was subsequently nominated by the provider to fulfil this role in addition to their management position.

Judgment: Not compliant

Regulation 15: Staffing

The provider continued to operate with a significant staffing deficit, with persistent vacancies and high turnover. This had an ongoing negative impact on the consistency and continuity of care and support for residents and remained an area where the provider had failed to achieve its stated targets.

In its compliance plan following the September 2025 inspection, the provider stated that the required staffing level for the centre was 39.9 whole-time equivalent (WTE). During the inspection, the provider supplied inspectors with documentation stating that 22.92 WTE staff were employed. However, minutes of the Quality, Risk and Compliance Board sub-committee meeting dated 04 December 2025 recorded that "staffing remains critical," with staffing levels noted as 18.63 WTE, which aligned with inspectors' findings on the day. In addition to changes at the person in charge level (outlined under Regulation 14), the centre was operating with only two house coordinators, against a stated requirement for five, representing a further reduction of one post at this level since the previous inspection.

Inspectors reviewed incidents in one house where a resident had left their home at night on more than one occasion to enter another house in search of food. The provider was unable to demonstrate that sleepover staffing arrangements had been reviewed in response to these incidents. For another resident with diabetes, records showed episodes of the resident being awake at night with elevated blood sugar levels, yet there was no provision of waking night staff nor records to demonstrate this had been reviewed. In a third house, where one staff member was rostered to support two residents, risks associated with epilepsy management are present and are discussed further under Regulation 26.

Inspectors acknowledge that following the previous inspection, the provider reviewed staffing supports for one resident and submitted a funding request to

implement 2:1 support. While awaiting the outcome of this request, the provider stated that a second staff member was being rostered during the day, which had increased opportunities for the resident to engage outside the home. However, this arrangement was not implemented consistently due to staffing deficits. On the day of inspection, the roster recorded the position for second staff member as "to be filled," with only one staff member on duty.

Review of rosters since the previous inspection showed the impact of the ongoing reliance on agency staff for residents. Some residents continued to be supported almost exclusively by agency staff, while others were predominantly supported by core staff. For one resident, 14 different agency staff had been rostered since the beginning of October, with only two shifts covered by the provider's own staff. In another house, rosters showed that two residents were predominantly supported by agency staff, including one week from 01 December, when agency staff covered five days, and three weeks in November, when all seven days were covered entirely by agency staff. The number of residents supported almost exclusively by agency staffing had increased since the last inspection.

Judgment: Not compliant

Regulation 23: Governance and management

Accessible management and local governance remained poor due to the absence of key local management personnel. As outlined under Regulation 15, since the previous inspection, the number of house coordinators had reduced to two, despite five being stated as required to support the centre. This significantly reduced management oversight and consistency of support.

Due to ongoing staff turnover and the frequent use of unfamiliar staff teams, inspectors were not assured that staff consistently understood or adhered to required systems and procedures. Where staff demonstrated awareness of systems, inspectors found that these were not reliably implemented. For example, a review of daily records showed that required daily fire safety checks and daily finance checks were not consistently completed. Where daily or weekly checks were recorded, there was limited evidence that gaps or concerns were identified, escalated or acted upon. This lack of oversight was also reflected in cleaning and environmental checks, as outlined under Regulation 6, where visible dirt was present in a resident's environment. The provider's checks completed by team leaders bi-weekly also refer to the condition of the premises and poor cleaning practices. Inspectors also reviewed handover logs and found gaps in completion, reducing assurance that critical information was being communicated between shifts.

The provider had introduced governance walk-throughs of the premises; however, the records reviewed did not clearly outline their purpose and failed to identify issues found by inspectors during the inspection. In addition, team leaders conducted bi-weekly walk-throughs, but inspectors found that issues identified

during these reviews were not clearly escalated or addressed. For example, on 03 October 2025, out-of-date food was identified in a resident's fridge, yet fridge and freezer check records reviewed showed significant gaps and were not completed as required. On 03 October 2025, the absence of handrails and associated risks to residents were recorded. Fire doors in one house were identified as not functioning on both 03 October and 30 October 2025. Inspectors also found a broken kitchen cupboard door remaining in residents' kitchen for several weeks, despite a provider memo issued on 04 November 2025 outlining procedures for the removal and management of broken furnishings. This hazard had not been identified during management walk-throughs and was brought to the attention of the Compliance, Safeguarding and Risk Manager by inspectors on the day of inspection.

Inspectors reviewed a sample of incident reports and found limited management oversight. Sections designated for review and sign-off by the person in charge were incomplete or left blank. There was no evidence that incidents were being trended, analysed or reviewed to identify patterns, learning or required actions.

Minutes of staff team meetings held across the five houses on 13 November, 19 November, 24 November and 01 December 2025 were reviewed. Inspectors found that senior management were present at only one meeting, despite ongoing concerns raised by staff. These included residents' increased anxiety in relation to potential moves, changes in medical presentation and increased reliance on multidisciplinary supports. The absence of senior management at these meetings reduced assurance that residents' healthcare and wellbeing concerns were being appropriately escalated.

Inspectors reviewed the supervision schedule for staff, a responsibility of the person in charge. The schedule listed planned supervision for 16 staff; however, records showed that six supervisions were overdue, with a further supervision due to expire in December 2025. This indicated that staff supervision was not being maintained in line with the provider's policy.

Inspectors issued a written documentation request at 10:40 to the nominated person in charge and the area service manager to verify progress against the provider's compliance plan. Information was provided very slowly throughout the day, with limited documentation available until later in the inspection when the Quality Manager, Head of Services and Area Service Manager attended the centre. At the close of the inspection, a substantial volume of requested evidence remained outstanding. This included records of communication with residents regarding the complaints process in formats appropriate to their communication needs; probation and performance reviews for the current nominated and former person in charge; resident inventory lists; financial capacity assessments; incident records for each house; induction packs; records of weekly governance and CEO meetings; details of grievances or concerns raised by staff or third parties; the business case submitted to the funder; updates on the skill-mix analysis; and evidence that an appropriate health or social care professional had validated assessments of need. As a result, inspectors were unable to verify the progress or impact of a number of actions that the provider themselves had committed to and outlined in their compliance plan to

demonstrate their capacity and capability to come into compliance and drive improvement.

The provider had previously developed a Quality Improvement plan (QIP) which was used to track progress against identified actions. This had been reviewed at the previous inspection and was reviewed again on this inspection. While a number of actions under the remit of senior management were progressing the actions attributed to local management remain. This was for the most part due to the absence of consistent personnel and therefore impact for residents was not observed.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the provider had failed to ensure that residents were consistently receiving safe, appropriate or timely care and support. Significant deficits in healthcare oversight, infection prevention and fire safety posed immediate risks to residents' health, wellbeing and safety. As a result of these findings, inspectors issued two urgent actions during the inspection under Regulation: 6 Health Care and Regulation 28: Fire Precautions, requiring immediate remedial action by the provider. These findings demonstrated a failure to identify, assess and respond to serious risks through the provider's own governance and monitoring systems.

Inspectors found that the provider failed to ensure residents had timely access to appropriate healthcare supports, despite identified clinical needs. Required reviews by external healthcare practitioners had not been progressed, including neurology and diabetes specialist input. Significant deficits were identified in catheter care, including poor infection control practices, inadequate equipment storage, lack of personal protective equipment (PPE) and inconsistent monitoring of health indicators. These failures represented an immediate risk to resident safety and resulted in the requirement for an urgent compliance plan.

Inspectors found that fire safety arrangements did not adequately protect residents in the event of a fire. Fire compartmentation was compromised by damaged fire doors and inadequate fire-resistant construction. A fire escape route was observed as unsafe, daily fire safety checks were inconsistently completed, and evacuation records did not demonstrate that all residents could safely evacuate with available staffing. These findings required urgent corrective action.

Inspectors found that risk management systems did not effectively identify, assess, manage or review risks in the centre. Risk assessments were outdated, did not reflect residents' current living environments and relied on control measures that were no longer in place. Management oversight of incident reports was inconsistent,

with limited evidence of review, escalation or learning from incidents. As a result, the provider failed to provide assurance that risks to residents' safety were being effectively managed.

Regulation 26: Risk management procedures

The provider reported that risk management systems had been reviewed since the previous inspection. Inspectors reviewed the centre's risk matrix and a sample of individual resident risk assessments. However, inspectors found that the effective management of risk was overly reliant on the presence of a person in charge and a stable local management structure. In the absence of consistent local management oversight, control measures were not being implemented as required. This failure undermined the effectiveness of the provider's risk management systems, leaving residents exposed to avoidable risks.

Inspectors reviewed a number of individual risk assessments and found that stated control measures were not being applied and, in some cases, could not be implemented in practice. For example, the risk of financial misappropriation for one resident could not be mitigated, as the provider had not ensured the resident had appropriate access to their personal finances and relied solely on cash reconciliations. For other residents, risk assessments identified daily balance checks as a control measure; however, these checks were not being completed. The oversight arrangements outlined in the risk assessments, namely review by a house coordinator and spot checks by the person in charge, were not in place. The house coordinator role was vacant and there was no evidence of oversight by the person in charge. Inspectors found records in which staff recorded that daily balance checks had not been completed, and in other cases, records were left blank. Local audits of residents' daily balances had not been carried out.

Inspectors also reviewed risk assessments relating to residents' healthcare needs and found that required control measures were not being implemented. For example, a risk assessment for one resident identified the need for waking night staff to mitigate risks associated with seizure activity. Inspectors found that no waking night staff were in place in the resident's house. When questioned, staff were unaware that this was a control measure for seizure management. They stated that a previous arrangement for wake night staff had been in place for safeguarding reasons linked to resident who had since moved. For another resident where control measures were identified, such as weekly checks of an epilepsy bed mat, inspectors found these checks were not consistently completed. On review one check was recorded as completed on 15 November and this was not repeated until 07 December. This failure placed the resident at risk, as the equipment may not have functioned as required.

Inspectors found that some risk assessments reviewed were not reflective of control measures in place. For example, one resident had risk assessments in place for pica (ingestion of inedible items) and behaviours of concern, with a key control measure

being the presence of waking night staff. Inspectors found that this stated control measure was no longer in place and that the resident's risk assessment completed on 15 August 2025 had not been reviewed or updated to reflect this change. Inspectors also reviewed records of health concerns and incidents involving residents leaving the house at night and found that it was unclear whether staffing levels were sufficient to manage these risks safely.

Inspectors reviewed a sample of 25 incident reports recorded between 26 September and December 03 2025. Incident reports for November 2025 were not made available at the time of inspection. Of the incidents reviewed, 24 had not been reviewed by a person in charge, and the area service manager/PPIM had reviewed four incidents. Inspectors found that on 80% of occasions, for incidents including physical aggression, property damage, environmental hazards, medication errors and a fall, neither the person in charge nor the area service manager/PPIM had reviewed the incident form. There was no evidence that incidents were being analysed, trended, or reviewed collectively to identify patterns, learning, or required improvements to practice. Inspectors found that the incident management system relied disproportionately on review by a clinical services officer, rather than on appropriate line management oversight. This meant that key responsibilities, including staff debriefing, learning from incidents, and updating risk assessments where required, were not being consistently undertaken.

In addition, as outlined under Regulations 6 and 28, inspectors found that significant risks impacting residents' safety had either not been identified or, where identified, had not been adequately assessed or addressed by the provider.

Judgment: Not compliant

Regulation 28: Fire precautions

Under this regulation, the provider was required to submit an urgent compliance plan to address an immediate risk to residents. The provider's response provided some assurance that the risk had been reviewed and that actions were proposed to address it. However, inspectors remained significantly concerned that the provider had not self-identified the issue through its own governance, audit or monitoring systems.

The inspectors found one house in the designated centre did not have adequate protection and subdivision with fire resistant construction. This premises had previously been closed by the provider in December 2020 as it had been found to have serious fire safety concerns. Significant remedial work at that time was completed to ensure that this building provided adequate fire safety protection for residents. It was of serious concern that a lack of fire containment was again identified by the Chief Inspector and not by the provider. Additionally concerns were compounded by findings of poor oversight of fire safety systems.

On this inspection during the walkthrough of the property which provides two homes one on the ground floor and one on the first floor the inspectors observed serious fire containment concerns. This included fire doors with large gaps present between the door and floor and damaged door frames. In addition there was concern about the fire containment between floors as in the laundry room, which is a high risk area, recent works had left pipe work passing through the ceiling and the surrounding areas were observed to be unsealed.

This was of significance as the only identified and utilised escape route for one resident was down a stairs and past the laundry room where the door did not provide adequate protection. In addition an additional safety measure stated by the provider as being in place, which was removal of lint from the tumble dryers was not being completed as required. The inspectors found for example on the week commencing 24 November 2025 that this had not been completed on two occasions.

Records of daily fire safety checks had gaps in recording in both homes within the house. Inspectors reviewed a sample of records and found that in addition to incomplete records of daily checks weekly checks were also not occuring as required. For example the weekly fire alarm review were last recorded as completed on 25 November

Fire evacuation records for all residents (both upstairs and downstairs) did not demonstrate that maximum residents could safely evacuate with minimum staffing. In one home the most recent fire drill evidenced that the resident did not evacuate and the responsibility for ensuring this risk was reviewed was for the house coordinator who was no longer in post. No fire drill with minimum staffing in the last year had been completed for the other home in this premises.

On arrival to this premises one inspector observed a fire door propped open with an armchair this was a staff sleepover room adjacent to a resident bedroom. In addition an electrical item was plugged in to charge and was placed on the armchair. In another area an inspector observed one extension lead and plug placed upon a radiator in the resident's bedroom.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Overall, inspectors were not assured that residents' needs were being appropriately assessed or that information arising from assessments was being used to update support plans in a way that effectively guided staff practice. Inspectors reviewed eight of 14 assessment of needs and support plans provided to them on the day. Matters relating to one resident's healthcare support plan arising from previous findings and assessments of need are detailed further under Regulation 6.

While the provider had updated its assessment of need documentation and revised assessments since the previous inspection, inspectors found that significant

inconsistencies remained. For example, where one resident had an identified need relating to periodic weight loss, the relevant section of the assessment of need was not completed. There was no named person responsible for reviewing the associated support plan or ensuring that changes were made when required.

Inspectors identified similar gaps across other assessments, where sections remained incomplete despite clearly identified needs. Discrepancies were also identified in assessments of need. For example, one resident experiencing incontinence had an assessment of need completed on 28 October 2025 in which sections relating to night-time continence and continence assessment were left blank, and urinary health was recorded as "not applicable." This did not accurately reflect the resident's identified needs.

Inspectors found that residents were required to have up-to-date annual and personal development plans. For one resident, the personal development plan had not been reviewed since June 2023. Although a note recorded in March 2025 indicated that the plan required updating, this still had not occurred at the point of this inspection. The plan contained no meaningful goals. For another resident their personal development plan had not reviewed since January 2024. Of three personal development plans reviewed in one house, only two showed evidence of active goal planning.

Inspectors also observed that a number of residents were awaiting access to psychology and speech and language therapy services. Inspectors found that recommendations for speech and language therapy to support residents' communication needs were recorded but had not been progressed. In addition, some support plans reviewed, related to previous houses where residents had lived and had not been updated to reflect their current living arrangements. Inspectors found that one resident, described as having limited communication skills, had developed their communication abilities through the use of assistive technology on an electronic tablet device, which had been reported as beneficial during key working sessions and goal setting. However, records last dated 18 August 2025 that had not subsequently reviewed showed that the resident remains without access to their communication system (the electronic tablet) due to it being broken, it had not been repaired or replaced at the time of inspection.

Inspectors found that where support plans identified the need for input from external healthcare practitioners, this input had not been consistently sought or utilised by the provider, despite being identified as essential to the resident's care. This included residents with long-term health conditions such as epilepsy and diabetes.

Minutes of a house meeting held on 13 November 2025 recorded that staff discussed one resident who was experiencing increased anxiety in relation to a potential move to another house within the designated centre in the new year. However, inspectors found no evidence in the resident's assessment of need or personal plans that this increased anxiety had been reviewed, nor was there any

documented transition planning or guidance for staff on how to support the resident in light of this change.

Since the last inspection, the provider had introduced folders in each house containing residents' overarching support plans, relevant risk assessments and key information intended to guide unfamiliar staff. Inspectors reviewed a sample of these folders and found that one contained a support plan referring to the wrong house and not the current version, despite being signed and dated as read and reviewed. This was changed for the correct version on the day of inspection when inspectors highlighted that documents were being signed as having been reviewed but clearly had not been read to ensure content was accurate.

Inspectors also found inconsistencies between assessments of need, support plans and staffing arrangements. For example, one resident's support plan stated that they required 1:1 support at all times, both at home and in the community, due to epilepsy-related risks. However, the assessment of need did not reflect this level of staffing, and the resident lived with a peer in a house where only one staff member was rostered. Inspectors observed several occasions during the inspection where the resident was without staff supervision for periods exceeding five to ten minutes. This was of particular concern as the epilepsy support plan stated that if a seizure lasted longer than five minutes, rescue medication was required.

Judgment: Not compliant

Regulation 6: Health care

Under this regulation, the provider was required to submit an urgent compliance plan to address an immediate risk to residents. The provider's response provided some assurance that the risk had been reviewed and that actions were proposed to address it. However, inspectors remained significantly concerned that the provider had not self-identified the issue through its own governance, audit or monitoring systems.

Inspectors found that a number of residents' healthcare needs had been identified as requiring review by external healthcare practitioners; however, on the day of inspection, these reviews remained outstanding, despite the provider identifying them as essential to maintaining residents' health, wellbeing and safety. For example, one resident's assessment of need and support plans identified the requirement for a neurology review. The last neurology review had taken place on 18 September 2024. Inspectors reviewed communications from December 2024 in which support staff had requested a review of the resident's epilepsy support plan and a follow-up neurology appointment. No further correspondence, appointments or reviews had occurred. Inspectors noted that the resident's support plans highlighted epilepsy management as critical, with seizures described as "usually triggered by illness or changes in medication."

Inspectors also reviewed medical notes completed by a resident's General Practitioner (GP) on 01 December 2025. These records showed that staff had raised concerns regarding fluctuating blood sugar levels, changes in behaviour and altered sleep patterns. During this consultation, the resident's GP advised staff to contact the diabetic clinical nurse specialist supporting the resident through outpatient services. On the day of inspection, no contact had been made with the diabetic clinical nurse specialist to discuss these concerns. Staff informed inspectors that contact would be made following the inspection.

Previous concerns in relation to catheter care support plans for one resident were raised at the time of the June 2025 inspection and the provider gave assurances that these plans were revised. A revised plan was seen at the time of the September 2025 inspection. On this inspection inspectors reviewed these plans in detail and identified ongoing significant risks. Inspectors found that the resident had three separate healthcare support plans relating to catheter care, including guidance based on urology advice dated 2023 and a more recently reviewed plan dated July and November 2025. The inspectors read the most recently reviewed support plan as guidance and endeavoured to carry out the steps of the plan during the course of the inspection by following the guidance in place. In addition inspectors requested that two support staff working in the house carried out the steps by following the guidance.

During this process, inspectors identified multiple concerns, including the presence of out-of-date equipment in use for the resident. Although the support plan stated that "the highest standard of hygiene must always be maintained," catheter care equipment and medical devices were stored on shelving that was visibly dusty and dirty. Incontinence products stored alongside this equipment were also visibly contaminated. The boxes in which the equipment was packaged in was also covered in dirt and dust. Packaging for catheter equipment was left open, with dirt observed on leg dressings and leg straps used as part of the daily procedure.

The room in which the resident was supported to have their catheter support carried out did not have access to standard personal protective equipment (PPE) such as gloves, alcohol hand gel or aprons. In order for staff to maintain hand hygiene, pre and post procedure as per guidance they had to go through two points of contact prior to reaching a hand washing sink. The support plan highlighted that staff should "dispose of used drainage bags sealed in a bin bag and placed in household rubbish dustbin", however during the walk through of the support plan inspectors found a used drainage bag discarded in a refuse bin in a shared bathroom and not with the additional measure of a sealed bag. The inspectors found that there was no refuse bin available in the residents' room to discard of used equipment post care.

During discussions with staff, the inspectors asked how the signs and symptoms of urinary tract infection were monitored for the resident and if regular observations were taking place for the resident in line with their identified health care need. Staff reported that monitoring was based solely on behavioural changes and that no routine clinical observations were undertaken. Inspectors requested records relating to antibiotic treatment for the resident over the previous 12 months; this

information was not available on the day of inspection and was subsequently requested as part of the urgent compliance plan.
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 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant

Compliance Plan for Dunshane Camphill Communities of Ireland OSV-0003616

Inspection ID: MON-0049057

Date of inspection: 08/12/2025

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:

Person in Charge

The report notes the following: "Following the inspection on 25 November 2025, the person in charge who had been appointed on 25 August was removed from post, and upon the inspectors finding that the individual did not meet the minimum requirements of the Regulations, CCoI immediately placed the Area Services Manager in post as Person-in-Charge."

Following the HIQA inspection, the Area Services Manager has been registered as the named Person-in-Charge since December 10, 2025.

Response

• The Area Services Manager is in post as Person-in-Charge and carrying out all required responsibilities as required under Regulation 14. The Residential Manager also provides governance support in overseeing the two Team Leaders, Administrator and House Coordinators. CCoI have also sourced a temporary administrative staff member until the end of February to assist with administrative tasks in Dunshane with the potential for this to extended to subsequent months as has been approved by the CEO.

Our Human Resource Department have confirmed as of January 22, 2026 that the employment of the employee nominated as Person-in-charge on August 25, 2025 has now ceased. Recruitment for the post of permanent Person in charge will commence immediately.

• The Statement of Purpose has been updated to reflect the current Person-In-Charge and been circulated in relevant documents, folders and locations through the campus have also been updated to accurately reflect the current management system.

• The Area Services Manager possesses the appropriate qualifications, experience and competence required under Regulation 14 to fulfil the role of Person-in-Charge whilst maintaining their Area Services Manager responsibilities.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Staffing issues
The report notes the following ”However, minutes of the Quality, Risk and Compliance Board sub-committee meeting dated 04 December 2025 recorded that “staffing remains critical,” with staffing levels noted as 18.63 WTE, which aligned with inspectors’ findings on the day. In addition to changes at the person in charge level (outlined under Regulation 14), the centre was operating with only two house coordinators, against a stated requirement for five, representing a further reduction of one post at this level since the previous inspection.”
Response:
• Based on the assessed needs of the residents, the required WTE for Dunshane Community is 39.9. Current staffing levels stand at 18.63 WTE, which CCoI acknowledge is a deficit. To address this deficit, the Residential Manager, supported by the Head of Services, Area Service Manager (ASM), HR Department, and Social Media Coordinator, is responsible for managing the recruitment, retention and training processes to achieve a full staffing complement and to reduce reliance on agency staff.

• A third house coordinator has accepted an offer of employment with a start date before 28 February 2026, with recruitment continuing to fill the remaining house coordinator vacancies. Interviews continue to be booked as applications are received. Multiple applications for House Coordinator, Social Care Worker and Social Care Assistant levels are at interview stage as of January 15, 2026 while two applications for SCA at an advanced stage with start dates planned before February 28, 2026

• As a further effort to address staffing issues, CCoI have reissued our Refer a Friend scheme to all staff, which offers a €500 tax free voucher incentive for successful referrals and is operational until January 31, 2026, with potential extension subject to the approval of the CEO.

• Further, as part of their efforts to ensure retention of staff, CCoI have completed The Great Place to Work (GPTW) survey was completed between December 1 and December 19, 2025, with results to be analysed and presented to Senior Management by February 28, 2026 to inform targeted retention strategies.

• Four policy briefings were completed on December 19, 22, 30 and January 6 2026, covering the following policy areas:

o Restrictive Practice, Standard Operating Procedure on Locking doors, Safeguarding, Personal Support Plans, Fire Safety, Protected Disclosures and Complaints Policy.

• The HSE training programme for all Dunshane staff (contracted employees and regular agency staff) has initial four sessions scheduled from 22 January 2026 for a number of weeks, covering Regulations as per the Health Act 2007, person centred planning and key working, awareness training on existing CCoI policies, policy development support and care plan review. While a final completion date is not available at this time as it is

dependent on HSE availability and the pace which topics are covered but an initial four dates are scheduled up to February 11, 2026.

• A targeted recruitment open day in scheduled for January 24, 2026 at two locations in County Kildare, with comprehensive advertising through local newspapers, local radio, online jobs sites, social media and direct outreach to social care training colleges.

• CCoI have revised the policy with a view that Relief Social Care Workers can be employed on a part time basis. This will give an additional channel of staffing, while also contributing to the continuity of care and support for the residents of the designated, as CCoI relief staff will attend team meetings, be trained and receive supervision in line with policy. CCoI employed relief staff will also contribute to consistency within the centre and minimise the reliance on agency staff. Recruitment for relief Social Care Workers commenced on January 15, 2026.

Specific Resident issues

• To address the incident where a resident had left their home at night on more than one occasion to enter another house in search of food and the concern that sleepover staffing arrangements had not been reviewed post incident; CCoI anticipates both these matters will be resolved when the transition of the community member from upstairs to downstairs in that house takes place by January 23, 2026 which includes the installation of new alert systems in the home.

• To address the concern regarding waking night staff provision in a home where a community member had elevated blood sugar levels. This matter has been reviewed and a waking night is not advisable as it assessed it would lead to negative outcomes for the community members patterns and behaviours. As noted elsewhere in the report, high blood sugar levels are notified to the house phone which is held by the staff member on a sleeping night.

• With regard to the concern around the implementation of the 2:1 support arrangement for one resident, these has been implemented by CCOI since October 2025. It is noted that this is a proactive measure to stave off burnout. In the rare situations where the second person cannot be filled, the first staff member is aware to notify the office if behaviours of concern arise.

The report cites the continued reliance on agency staff in various cases.

• As stated elsewhere in the report, recruitment efforts continue at an advanced phase to recruitment directly employed full time and part time care facing staff at Dunshane to have a full complement of CCOI staff by April 30, 2026.
• Where agency staff are used there is consistency for many community members in the agency staff who care for them while there is an understandable preference for agency staff who have attened Dunshane previously when additional agency staff are being requested.

• HSE training being provided in January 2026 is being attended by CCOI staff and regular agency staff also to ensure training is being provided consistently to all working at Dunshane.

The phased approach to recruitment and training allows for sustainable implementation whilst maintaining service delivery. The recruitment of 3 additional house coordinators will restore the required complement of 5 house coordinators to provide adequate management and oversight and consistency of support. The review of staffing arrangements for individual residents' needs will ensure that control measures identified are implemented in practice.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Absence of key local management personnel
CCoI has implemented enhanced governance and oversight processes to address the issues identified in the inspection. The Senior management team is now fully staffed as of 15 January 2026, comprising CEO, Head of Service, Head of HR, Chief Financial Officer and Head of IT. The current governance structure includes Board oversight, Senior Management Team meetings, weekly governance meetings with Area Services managers, and house-level team meetings.

A comprehensive review of the best use of the Dunshane campus is being carried out by the senior management team to address the long-standing concerns regarding Dunshane House and Garden Cottage. An Admission, Transition, Transfer, Discharge Planning Tool (ATD) has been developed by the Compliance, Safeguarding & Risk Manager to guide all transition processes.

The Board met in person on December 16, 2025, with the Quality, Risk and Compliance subcommittee of the Board meeting on December 4, 2025. The next date of the Board meeting in person is February 23, 2026 with the QRC subcommittee of the board meeting on February 12, 2026.

On December 16, the board approved a third post of Behaviour Support Officer to be advertised and recruited to support the workload of the existing two BSOs nationwide. Recruitment is underway with the role expected to be filled by February 28, 2025

Weekly governance meetings take place with the CEO, Head of Service, CFO and three Area Service Managers since October 2025 and first weekly meeting of 2026 held on January 9, 2026.

Weekly governance meetings take place with the Head of Service and three Area Service Managers since October 2025 and the first weekly meeting of 2026 held on January 5, 2026.

With regard to the comment that "since the previous inspection, the number of house coordinators had reduced to two, despite five being stated as required to support the

centre", CCoI accepts that two house coordinators are in post. A third house coordinator has accepted an offer of employment with a start date before February 28, 2025. Recruitment continues to fill the remaining vacancies.

As noted elsewhere in this report, a team meeting has been scheduled for each house for each month for next six months commencing before 31 January 2026. The ASM/PIC or the RM will be in attendance with the associated TL to review the compliance with all regulations for each community member in that house. The meeting will address the implementation of systems issues that were identified in the Report, including the following:
o The required daily fire safety checks, daily finance checks, cleaning and environment checks and handover logs;
o To ensure any gaps or concerns identified in daily checks are addressed, escalated and acted upon;

In line with previous compliance plans, a full review of the best use of the Dunshane campus will be carried out by the senior management team scheduled for 29 January 2026

A number of preliminary planning and oversight meetings have been held including the CEO and HoS to put in place a planned structure for potential moves.

With regard to the comments that "The provider had introduced governance walk-throughs of the premises; however, the records reviewed did not clearly outline their purpose and failed to identify issues found by inspectors during the inspection. In addition, team leaders conducted bi-weekly walk-throughs, but inspectors found that issues identified during these reviews were not clearly escalated or addressed"

The governance structure provides multiple layers of oversight to ensure effective monitoring and implementation of improvements. Monthly house team meetings will enable detailed review of compliance with all regulations for each resident and outcomes from walk throughs.

Any urgent issues identified by the Team Leaders are escalated to the Residential manager and/or PiC immediately.

A review of handovers between shifts is under review by Management with a proposal to include the SBAR communication tool (Situation, Background, Assessment Recommendation) with a plan that more formalized handovers procedures are in place by April 30, 2026 that would also include communication of issues identified during walk throughs.

Potential internal moves

The report notes the following: "Despite the provider's assurances, inspectors found evidence that discussions regarding transfers were ongoing over a prolonged period and

that residents' expectations were being set in relation to future moves that had not yet been approved."

Any proposed transfers will only occur following the appropriate risk assessment, compatibility assessment, consultation with Residents and their family/representatives and subsequent applications to HIQA as required. CCOI have no intention of expanding the size of the designated centre but have been conscious of two reports in relation to Dunshane House & Garden Cottage since 2022 and 2023, indicating that residents would require alternative accommodation. In the event that residents would be transferred, CCOI would de-register Dunshane House & Garden Cottage.

It should be noted that some support plans do mention potential long-term transitions, but this is in line with the awareness that long-term transitions are inevitable due to the unviability of Dunshane House and Garden Cottage.

An urgent building related health and safety concern requiring the moving of one community member from one bedroom to another bedroom within an existing house is at an advanced stage and it is anticipated this move can happen by January 23,2026 with the associated application to deregister upstairs in Garden Cottage anticipated in line with this. This is a temporary move for the community member due to health and safety concerns within an existing house and does not compromise or prejudice any potential assessments of need or compatibility.

A move of one community member from their sole occupancy bungalow to a sole occupancy apartment is at an advanced stage with assessments carried out of that community member and their needs and taking into account the wishes of the community member and their family's wishes and an application to register this apartment is anticipated by January 23, 2026 with the move pending HIQA registration approval.

In the medium term, it is intended that by 31 March 2026, CCOI will apply for the registration of a new centre at Dunshane. This development will result in the Dunshane campus being structured as two separate centres, each overseen by its own Person in Charge (PIC) who will be supported by a Team Leader to fulfil their regulatory responsibilities.

In response to the statement in the Inspection report relating to requested documents that at close of Inspection "a substantial volume remained outstanding", it should be noted that large volumes of documents, minutes were printed and handed over to Inspectors throughout the day. It is

Other enhanced governance measures are listed individually under the subsequent regulations.

In response to the report feedback about incident reports not being followed up, the trending and analysis of Q4 2025 has been completed. The ASM/PiC and the Residential manager have a new weekly process for reviewing incidents. The ASM/PiC is to update a specific oversight meeting on February 24, 2026 on trending and analysis of incident reports.

In response to the report feedback as to presence of senior management at staff team meetings, A team meeting has been scheduled for each house for each month for next six months commencing before 31 January 2026. The ASM/PIC or the RM will be in attendance with the associated TL to review the compliance with all regulations for each community member in that house.

In response to the comment that "the six supervisions of staff were overdue"; A new supervision template has been drafted and circulated as of January 15 2026 with all Dunshane Supervisions to be completed by February 28, 2026.

The report mentioned reviews by external healthcare providers had not been progressed, this is addressed in detail under regulation 6 below.

The report mentioned "fire safety arrangements did not adequately protect residents in the event of a fire". A Comprehensive fire inspection by independent agency BB7 has been confirmed for January 21 2026 for the full campus of Dunshane and the result of this report will be reviewed immediately by Senior Management upon receipt of inspection report.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The report notes the following: "The provider reported that risk management systems had been reviewed since the previous inspection. Inspectors reviewed the centre's risk matrix and a sample of individual resident risk assessments. However, inspectors found that the effective management of risk was overly reliant on the presence of a person in charge and a stable local management structure. In the absence of consistent local management oversight, control measures were not being implemented as required."

Response:
• As noted above, CCoI is actively recruiting, and two house coordinators are in post with a third coordinator having accepted an offer and with a start date before 28 February 2025, with other recruitment drives active to ensure stable local management with all roles to be filled by April 30, 2026

• Following consultation with HSE, a review of all individual risk assessments is under way for all community members by February 28, 2026. All updated risk assessments will be discussed at team meetings, updated on local risk register (as required) and printed and added to CM files and house induction folders.

Risk management Policies and Procedures

The inspectors found that "risk management systems did not effectively identify, assess, manage or review risks in the centre" and that "some risk assessments reviewed were not reflective of control measures in place".

Response:
o A review of our Risk Management Policies and Procedures in line with the HSE Enterprise Risk Management Policy 2023 by February 28, 2026.

o Review and update of the Risk Register for Dunshane Campus to ensure alignment with policy by February 28, 2026.

o The Emergency Planning Policy and Procedure was last reviewed on June 20, 2025 and due for review by June 20, 2026. The Head of Service will have reviewed the Dunshane version of the Policy by January 31, 2026 to confirm local arrangements for evacuation and will confirm and re-circulate to all.

Inspectors also found that "inspectors also reviewed records of health concerns and incidents involving residents leaving the house at night and found that it was unclear whether staffing levels were sufficient to manage these risks safely."

Response:

o The Missing Person Policy and Procedure was last reviewed on November 6, 2023 with a scheduled revision due November 5, 2026. An individual case mentioned in the HIQA report of a community member leaving their house is being managed in tandem with the expected move from one bedroom to another in Garden cottage by January 23, 2026.

o A review of handovers between shifts is under review by Management with a proposal to include the SBAR communication tool (Situation, Background, Assessment Recommendation) with a plan that more formalized handovers procedures are in place by April 30, 2026.

o While data is reported to the HSE in quarterly IMR meetings, a wider action plan on the trending and analysis of data, incidents, compliments, complaints, safeguarding notifications, HIQA notifications and After Action Reviews (AAR) of same is underway to assess all technical manners in which this can be achieved. The Head of IT leading the review of these systems and will give an update to the weekly Risk and Compliance Meeting with the CEO on Friday February 27, 2025

o Residents Questionnaires as well as Family Satisfaction Surveys will be issued by February 28, 2026.

Financial Risk management:
For one resident "the risk of financial misappropriation could not be mitigated, as the provider had not ensured the resident had appropriate access to their personal finances and relied solely on cash reconciliation"

Response:
This matter will be addressed in the above-mentioned review of all risk assessments by February 28, 2026 including all control measures as required e.g. daily reconciliations.

The Chief Financianial Officer has carried out a review of the Finance Policy incorporating a recent report of a forensic account into Camphill's governance of community members

finances.

Healthcare Risk Management:
The report mentions a number specific risks in terms of measures ie. In one case, the need for a waking night staff member to "migrate the risks associated with seizure activity"; in another case "weekly checks of an epilepsy bed mat" and the need for a waking night staff member for "pica (ingestion of inedible items) and behaviours of concern"

Response:
This matter will be addressed in the above-mentioned review of all risk assessments by February 28, 2026 and appropriate controls will be implemented

Incident Management Oversight:
"Inspectors reviewed a sample of 25 incident reports recorded between 26 September and December 03 2025. …"

Response:
To address this critical finding the ASM/PiC and Residential Manager are reviewing incident reports weekly to ensure they are up to date and being reviewed together for trends and analysis. The ASM/PiC Will report on this to the specific oversight meeting scheduled for February 24, 2025 with the CSR manager, HoS, ASM/PiC, Quality and Compliance officer meeting to discuss Dunshane.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
o In response to the specific Red risk identified for fire safety in one building in the designated centre, this was responded to HIQA on 11 December 2025 with full and complete follow up relating to fire safety in that building.

o The issues identified in the report were addressed in the compliance plan submitted on 11 December 2025 and they should be considered as part of the response to this section of the full report.

o A Comprehensive fire inspection by independent agency BB7 has been confirmed for January 21, 2026 for the full campus of Dunshane and the result of this report will be reviewed immediately by Senior Management upon receipt of inspection report.

o The Emergency Planning Policy and Procedure was last reviewed on June 20, 2025 and due for review by June 20, 2026. The Head of Service will have reviewed the Dunshane version of the Policy by January 31, 2026 to confirm local arrangements for evacuation.

o A review of all 14 community member Personal Emergency Evacuation Plans (PEEPs) is under way by the ASM/PiC and will be completed by February 28, 2026

o Substantial physical upgrades to the wider premises continue on the Dunshane campus

and as of January 14, 2026, substantial works on paths and roadways has been completed as well as removal of former furniture, waste and other materials.

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:
The report stated: "Overall, inspectors were not assured that residents' needs were being appropriately assessed or that information arising from assessments was being used to update support plans in a way that effectively guided staff practice." And "While the provider had updated its assessment of need documentation and revised assessments since the previous inspection, inspectors found that significant inconsistencies remained."

As with the response to Regulation 6, a special compliance group has been convened by the Compliance, Safeguarding & Risk team and held their inaugural meeting on January 8, 2026 in Dunshane.

The meeting was chaired by the Compliance, Safeguarding and Risk Manager and included the attendance of the CEO, HoS, ASM/PiC, Residential Manager, TLs, HCs, Clinical Support Officers and other support staff from around the organisation. The meeting committed to significant reviews of all regulations for each community member and each residence on the Dunshane Campus.

The action plan of the special compliance group is devised from HIQA Inspection feedback, HSE site visit feedback, internal audits and other internal reports.

The progress of this action group is being reviewed weekly in meetings convened by the Compliance, Safeguarding and Risk manager and will be recorded in an updated action plan circulated after each meeting.

In the report a number of individual concerns have been mentioned e.g. weight loss, personal goals, speech and language therapy.

As part of the special compliance group process: the Behaviour Support Plans are being reviewed by the BSO to verify their accuracy and their presence in each induction folder. The Clinicial Support Officer is reviewing and updating needs assessments for all Community members while also verifying care plans are in place for each diagnosis of community members. These reviews are to be completed by February 28, 2026.

A team meeting has been scheduled for each house for each month for next six months commencing before 31 January 2026. The ASM/PIC or the RM will be in attendance with the associated TL to review the compliance with all regulations for each community member in that house.

This will be further overseen in a specific oversight meeting scheduled for February 24, 2025 with the CSR manager, HoS, ASM/PiC, Quality and Compliance officer meeting to discuss Dunshane.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
In response to the specific Red risk identified for an individual community member, this was responded to on 11 December 2025 with full and complete follow up relating to the community members Catheter care.

As with the response to Regulation 5, a special compliance group has been convened by the Compliance, Safeguarding & Risk team and held their inaugural meeting on January 8, 2026 in Dunshane.

The meeting was chaired by the Compliance, Safeguarding and Risk Manager and included the attendance of the CEO, HoS, ASM/PiC, Residential Manager, TLs, HCs, Clinical Support Officers and other support staff from around the organisation. The meeting committed to significant reviews of all regulations for each community member and each residence on the Dunshane Campus.

The action plan of the special compliance group is devised from HIQA Inspection feedback, HSE site visit feedback, internal audits and other internal reports. The progress of this action group is being reviewed weekly in meetings convened by the Compliance, Safeguarding and Risk manager and will be recorded in an updated action plan circulated after each meeting.

The Clinicial Support Officer is reviewing and updating needs assessments for all Community members while also verifying care plans are in place for each diagnosis of community members. These reviews are to be completed by February 28, 2026.

A team meeting has been scheduled for each house for each month for next six months commencing before 31 January 2026. The ASM/PIC or the RM will be in attendance with the associated TL to review the compliance with all regulations for each community member in that house.

This will be further overseen in a specific oversight meeting scheduled for February 24, 2025 with the CSR manager, HoS, ASM/PiC, Quality and Compliance officer meeting to discuss Dunshane.

Neurology Reviews:
"for example, one resident's assessment of need and support plans identified the requirement for a neurology review. The last neurology review had taken place on 18 September 2024. Inspectors reviewed communications from December 2024 in which support staff had requested a review of the resident's epilepsy support plan and a follow-up neurology appointment. No further correspondence, appointments or reviews had occurred. Inspectors noted that the resident's support plans highlighted epilepsy management as critical, with seizures described as "usually triggered by illness or changes in medication"

Response:
• As noted in the Urgent compliance plan submitted on 10 December 2025, the Local Management Team contacted the Neurology Department on 10 December 2025. There is currently no Neurologist in the local hospital, they are currently recruiting. All emergency appointments are being referred to another hospital, and any non-emergent cases are remaining on a waiting list in the local hospital. The Resident's name is on a waiting list, and the clinic will send a letter to reflect same.
• CCoI will continue to monitor the waiting list status and will escalate to the HSE if the wait time becomes unreasonable. The Residential Manager will review the resident's epilepsy support plan monthly to ensure it remains appropriate while awaiting the neurology review

Diabetes Management:

"Inspectors also reviewed medical notes completed by a resident's General Practitioner (GP) on 01 December 2025. These records showed that staff had raised concerns regarding fluctuating blood sugar levels, changes in behaviour and altered sleep patterns. During this consultation, the resident's GP advised staff to contact the diabetic clinical nurse specialist supporting the resident through outpatient services. On the day of inspection, no contact had been made with the diabetic clinical nurse specialist to discuss these concerns. Staff informed inspectors that contact would be made following the inspection".

Response:
• As noted in the urgent action plan submitted on 10 December 2025, the Area Services Manager confirmed the team contacted the Diabetic Clinic on 10 December 2025, the clinic arranged for the Resident to be seen in the walk-in clinic during the week ending 19 December 2025 to update current sensor and review recent fluctuating blood sugar levels which they believe are linked to a UTI which the Resident has been on antibiotics for. The Local Management Team contacted the resident's GP on 10 December 2025 to determine the number of UTIs the resident has had, and the information received from GP on that date was brought to the Diabetic Clinic's attention during the appointment in the week ending 19 December 2025 including to discuss fluctuating blood sugars and changes in behaviour.

• A full review of this community members care plan has taken place since the inspection. High sugar levels are notified to the house phone for resolution as per the protocol on high blood sugars.

Equipment Storage and Hygiene Standards:
"During this process, inspectors identified multiple concerns, including the presence of out-of-date equipment in use for the resident. Although the support plan stated that "the highest standard of hygiene must always be maintained," catheter care equipment and medical devices were stored on shelving that was visibly dusty and dirty. Incontinence products stored alongside this equipment were also visibly contaminated. The boxes in which the equipment was packaged in was also covered in dirt and dust. Packaging for catheter equipment was left open, with dirt observed on leg dressings and leg straps used as part of the daily procedure."

Response:
• As noted in the urgent action plan submitted on 10 December 2025, the out-of-date catheter bag noted by Inspectors was removed on 09 December 2025. The Provider ensured a review of the catheter supplies which was carried out on site by the Clinical Support Officer and it was confirmed that all other supplies are in date. Daily checks on the catheter equipment/supplies were implemented on 10 December 2025, completed by staff and overseen by the Local Management Team. The resident's bedroom has been cleaned and all items required for personal and intimate care, including catheter care are clean – completed on 10 December 2025.

• The Clinical Support Officer (CSO) reviewed the resident's bedroom in relation to a sanitary environment for pre and post catheter care on 10 December 2025. The CSO provided recommendations to the local management team on 10 December 2025, including storage of catheter care equipment and supplies to prevent cross contamination, PPE, sanitary provisions for hand hygiene and disposal of medical waste. All recommendations were implemented by 19 December 2025 and verified by the Area Services Manager.
• Monthly audits of equipment storage and hygiene standards will be conducted by the Residential Manager, commenced in December 2025, to ensure ongoing compliance with infection control standards.

Personal Protective Equipment (PPE) and Hand Hygiene:
"The room in which the resident was supported to have their catheter support carried out did not have access to standard personal protective equipment (PPE) such as gloves, alcohol hand gel or aprons. In order for staff to maintain hand hygiene, pre and post procedure as per guidance they had to go through two points of contact prior to reaching a hand washing sink."

Response:
• As noted in the urgent action plan submitted on 10 December 2025, the CSO provided recommendations to the local management team on 10 December 2025, including PPE and sanitary provisions for hand hygiene. All recommendations were implemented by 19 December 2025 and verified by the Area Services Manager.

Waste Disposal:
"The support plan highlighted that staff should "dispose of used drainage bags sealed in a bin bag and placed in household rubbish dustbin", however during the walk through of the support plan inspectors found a used drainage bag discarded in a refuse bin in a shared bathroom and not with the additional measure of a sealed bag. The inspectors found that there was no refuse bin available in the resident's room to discard of used equipment post care."
RESPONSE:
• On January 15 2026, the CEO has approved the procurement of a Clinicial Waste bin for the disposal of used catheter bags at this house in Dunshane.

Clinical Monitoring and Observations:
"During discussions with staff, the inspectors asked how the signs and symptoms of urinary tract infection were monitored for the resident and if regular observations were taking place for the resident in line with their identified health care need. Staff reported

that monitoring was based solely on behavioural changes and that no routine clinical observations were undertaken. Inspectors requested records relating to antibiotic treatment for the resident over the previous 12 months; this information was not available on the day of inspection and was subsequently requested as part of the urgent compliance plan."

RESPONSE:

• As noted in the urgent action plan submitted on 10 December 2025, the Provider will ensure that the CSO - medical, will perform a fortnightly urinalysis commencing on 22 December 2025 on the resident's urine to monitor for UTI together with temperature checks to ensure that a UTI is not missed or that treatment and care is prolonged. If a UTI is suspected from the urine analysis, staff will support the resident to the GP/KDOC.

• The Local Management Team contacted the resident's GP on 10 December 2025 to determine the number of UTIs the resident has had, and the information received from GP on that date was brought to the Diabetic Clinic's attention during an appointment in the week ending 19 December 2025.

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(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	30/04/2026
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	30/04/2026

Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2026
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 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	28/02/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in	Not Compliant	Orange	31/01/2026

	place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	05/01/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	05/01/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	28/02/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet	Not Compliant	Orange	28/02/2026

	the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	28/02/2026
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	28/02/2026
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	28/02/2025

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Red	23/12/2025