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:	25 September 2025
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0048141

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
Thursday 25 September 2025	07:30hrs to 17:30hrs	Erin Clarke	Lead
Thursday 25 September 2025	10:00hrs to 17:30hrs	Michael Keating	Lead
Thursday 25 September 2025	07:30hrs to 17:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection was carried out over one day by three inspectors as a follow-up to an inspection conducted in June 2025. Following that inspection, a Notice of Proposed Decision (NOPD) to cancel the registration of the designated centre was issued to the provider. The purpose of this inspection was to assess the provider's response to significant and ongoing concerns identified on previous inspections, including their capacity to achieve compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and to sustain any improvements.

While inspectors found some improvements at centre level to the physical premises, significant concerns remained that the provider had not prioritised the needs and welfare of residents. Ineffective oversight and an inability to respond to residents' assessed needs continued to have a significant impact on their quality of life. There remained severe deficits in staffing, governance and management, risk management, and in the development and implementation of residents' personal plans. Failures in both staffing and internal transfers reflected fundamental weaknesses in governance. Decisions continued to be reactive, poorly documented, and not grounded in comprehensive assessments of residents' needs. As a result, the service was unable to provide safe, consistent care or to uphold residents' rights. Inspectors also found evidence of poor culture related to governance issues, where ineffective oversight and poor management systems had allowed staff to create their own "common knowledge" practices. These informal arrangements were not in residents' best interests and were particularly evident in internal resident transitions.

Inspectors were not assured by the governance arrangements observed during this inspection, nor by the provider's efforts to bring the centre into compliance. The provider had submitted action plans to the Chief Inspector of Social Services following previous inspections, with actions committed to, not delivered within the agreed timeframes. The actions submitted following the June 2025 inspection were also found not have been implemented. Inspectors met with the Chief Executive Officer (CEO) who was also appointed the person participating in management (PPIM) due to wider governance absences across the organisation. (PPIM meaning a person or people who are actively engaged in and responsible for the operational management of the overall designated centre). Inspectors found that they were disconnected from the operational management of the centre. It was apparent that the senior management and executive involvement in the centre, which had been committed to, had not been realised. On conclusion of this inspection, inspectors were not assured that the provider had the capacity to implement and sustain a return to compliance.

The designated centre is registered to provide homes for up to 18 residents and, at the time of this inspection, was home to 14. Inspectors arrived at the designated centre at 07:30 am to commence the unannounced inspection and were joined later

in the day, at 2:30 pm, by the PPIM**.** Inspectors commenced the inspection meeting with staff on night duty as well as staff coming on duty throughout the day. All houses that form part of the designated centre were visited, and inspectors had opportunities to engage with residents and staff throughout the day. Extended time was spent in some homes to gain a clearer understanding of residents' daily lived experiences. In total, inspectors met with seven residents, two team leaders, six staff members, the quality, risk and compliance manager, the head of property, and the PPIM.

As part of the walkthrough of the designated centre, inspectors observed that works to the external premises were underway in response to findings from the June 2025 inspection. These included clearing undergrowth and trees, creating pathways around houses, installing external lighting, and improving vehicle access. The provider had also carried out safety works in areas of the wider campus that were not part of the designated centre but had previously been identified as presenting potential risks to residents, including outbuildings, farm buildings, and the storage of tools and equipment.

In addition to the external works observed, inspectors found that renovation works were also underway in an unregistered part of the designated centre. Other registered sections of this building already accommodated three residents. This building had previously been de-registered, and the provider had applied to partially reopen it in January 2024 due to safeguarding concerns in other parts of the campus. However, it was unclear why the provider was extending the designated centre while it remained subject to a proposed decision to cancel its registration. No clear rationale was provided for the planned internal transfers, including how high-risk or safeguarding considerations had been assessed or managed. These proposals were expected to have knock-on effects on the placement of other residents. Inspectors spoke with one resident currently living in the centre, who expressed strong satisfaction with their home environment. However, staff indicated that this resident would be included in the planned transfers.

During the April 2025 inspection, inspectors also identified that internal transfers undertaken in 2024 were not supported by assessments of need or multidisciplinary input. At that time, senior management confirmed that no records of these transfers were available. As a result, there was poor planning and insufficient resourcing of one building when residents moved in. Inspectors found that these residents' needs still were not fully met, and deficits had not been addressed at the time of the current inspection. Specifically, the required staffing complement to support residents safely, and with staff familiar to them, was not in place, with one resident remaining without access to a kitchen since January 2024.

Further clarification was sought from the PPIM, who was also a member of the admission, discharge and transition (ADT) committee, regarding the proposed residential transfers. However, they were unaware of the details and could not confirm what transfers, if any, were occurring. Their response was limited to assurances that the correct documentation would be in place for any transfers and that staff may have communicated information to residents. This account did not reflect the reality on the ground, where some residents were already aware of their

proposed moves, had been actively involved in choosing furniture and colours for new residences, and where building works were visibly underway. This inconsistency highlighted a lack of operational oversight and accountability in decision-making processes, raising concerns about governance, transparency, and the provider’s ability to safeguard residents’ rights and ensure informed participation in significant life decisions. It also raised concerns about the rationality of decisions regarding residents' transitions, as they were not informed by assessed need and preference.

During discussions with a resident, inspectors were informed that while the recent improvements to the external environment, such as new paths and the clearing of overgrowth, were welcome, a deficit in transport arrangements remained. This was more of a priority the resident stated. The resident highlighted that, due to the rural location of the centre and the absence of public transport, access to vehicles was essential. However, they explained that they had to share a vehicle with another house on the campus, which often led to competing needs.

Overall, the inspection found that the provider’s strategic and operational decision-making, as well as the management and resourcing of the centre, remained ineffective. Governance arrangements were not driving sustained improvement, leaving residents at ongoing risk and with a diminished quality of life. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

The previous inspection on 30 June 2025 found that the provider had not ensured that appropriate actions were implemented in line with the compliance plan response to the inspection on 3 April 2025, nor with their submitted response to the warning letter issued on 2 May 2025. The warning meeting was attended by the former Head of Services and Chief Executive Officer. Furthermore, the provider failed to respond to the warning letter within the specified timeframes and only submitted their response following regulatory follow-up, 12 days beyond the required deadline.

On 31 July 2025, following repeated findings of serious non-compliance during inspections in April and June 2025, the provider was issued a Section 51 Notice of Proposed Decision to cancel the registration of Dunshane Camphill Communities of Ireland designated centre. This notice was issued due to the provider’s repeated failure to comply with regulations and standards, which had a direct impact on the quality of life and safety of the service provided to residents. The provider informed the Chief Inspector of their intention to submit a written representation against the proposed decision to cancel the centre registration, which they stated would outline

the measures proposed to address the ongoing and repeated non-compliance identified within the centre.

On 18 August 2025, the provider submitted its written representation, outlining its proposed actions to bring the centre into compliance and address governance concerns identified during previous inspections. Upon review, the content of this representation was found to be poor, reflecting ongoing concerns regarding the registered provider's overall capacity to manage this centre effectively. The document did not provide the required assurances that Camphill Communities of Ireland would be in a position to bring the centre into compliance with the regulations. Furthermore, the representation failed to outline measurable actions to demonstrate how the registered provider intended to fulfil its obligations under the Health Act 2007 (as amended).

A request was also made for the submission of a revised compliance plan in response to the findings of the 30 June 2025 inspection, as the original plan lacked measurable actions. The revised compliance plan provided some additional assurances and identified measures not included in the provider’s representation document. Both documents were considered collectively by the Chief Inspector when assessing the provider’s capacity to achieve compliance with the regulations. However, this inspection found that the provider had not progressed many of these actions and had failed to prioritise the needs of the residents.

Inspectors found that the provider’s governance and management arrangements remained ineffective in addressing serious and repeated non-compliance. Over the previous three years, seven inspections had identified repeated failings, with the provider consistently failing to implement its own improvement plans submitted after each inspection. Inspectors found for instance, on this inspection that the Board of Management had not convened a formal and full Board meeting since 30 June 2025, despite the centre having received a notice of proposed decision to cancel its registration.

The provider’s management and oversight systems failed to ensure continuity of local management, accountability, and oversight of the designated centre's operations. Frequent changes in persons in charge, a lack of robust safeguarding oversight, decision-making that was not underpinned by comprehensive assessments of need, and a continued over-reliance on agency staff all contributed to ongoing risks for residents. Previous compliance plans and assurances had not been implemented, resulting in ongoing risks for residents, changing environments, and unmet support needs. The repeated failure, as observed during this inspection, to embed learning or follow through on agreed-upon actions demonstrated that governance arrangements were not driving sustained improvements, this was indicative of the findings at the time of this inspection. Also as reflected in the providers levels of compliance on seven inspections during this cycle of registration. The governance arrangements were further compounded by a significant loss of senior management personnel in quick succession leaving residents exposed to continued risks and a poor quality of life.

Following the inspection, correspondence was received from the PPIM, under the direction of the Board of Management, outlining the identified tasks and actions that had been completed. These had not been presented during the inspection nor had led to meaningful change for the residents.

Regulation 15: Staffing

The provider had persistent high staff vacancies and turnover, which had not been addressed in a substantive or sustainable manner despite repeated assurances to the Chief Inspector. Inspectors found that the provider was unable to demonstrate that staffing figures were based on residents' assessed needs. Whole-time equivalent (WTE) figures varied depending on the context in which they were reported (compliance plans, representations, or verbal updates), highlighting the absence of a structured or credible workforce plan.

In its written representation, the provider committed to improved staffing arrangements, stating that the overall complement would increase by 6.5 WTE, while also projecting a reduction in required staffing (from 36.2 to 34.2 WTE) linked to the planned transfer of two residents. However, despite the onboarding of new staff, ongoing resignations meant that the number of contracted permanent staff remained static. The April 2025 inspection identified a staffing deficit of 27 posts against a required complement of 43 WTE, with only 16 WTE in post. By the June 2025 inspection, the provider reported a required complement of 40 WTE, with only 17 WTE in post. At the time of this inspection, staffing levels remained at 17 WTE, resulting in a continued and significant reliance on agency staff. Inspectors also noted ongoing discrepancies in the reported overall staffing requirement, which further undermined assurance.

Of particular concern was the provider's failure to review staffing allocations in line with residents' needs. One resident continued to be supported entirely by agency staff, with 11 different agency workers having supported them since the previous inspection of 30 June 2025. Despite assurances that a core team would be built around this resident, no such action had been taken. Inspectors were informed at the outset of the inspection by senior management that this resident was considered the centre's "most significant risk", yet permanent staff continued to refuse to work with them. This was in direct conflict with both the resident's behaviour support plan and the provider's own risk assessments, which identified core staffing as a key control measure. Despite new staff, including qualified social care workers, having commenced employment in the centre, this resident's needs were not prioritised. This resulted in the resident not being supported to engage in activities outside of their home, to develop a daily meaningful routine and experiencing frustration when staff were unfamiliar with their preferences and communication strategies.

Inspectors also observed that staffing deficits directly impacted the daily lives of other residents. For example, one resident had to accompany their peer on an outing, despite expressing a preference to remain at home, as there were no

additional staff available to support them. On another occasion, inspectors observed a resident leaving their home to go to a neighbouring house while their allocated staff member was completing household tasks. This left one staff member temporarily responsible for three residents across two houses, a situation not reflected on the roster and which arose from staff being required to cover domestic duties alongside care provision.

These findings demonstrated that staffing arrangements were not safe, consistent, or aligned to residents' assessed needs, and that the provider had not taken adequate action to implement its own commitments or regulatory requirements.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors reviewed minutes of Board meetings provided by the PPIM and noted that the Board of Management had not convened a formal and full Board meeting since 30 June 2025, despite this centre having been issued a Section 51 notice of proposed decision to cancel registration. This gap in governance did not provide assurance that the provider was fully informed or actively engaged in the oversight of the centre. Inspectors also reviewed the operations report, which was prepared in advance of the September 2025 Board meeting. This report is intended to provide operational assurance to the Board. In the absence of a National Operations Manager, this report had been compiled by the newly appointed person in charge, who had only been in post since 25 August and whose input was therefore limited to the short period they had worked.

The report highlighted, once again, that staff refused to work with one resident. As a result, this resident rarely left their apartment and often disengaged from staff. Numerous staff and managers referred to the resident's high levels of anxiety, particularly around unfamiliar people. This anxiety was frequently expressed through throwing items, refusing to leave the apartment, or withdrawing from staff. The provider's continued inability to respond to the resident's support needs had created an environment where the staff's fear of working with this resident was allowed to persist.

Following the June 2025 inspection, the provider implemented a complete change in the management team for this centre as an interim measure, alongside restructuring management systems within the individual houses. New house co-ordinators were appointed, but inspectors found that one had since stepped down and a further two had resigned since June 2025. This continued instability meant that a sustainable governance and management team was not yet in place, despite repeated assurances.

Over the course of this three-year registration cycle, the provider had appointed five different persons in charge, resulting in inconsistent governance. The centre had

been without an appointed person in charge since June 2025, following the previous post-holder's departure at that time. During this period, and at the time of inspection, the CEO was assigned to cover the role of PPIM. However, inspectors found no evidence that the PPIM had maintained an active presence in the centre or overseen the implementation of required actions since the previous inspection. Although the PPIM held overall responsibility as the senior manager, there was no indication that direct oversight or operational management had been provided in the absence of an appointed leadership team.

A new person in charge was appointed on 25 August 2025, but commenced planned leave shortly afterwards. Staff reported that they had met the new person in charge only once, in an informal capacity, and that no team meetings had been held. On the day of inspection, staff were unsure whether the person in charge was working or when they would next be present. A quality improvement plan was presented to inspectors during the inspection; with a substantive number of actions assigned to the newly appointed person in charge. This was of concern as the PPIM had been in post for two months prior to the person in charge taking up the role, and the provider was aware in advance that the person in charge would be on leave. Despite this, responsibilities had not been reassigned to ensure oversight and progression of the required improvements.

In addition, six different persons participating in management had been appointed during this cycle of registration, all of whom held senior governance roles, all of whom resigned. The provider had assured inspectors that governance cover would be provided by an Area Service Manager from another region; however, this did not occur. Similarly, assurances were given that the PPIM would attend scheduled meetings, such as the monthly community management meeting. While one meeting took place on 30 July 2025, no meeting was held in August, and the meeting on 03 September proceeded without senior management present. Inspectors also found no evidence of management presence at staff team meetings. Minutes from the previous two months showed that in some cases, meetings had been attended only by team leaders or house co-ordinators, with no wider management involvement.

The provider had also outlined repeated governance improvement assurances as part of responses to eight Provider Assurance Reports (PARs) during this registration cycle. These reports, issued in response to both solicited information (such as provider notifications) and unsolicited information (such as third-party concerns), were intended to secure improvements. Despite this, the provider failed to implement the identified actions, and at the time of this inspection, many outstanding commitments remained. These include commitments to develop of a consistent staff team around one resident, as outlined in a written response to the Chief Inspector in December 2024, and to complete a full review of all supporting documentation in place for each resident by February 2025, both remain incomplete.

Similarly, in their formal representation to the Chief Inspector and re-submitted compliance plan following the June 2025 inspection, the provider made further assurances of governance improvements. The Chief Inspector took these documents together as sufficient to schedule a follow-up inspection. However, this inspection

found that many of the promised actions had not been implemented. No clear rationale was provided for the lack of progress, and inspectors saw limited evidence of coordinated systems to track actions or ensure accountability of responsible persons.

Inspectors were informed by senior personnel in the property department of further proposed internal transfers within the campus, including plans to renovate another unregistered area for one resident. One area, as stated, was already being renovated; however, the provider had not submitted any applications to vary the centre registration, nor had they engaged with the regulator regarding proposals as part of their financial governance mechanisms. When inspectors sought clarification from management on the rationale for these moves, the explanations provided were limited. The rationale did not evidence adequate consideration of residents' assessed needs or preferences, nor did it ensure that the significant cost of renovating and reopening an unregistered part of the centre was aligned with the provider's fiscal strategy. The justification offered by management primarily centred on staffing implications across several buildings, rather than on person-centred planning or the rights of residents to remain in their chosen homes.

Judgment: Not compliant

Quality and safety

On this inspection, inspectors found that the registered provider remained non-compliant across all regulations reviewed. Significant difficulties persisted in meeting the basic needs of residents in a consistent manner, with ongoing failures to address assessed care and support needs. Individual support plans were not updated and were not being used to guide the delivery of care.

Inspectors noted that remedial works were underway on the external site following the poor findings of the June 2025 inspection. While these works were not yet fully completed, some progress had been made. In addition, the provider was developing an internal apartment that would require an application to vary the footprint and expand the size of the designated centre. However, inspectors found that a resident had already been informed of their planned move to this apartment, despite no application being submitted to the Chief Inspector, no transition risk assessment being completed, and no accessibility assessments having been undertaken by appropriate health and social care professionals.

The provider had reported a stronger focus on risk management since the last inspection, which had highlighted serious concerns. However, inspectors found that the provider continued to fail to implement its own risk control measures in practice, resulting in ongoing risks to the quality and safety of care for residents.

Regulation 26: Risk management procedures

While the provider had reviewed risk management processes since the June 2025 inspection, inspectors found that the systems in place for assessing, managing, and reviewing risk did not provide assurance that they were effective.

The provider had reviewed the risk assessments present in the centre and ensured that a risk register was maintained. The provider identified four risks rated by them as the highest concerns, one of which related to a resident and their individual support requirements. Reference to a resident as a red risk within the centre was reflective of what inspectors found to be the overall culture of disparaging narrative that was in place to refer to that individual resident.

In relation to the risks identified for this resident, the control measures identified by the provider to manage these risks were still not being implemented consistently. For example, several resident-specific risk assessments highlighted the need for consistent staff support as a control measure. A review of staffing rosters showed that the provider continued to rely solely on agency staff, contrary to the control measures outlined.

Additionally inspectors found that a risk assessment which was recently reviewed, related to achieving and maintaining staffing levels in the designated centre, referred only to the recruitment of staff but failed to identify the risks related to retention and the consistent loss of staff members. This resulted in the provider's focus only on recruitment and was found to be reflective of poor strategic awareness of the overall staffing position within the centre. In addition this assessment failed to reflect the need to utilise staff in a manner that supported and enhanced any positive risk taking that would promote an improvement in residents' quality of life.

Additional risks found by inspectors had not been identified by the provider. For example, during a 20-minute period while inspectors were in the living room of one home, two strangers entered directly into the hallway of the house, mistakenly assuming it was the provider’s offices due to signage issues. Neither person identified themselves, signed in, nor rang a doorbell, and staff were required to redirect them. This unmonitored access to residents' homes not only interrupted residents but raised concerns regarding the presence of third parties entering designated centres unknown. Similarly, during a walk around, inspectors observed broken and discarded furniture left in a fire evacuation corridor, as well as a bag of household chemicals left on the floor and in a cupboard along the same route. While the provider cleared the corridor on the day of inspection and submitted photographic evidence afterwards, the risks had not been previously identified, and staff were unaware of the need to report the need to remove these items or how to use the new procedure for disposing of broken furniture.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents’ assessed needs and support levels remain not clearly defined or consistently applied. A new assessment of need document was reviewed by inspectors. It was being completed by staff for residents, however, there was a lack of input from relevant health and social care professionals. This is contrary to the provider's commitment to undertake an in-depth, multi-disciplinary review. As per the findings in previous inspections it was not apparent that residents’ needs were being fully identified or met. There was no evidence that the assessments contributed to care plans or guidance for staff.

For example, one resident told inspectors that they were capable of remaining alone in their home for short periods, while their peer was supported to attend an activity off-site in the vehicle as part of their usual routine. However, on the morning of inspection, this same resident was observed travelling with their peer and not staying at home alone. Inspectors later spoke to the resident who expressed their distress at decision making that was not in line with their wishes. It was unclear whether this restriction reflected an assessed need, an organisational rule, or ad-hoc decision making, and there was no supporting documentation available to justify changes.

In addition where residents lived with peers there was no evidence provided that compatibility assessments had been updated or reviewed despite inspectors requesting documented evidence. This was of particular concern as in two houses there were active safeguarding plans as an outcome of peer to peer safeguarding concerns and there had been one serious peer to peer incident of physical abuse since the previous inspection. In one of these houses inspectors observed a resident from another house access this house in the morning while their support staff completed household tasks. Staff stated that the resident regularly visited the home despite no changes in staffing levels to ensure safeguarding plans could be maintained.

Inspectors were informed that one resident had experienced a reduction in activities, a decline in engagement with personal care, and reduced attendance at day services however, this was not found to be clearly documented nor with a corresponding plan to address these changes. Behaviours of concern also remained an ongoing area of concern for the resident. The provider in previous assessments had indicated the service could not meet the resident's needs however, no actions have been taken to resolve this and ensure the resident is provided with good quality care and support. On the day of inspection despite repeated reassurance from the provider this resident remains without a clear plan to meet their needs, without a core staff team and without opportunities to engage in activities with meaning in or out of their home.

The approach to internal transfers on the campus previously discussed was not consistent with the principles outlined in a human rights based approach to care and support, which emphasises planned, person-centred transitions towards community-

based living. Instead, proposed transfers were reactive and service-led, raising concerns regarding governance, planning, and the protection of residents' rights.

Delays in the completion of assessments were also noted, where external third parties had requested these as part of a review of a resident's placement. Documentation reviewed by inspectors showed that, in September 2024, the person in charge had been asked to arrange financial capacity assessments and a referral to an advocate "as soon as possible" given the potential for financial safeguarding concerns. However, while these processes were reportedly underway, they remained outstanding at the time of the third party's return in August 2025. It was also noted in the third-party report that residents were able to access houses in which they did not reside. This practice was still occurring at the time of the inspection, when inspectors observed both residents and unfamiliar visitors entering residential houses unannounced.

As previously stated in the report one resident was reportedly to move into a new apartment within the premises which had been renovated although not yet registered. The resident had been informed of the move, had engaged in shopping for furniture and engaged in selection of decor. As referred to above these purchases were completed by the provider in the absence of a confirmed registration for aspects of the premises. Inspectors requested on multiple occasions the assessment that underpinned this move and the assessment on the suitability of the new proposed first floor accommodation. The resident currently lives in ground floor accommodation. There were no assessments completed to inform this decision. This was of particular concern given the resident's health vulnerabilities. The lack of health and social care professional assessment to support this decision left the resident at risk of falls or reduction in accessing their environment without support which had the potential to impact their independence.

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 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Dunshane Camphill Communities of Ireland OSV-0003616

Inspection ID: MON-0048141

Date of inspection: 25/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The Compliance Team with Local and Senior Management of Dunshane reviewed and updated assessment of needs November 10, 2025. The Compliance Team updated needs assessment template to include information from relevant MDT. Additionally, a scoring system was added. Based on the assessed needs of residents, the WTE was established as 39.9 WTE.

The Provider ensured this WTE was included in the centers Statement of Purpose issued to the Chief Inspector on 12.11.2025. Email issued by the Operations Team Support Officer on 12.11.2025, ensuring all relevant personnel are aware of the WTE and subsequently understand the recruitment requirements.

Between June and October 2025, we recruited:
- Person in Charge commenced 25.08.2025
- Area Services Manager commenced 09.10.2025
- Head of Service commenced 13.10.2025
- Residential Manager commenced 28.10.2025
- 1 House Coordinator commenced 25.08.25
- 2 Social Care Workers commenced 26.09.26, 03.11.25

Current CCOI employed Social Care frontline staff is 18.32 WTE. This does not include the 4 WTE of PIC, Residential Manager and two Team Leaders. Important to note each Team Leader directly supports Residents in their houses by each completing 1 sleep over shift per week equating to .85 WTE.

One Social Care Worker (SCW) was offered and accepted. Two Social Care Assistance (SCA) positions were offered and accepted on 26.09.2025 and 03.11.2025. This will increase the CCOI employed staff WTE to 22.17.

The deficit is 16.73 WTE following newly recruited staff. This deficit is met through

agency staff and regular staff work additional hours until such a time CCOI can recruit the necessary WTE. From a review completed by payroll on 11.11.2025, CCOI staff have completed on average an additional 157 hours per week, equating to 3.92 WTE.The staffing complement changed as the residential resident numbers decreased from 17 to 14.

Following a review of assessed needs in November 2025, CCoI increased staffing complement for one resident, raising the WTE from 35 to 39.9.

Recruitment efforts are ongoing, with a projected completion date of 30 April 2026. The PIC, supported by the Head of Services, ASM, HR Department, and Social Media Coordinator, is responsible for managing the recruitment process. Recruitment and retention remain a priority and have been added as a standing agenda item at monthly Community Management Meetings. Updates and feedback from these meetings are shared at Senior Management Team meetings every Friday. CCoI engaged an additional external agency to support the hiring of staff. The HR Department informed by community needs, liaises with external agencies to ensure the staff profile and skillmix align with residents' requirements.

In relation to one individual referred to in the inspection report, CCOI have submitted a business case to the Funder proposing a new rostering model designed to better support this community member. The proposal recommends a 2:1 staffing ratio during daytime hours (11am–9pm). The Provider has instructed that the staff increase is implemented in the interim and required adjustments are now in place. Where new staff are required for the case, a robust induction will be completed with each staff member including consultation with the Clinical Support Officer for Behavioural Support upon their commencement.

PIC will ensure that new staff are appropriately assigned to ensure all houses include CCOI employed staff and that no one house is solely reliant on agency staff when new staff are recruited. The PIC will conduct a skillmix analysis of all staff including regular agency (agency staff engaged exceeding six months) in Dunshane in consultation with the Clinical Support Officer Behavioural Support and the ASM and subsequently the HR Department. Analysis will be completed by 12.12.2025.

CCoI have established a trained staff team, including agency staff for this resident. Following implementation of a second staff during the day with staff swapping out every two hours, early indications are that this is having a very beneficial effect for the quality of life for the resident. CCoI are committed to continuing this level of staffing support and to recruiting a permanent staff team.

Due to the risk associated with the impact on the Resident's quality of life, CCOI have engaged with the individual's Assisted Decision Maker on 03.11.2025 and obtained consent to seek external expertise and guidance to ensure the supports in place are fully responsive to the person's unique needs, promote their wellbeing, and contribute to positive outcomes within their life. The ASM sent an email on 11 November to an external service regarding the supports in the case including support plan and a recent sensory assessment for further advice. A response is due from the external service by 10 December 2025 as to their advice.

CCOI has developed bust induction folder as a quick reference guide for staff. The folder includes information in relation to the day-to-day operations of the house, SOPs to be followed and will include relevant documentation to effectively support Residents contributing to continuity of care and support. It will complement the individual induction process for staff supporting Residents. In addition, the folder will include the most recent team meeting minutes for the house. The induction folder has been individualised for each house completed 14.11.2025. The PIC will ensure a subsequent review of the induction folder is completed monthly (or sooner if required) to ensure the most up to date information. The first review will occur on or before 12.12.2025. The PIC supported by the Residential Manager will oversee the induction process for all staff including agency staff.

In relation to a specific incident mentioned, staff involved have been informed that this should not have occurred and the resident should have been allowed to stay or if the trip could have lasted more than the 20 minutes the resident was permitted to remain home alone, they should have sought assistance from another member staff. Since 25.09.2025 additional staff are in place and are now available if a similar circumstance was to arise again. All staff have been informed on 11.11.2025 of the practice to be followed if a similar event were to occur.

The Provider has initiated a conversation with each Resident, reminding them of their right to make a complaint to ensure they are aware of how or when to raise any issues of concern. The complaints process will be discussed individually with each Resident by a member of the local management team and the account documented. This will be completed by 05.12.2025 and the PIC will oversee this to ensure it is completed.

Additionally, staff handovers occur within the houses of the centre, and the handover now includes a shift planner to ensure the completion of household tasks does not impact on care provision. This planner was implemented in all houses on 28.11.2025

The local management team will conduct spot checks throughout the day in each of the houses to ensure "common knowledge" practices are not occurring. These visits will be documented on management specific sign-in sheets in each house subsequently checked by the ASM during their weekly visit to the centre. The sign-in sheets have been implemented 12.11.25. Any identified areas for concerns will be immediately addressed and an action added to the centre QIP.

The PIC in conjunction with the Team Leaders conducts a review of the rosters on a daily basis in each house to ensure suitably qualified staff with the appropriate skillmix in place to meet the Resident's needs.

CCOI have committed to a 3-year road map by partnering with X institute in an effort to put in place a strategy to drive staff retention. CCOI commenced an organisation wide employee survey December 1, 2025, to gather anonymous feedback from employees to ensure action planning reflects the needs.

The Provider implemented the following staff retention measures:
• Salary increment review 09.05.2025 for eligible employees (over one years service with

CCoI)
• Refer a Friend Scheme increase from €150 to €300 per referral, from 10.07.2025
• WRC Pay Award Implementation: 2.25% on 01.10.2024; 1% on 01.04.2025; 2% on 01.11.2025; 2% on 01.04.2026; 2% on 01.10.2026
• Individual pay reviews and regrading completed for eligible staff by 30.09.2025
Retention measures are monitored through HR reports to Senior Management Team weekly.

Commitments led by the new Head of HR for 2026
• Pay and Benefits Review: Complete a full benchmarking analysis against sector standards by 30.04.2026; implement approved salary adjustments and other changes by 30.06.2026; Head of HR to report completion to Board by 01.07.26
• Workplace culture framework: Develop standardised culture framework assessment through external X survey by 31.03.2026 and deploy to all employees by 30.06.2026; implement priority actions by 01.07.26; track completion through quarterly governance meetings
• Career Development: Publish documented career pathways for all roles by 31.05.2026; publish a 12-month training schedule by 31.05.2026; track quarterly uptake rates and report to Senior Leadership Team from 01.07.26
• Recognition Programme: Launch structured employee recognition programme on 31.03.2026 with the defined criteria and nomination process; conduct first recognition cycle by 30.06.2026; conduct annual awards process by 21.12.2026
• Work-Life Balance: Publish 12-month wellbeing calendar specifying Publish 12-month wellbeing calendar specifying wellness programme by 31.01.2026.
• Onboarding: Develop structured 90-day onboarding programme by 31.03.2025 and implement for all new starters from 01.04.2026; track compliance rates monthly
• Leadership Communication: Issue monthly organisational updates and quarterly leadership briefings from 05.01.2026; maintain distribution records and audit trail

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Board of Management meets formally at regular intervals, on average 7 board meetings per year. The last meeting was on 1 November 2025 and the next one takes place on 16 December 2025 all Board meetings are formally minuted and actions tracked. Outside of formal Board meetings, the CEO and Board have weekly communications regarding CCoI.

As detailed in the Regulation 15 response above, we have taken comprehensive action to address the support needs of one resident.

The PIC (formerly member who commenced in the role of Residential Manager) is

present onsite Monday to Friday, bringing vast experience commensurate with the Person in Charge (PIC) requirements.

Please note that we have established a stable senior management structure:
• Person in Charge: Appointed 28 October 2025 (formerly Residential Manager who commenced 28 October 2025), present onsite Monday to Friday
• Area Services Manager: Commenced 9 October 2025, commits to being onsite in Dunshane at least one full day per week
• Head of Services: Commenced 13 October 2025, has considerable presence onsite
• Head of HR: In post with 25 years' experience commenced 6 October 2025
• National on-call management support: In place for out of hours

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.

The PIC commenced the monthly Community Management Meetings (CMM) with the management team and the Area Service Manager in Dunshane Community on Nov 5, 2025. The CMM will consider updates from the Clinical Support Officers and the National Safeguarding Lead who will attend the CMM. The CMM discussion includes the day to date operations of the centre, an overview of all Residents, any safeguarding concerns, behavioural support needs, medical needs, restrictive practice and risk assessments, maintenance issues, review of the centre QIP, staff recruitment and retention. These meetings are held monthly with all meetings documented with action logs.

Since 10 November 2025, the ASM conducts daily check-ins with the PIC and Residential Manager and provides guidance on any support needs. The Head of Service is available to the Community also.

• The Head of Services has commenced a weekly governance meeting with the three nationwide Area Services Managers to review the governance levels since October 20, 2025 These meetings allow for shared organisational learning and relevant information will be filtered back to the community via the CMMs. All meetings are minuted.
• The CEO has commenced a weekly governance meeting with the Senior Leadership Team including the Head of Services and Head of HR since October 24 2025
• The CEO has also commenced a weekly governance meeting with the Head of Services and the three nationwide Area Services Managers since October 24 2025

The Head of Services and Compliance, Safeguarding and Risk Manager have commenced monthly 1:1 meetings with the first meeting occurring on 22.10.2025 to discuss overall compliance and risk of the organisation. At the initial meeting, the sole focus was in relation to Dunshane Community.

The PIC will ensure that all new personnel who have recently commenced in CCOI and are associated with Dunshane Community will be discussed with the Residents, and this will be facilitated through their communication styles. These conversations will be

completed by 12 December 2025.

Further, a quality improvement plan was developed on 10 November 2025and includes specific actions assigned to named personnel with due dates set out. This is a live document, which records progress updates and completion status with the vast majority of actions recorded as "completed", demonstrating CCoI's continued capacity to deliver on commitments and implement effective remedial measures.

The Support Plan was reviewed on 23.09.2025 and subsequently on 06.11.2025. A meeting was held with staff and management by 30.11.2025 to discuss the support plan and any supporting documents to ensure all staff have a sound understanding of the plans.

The PIC will ensure that all new personnel who have recently commenced in CCOI and are associated with Dunshane Community will be discussed with the Residents, and this will be facilitated through their communication styles. These conversations will be completed by 12.12.2025

A schedule for team meetings for each house has been developed and will be overseen by the PIC and meetings will be attended by the PIC or the Residential Manager as well as other local management team members. This ensures that team meetings occur regularly with management presence. This ensures 100% management presence at all team meetings.

As note under Regulation 15 in our compliance plan above, we are establishing a core staff team by 30 April 2026 for a specific resident. Further, 14 needs assessments have been completed for all residents between July and August 2025, and a further review was undertaken in November 2025.

The Compliance Team developed a new Quality Improvement Plan (QIP) for the centre on 31.10.2025. The QIP includes action from HIQA inspections, provider audits, external health and safety audits, national audits and all internal audits carried out within the Community. Additionally, actions arising from team meetings, resident meetings, consultation with residents and staff and actions arising from observation of practice and walk arounds completed in the community are added to the QIP. This is a live version with access to the QIP from the local management team, the ASM, the HOS and the CEO who all have oversight and can review the progress on actions. Additionally, to ensure actions are closed out appropriately, all completed actions are verified by a second person. An evidence folder has been set up to include evidence of closed actions contributing to further governance and oversight.

The Compliance, Safeguarding and Risk Manager will complete a bimonthly progress review in relation to the progress of actions outlined on the QIP. The CRS Manager will pay particular attention to the progress of the actions outlined in CCOI's compliance plan to HIQA. The CRS Manager will compile a report and issue it to the Quality and Safety subcommittee to the Board. The first report will be furnished by 31.01.2026.

We have implemented a Consolidated Quality Improvement Plan 31.10.2025 documenting all remedial actions across multiple regulatory areas:

• Actions arising from inspections on 30.06.2025 and 25.09.2025 and internal audits June-November 2025 included
• Specific actions assigned to named personnel (Provider, PIC, ASM, Team Leaders, Compliance Manager) with due dates
• Progress updates and completion status recorded
• Second individual to cross-check action completion as governance measure

A full review of the best use of the Dunshane campus will be carried out by the senior management team by 31 January 2026. Subsequent to this, the plan for the required transfer from Dunshane House and Garden Cottage will be initiated, and any other internal transfers will be considered. 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.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
we have taken the following steps:
• Implemented enhanced walk arounds by local management from 12 November 2025, documented on management-specific sign-in sheets
• Installed clear and accessible directional signage to guide visitors safely from the car park to reception
• Communicated a clear procedure on 4 November 2025 to all staff regarding safe and timely removal of broken or damaged furniture
• Added risk assessments to the induction folder, implemented as of 14 November 2025
• Commenced review of risk assessment regarding staff recruitment and retention, to be completed by 1 December 2025

A full review of all Resident risk assessments will be r completed by 31 January 2026] to ensure they are person-centred, evidence-based, and focused on support needs rather than characterising individuals. The PIC will oversee this review in conjunction with the Compliance, Safeguarding and Risk Manager.

In response to the Inspectors findings on the day regarding a disparaging narrative regarding the Resident, the Provider has initiated a Management Commitment Plan to

cultural change to be rolled out at team meetings commencing by 10.12.2025 with all staff and embedded by regular communication and checks by local management and the ASM.

In addition, the following actions will be taken:
• Focused training sessions will be organised by S our Compliance, Safeguarding and Risk Managerd on risk assessment principles, differentiating between perceived and actual risk, and understanding the impact of labelling on residents. The training will take place by 31 March 2026
• Risk assessments will be reviewed at all team meetings to ensure staff are aware of all risks identified pertaining to the Resident they are supporting. Risk Management is included as standing agenda at team meeting and the meeting minute template has been updated and circulated on 03.12.2025.
• The Compliance Team will also develop a workshop to be completed at team meetings regarding risk assessments, how risk assessments are completed, the review and implementation of control measures. This will be completed by 31.01.2026.

• Reflective supervision – Regular 1:1 and group supervision sessions to review complex needs, challenge assumptions, and promote professional curiosity. The first group supervision will occur by 31.12.2025. The 1:1 sessions will commence by 05.01.2026 and will occur monthly.
• Mentorship and peer support – Encouraging experienced staff to model balanced approaches and guide newer colleagues. On the floor mentoring led by the local management team and responsibility has been assigned to the PIC to ensure this takes place and to monitor it monthly.

Enhanced walk arounds completed by the local management have been implemented from 12.11.2025 and will occur weekly. This will include observation of practice and ensure staff are following the control measures outlined in the risk assessment as an example. These walk arounds will be documented on management specific sign-in sheets in each house and subsequently checked by the ASM during their weekly visit to the centre. The sign-in sheets have been implemented on 12.11.25. Any identified areas for concerns will be immediately addressed and an action added to the centre QIP.

The following specific risk control measures have also been implemented:
• Clinical Risks: Catheter guidance revised 27.07.2025; all staff trained 01.08.2025; individualised care plan implemented with monthly PIC review
• Staff Safety: Lone worker safety system procured August 2025; rollout completed 30.09.2025; Lone Working Policy implemented 15.10.2025; personal safety devices with SOS/GPS and escalation protocol in place; staff acknowledgement requirements completed by 01.11.2025
• Premises Safety: Gates erected and tools removed to restricted area by 08.08.2025; new safety signage installed by 30.06.2025; risk assessment for unauthorised persons added to risk register 28.08.2025
• Local Risk Register: Fully updated and reviewed 07.08.2025; 30 risk assessments completed covering all identified risks; review dates assigned

A risk assessment review in relation to staff recruitment and retention has been completed to include control measures specifically regarding retention of staff. A discussion was required with the new Head of HR prior to this review occurring to ensure effective control measures could be implemented. This is being reviewed by the PIC, CSR Manager and the Head of HR and was completed by 03.12.2025. The local risk register will subsequently be updated on 04.12.2025.

, the following steps have been taken the risk assessment was updated on 03.12.2025 with the following outcomes: -

• All new staff members, including agency personnel, will receive a full induction from the Person in Charge, Residential Manager, or Team Leaders prior to undertaking any care duties, ensuring consistency in practice and high standards of care.
• Risk assessments have been added to the induction folder, which acts a quick reference guide for staff. These folders have been implemented as of 14.11.2025.

clear and accessible directional signage has been installed to guide visitors safely from the car park to the reception area in November 2025. Additional signage has also been placed to indicate that Dunshane House and Garden Cottage are private residences, ensuring privacy and clarity for residents and visitors alike.

On 04.11.2025, the Property and Asset Management Lead communicated a clear procedure to all staff regarding the safe and timely removal of any broken or damaged furniture, promoting a safe and comfortable environment for everyone.

The Compliance, Safeguarding and Risk Team will conduct spot checks on risk assessments and the implementation of control measures during visits to the centre. Any identified actions will be brought immediately to the Management team including the ASM and HOS and actions will subsequently be added to the QIP. A member of the team will be present in the centre at least once per month.

The following Health and Safety Management actions have also been taken:
• Safety Statement Version 6.1 revised 08.09.2025 and approved 09.09.2025
• Safety Statement sets out organisation-wide health and safety policy, governance structures, risk management framework, incident management procedures, emergency preparedness protocols, and mandatory training requirements in accordance with Safety, Health and Welfare at Work Act 2005
• Safety Statement displayed in corridors at Dunshane premises for staff access
• Safety notices displayed in November 2025.

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:
• Completed 14 comprehensive needs assessments and updated support plans between July and August 2025, with all support plans under further review for completion by 31 December 2025
• Conducted 16 appointments/meetings with relevant MDT between 9 September 2025 and 28 October 2025.
• The Provider has ensured the review the assessment of needs for all Resident to ensure it captures all areas of identified needs and include information from relevant MDT. This was completed on 10.11.2025. The PIC is currently completing and overseeing the review of all support plans and associated documents in place to ensure all information provides effective guidance to staff and captures all areas of support needs for each Resident. This review will be completed for all Residents by 05.12.2025.

Further, the following comprehensive Needs Assessments have been completed:
• 14 comprehensive needs assessments completed for all residents between July and August 2025
• 14 updated support plans completed for all residents between July and August 2025
• All needs assessments underwent full review in November 2025 following updates to Needs Assessment Templates to include multidisciplinary team input and scoring system
• All support plans currently under further review with completion date 31.12.2025
• Compatibility assessments for all residents requiring them will be completed by 31.01.2026 by the PIC in conjunction with local management team, clinical support, Area Service Manager and Compliance, Safeguarding and Risk Manager

With regards to HIQA's finding in paragraph 2 of Regulation 5 that a resident was observed travelling with a peer rather than staying home in accordance with her own wishes, this was addressed and it was communicated to local management that decisions not in line with resident wishes should not occur going forward, with the PIC providing oversight, effective immediately. The staff involved have been informed on 11 November 2025 that this should not have occurred and the resident should have been allowed to stay or if the trip could have lasted more than the 20 minutes the resident was permitted to remain home alone, they should have sought assistance from another member staff. Since 28 October 2025, additional management in place and will be available if a similar circumstance was to arise again. All staff in Dunshane have were informed by 11 November 2025 of the practice to be followed if a similar event were to occur.

A communication has been made to all staff that houses should be locked when houses are unattended. An SOP is being drafted and will be completed by 05.12.2025 and issued to all staff in Dunshane on the same day. Management have installed lock boxes for keys as a contingency to ensure that houses can be accessed by the CMSN and staff at all times.

The PIC in conjunction with the local management team, CSO Behavioural Support, the Area Service Manager and the National Safeguarding Lead will ensure that compatibility assessments will be completed for all Residents who require them. This will be completed by 31.12.2025.

To address any concerns, all further steps regarding transfers or transitions were paused.

This decision was communicated to residents on 28 November 2025, ensuring transparency and reassurance throughout the process.

. The GP offered a date for 25.11.2025 where the financial capacity assessment was completed. A report is awaited which will be reviewed by the Area Services Manager and Person in Charge. CCoI has made continued efforts to expedite this process.

In relation to the Resident referred to in the inspection report, the local management have been in contact with the Funder, and the Case Manager advised that a referral be sent to get the Resident on a waiting list for Case Management. This referral was sent on 06.08.2025. Following this HIQA inspection, a review of all of the support and input from the MDT support for this Resident was undertaken to ensure that appropriate support was in place for the resident and that all relevant assessments and interventions were coordinated in a timely manner

As part of this process, the Provider engaged with internal teams and relevant multidisciplinary professionals to review support needs, implement recommendations, and progress required assessments.

. Between the 09.09.2025 and 28.10.2025, there have been 16 appointments/ meetings with relevant MDT. These include Psychiatry, Speech & Language Therapy, Occupational Therapy, environmental assessments, GP visits, and the internal ADT panel. Engagement with the resident's representative also took place to ensure ongoing communication and involvement in planning. The provider also sought access to advocacy supports where appropriate.

On 10.10.2025, a meeting was held with the local management team, the CEO and the family where the Residents quality of life and the best possible outcomes for the Resident was discussedThe majority of reports have been returned, and the PIC will ensure a meeting will be scheduled without delay when all final reports are received. The ASM will ensure follow up on reports by 05.12.2025.

Following the ADT meeting on 24.10.2025, CCOI has begun engaging an external agency to provide additional support and guidance in understanding and responding to this community member's needs.

Further, we note a transition planning tool has been developed by the Compliance Team which coincides with the ADT policy. The tool outlines all steps to be taken when any transition is proposed due to change in needs or due health and safety reasons as examples. This will be issued nationwide to all communities following final review with the CEO, HOS and CSR Manager on 05.12.2025

While conversations in relation to transitions have occurred with Residents and their families, the provider has initiated formal communication on 11.11.2025 to the local management team and the ASM that all transitions would be paused until all assessments are fully complete. The local management team have been instructed to

ensure to communicate this with the Residents in line with their communication style and this was completed on 28.11.2025. This was also communicated to families on 11.11.2025.

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 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 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	12/12/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	30/04/2026

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	04/12/2025
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	04/12/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Not Compliant	Orange	15/12/2025

	responding to emergencies.			
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	04/12/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	05/12/2025