Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Camphill Jerpoint
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	03 July 2025
Centre ID:	OSV-0003624
Fieldwork ID:	MON-0047555

About the designated centre

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

Camphill Jerpoint provides long-term residential care to 10 adults, over the age of 18, both male and female with intellectual disability, autism sensory and physical support needs. The centre is made up three premises, two detached two-storey houses each accommodating between one and four residents and one apartment accommodating up to two residents. All premises are in in a farmyard rural setting. Each resident has their own bedroom and other facilities throughout the centre including kitchens, dining rooms, living rooms, laundries and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (including house coordinators and social care assistants) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 3 July 2025	12:00hrs to 20:30hrs	Linda Dowling	Lead
Thursday 3 July 2025	12:00hrs to 20:30hrs	Conan O'Hara	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to provide assurance that safe and good quality care was being provided to residents in this centre. The inspection was carried out as part of a wider regulatory programme of inspections of centres operated by this provider in response to information received by the the Chief Inspector of Social Services. The inspection was completed by two inspectors over one day. Overall, the residents were receiving a good standard of care and support, although there were areas that required improvement such as staffing and governance and management.

The inspectors had the opportunity to meet with all eight residents who lived in this centre over the course of the inspection. The inspectors spent time engaging with residents, spoke with five staff members, carried out a walk around of all three premises, observed care and support practices, observed daily routines and the activities in the centre as well as reviewed documentation.

The centre comprised of three individual properties all within a short walk of each other.

The inspectors arrived at the first property which was a two-storey house with an adjoining apartment. The main house was home to two residents and inspectors found it to be bright and spacious. The first resident greeted the inspectors on arrival and gave a tour of their house. They had their own en-suite bedroom, a kitchen and sitting room located upstairs. They showed the inspectors their art and photography work along with their photography equipment and business card. The inspectors met the second resident in the evening as they returned from accessing the community. They were relaxing in the sitting room and preparing to watch a movie. They noted that they liked their house and the staff team. The communal areas of the house included a large kitchen, utility and sitting room downstairs, these areas were utilised by all residents including the resident from the adjoining apartment as they liked to spend time in the main house. The front garden was surrounded by a fence and had large swings and an in ground trampoline. One resident told us they really like the trampoline and use it regularly.

The adjoining apartment was home to the third resident and consisted of a sitting room, bedroom, bathroom, laundry room and sun room. On the day of inspection, this apartment was fitting with new flooring in the sitting room, the bathroom was in progress of renovation and further flooring was due to be replaced in the coming days. The third resident was happy for inspectors to look around their apartment and they were seen spending time in the garden, kitchen and sitting room.

The second property was a single-occupancy apartment on the upper level of a two-storey building. The ground floor was unoccupied and not part of the designated centre. This resident had a kitchen dining area filled with art and craft supplies, jigsaws and paintings. There was a bedroom for the resident and a sleepover room

for staff. The office space included a large art desk with lots of supplies, the staff member informed the inspectors the resident liked to use this space when staff were on the computer. The apartment was clean, tidy and in good state of repair. This resident was very active, attending day service, art classes and walks on the river. The staff member informed the inspector the resident is well know by artists around the country and they have in the past sold paintings to famous people.

The third property was a two-storey house which was home to four residents. It was divided into three areas, a main house and two single occupancy apartments. The inspectors visited the first apartment and the resident gave a tour showing them their bedroom, storage room, kitchen living room and art areas. They had lots of belongings and did not like to get rid of anything, this was identified as an area of support for the residents and the inspectors reviewed their support plan and risk assessment in relation to this. The second apartment was home to one resident which consisted of a kitchen/dining room, sitting room, bedroom and bathroom. The inspectors found that the apartment was personalised and decorated in line with the preferences of the resident. The inspectors met the resident in the evening when they had returned from day services. They appeared content and comfortable in the dining room. The remaining middle section of the property was home to two residents. The inspectors met the residents as they were enjoying their dinner. The residents of this house were seen to come and go throughout the day, they had visited the mart in the local city in the morning, this was something they liked to do on a weekly basis. In the evening, one resident had decided to go to bed while the second resident was observed watching TV in a large sitting room. The resident was observed requesting to watch a soccer match on the TV of their preferred team from their support staff. Overall, the property was clean and tidy and was decorated in a homely manner. This was part of their regular night-time routine.

In summary, based on what the residents communicated with the inspectors and what was observed, it was evident that the residents received good quality of care and support in the designated centre. However, improvement was required in governance and management and staffing.

The next two sections of this report will 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 provided.

Capacity and capability

The findings from this inspection highlighted that while residents were receiving a largely good quality of care and support, improvements were required in relation to the provision of consistent and sustained governance and management and staffing arrangements.

The centre was managed by a full-time person in charge. On the day of the

unannounced inspection, the person in charge was on planned annual leave. However, there had been recent changes in the senior management of the service which meant the lines of authority and accountability were unclear on the day of the inspection. In addition, the inspectors were informed that the person in charge was supported in their role by two house coordinators. However, on the day of the inspection these positions were vacant.

The provider had systems in place to monitor the quality and safety of the care and support provided to residents including the annual review and unannounced provider audits every six months. Although, the provider had not completed their annual review in line with the required time-frame set out in the regulations.

The staffing arrangements required improvement to ensure appropriate staffing levels at all times and that consistent care and support was provided to residents. A review of a two months of rosters demonstrated that there was a high reliance on agency staffing to maintain the staffing complement. At times the staffing levels fell below the planned staffing complement. In addition, it was not demonstrable that the staffing levels were in line with all residents assessed needs. While, the inspectors were informed of efforts to increase staffing levels and improve consistency of staffing, however the actions taken had yet to effectively and sustainability resolve the staffing issues.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably qualified and experienced. The person in charge was responsible for this designated centre only. There was evidence to show the person in charge was completing regular audits to ensure oversight of the service provided to the residents.

Judgment: Compliant

Regulation 15: Staffing

The inspectors found that the staff team were striving to provide care in line with residents' assessed needs. However, the staffing arrangements required improvement to ensure all residents were supported in line with their assessed needs and preferences.

The inspectors reviewed the roster for the month of May and June 2025 and found they reflected the cover assigned to each house and in some cases, where required, each resident. The first property which supported three residents has two staff assigned per day and one waking night shift. The second property had one staff at all times throughout the day and a sleepover staff at night to support one resident.

The third property which was home to four residents has two or three staff assigned per day depending on residents attendance at day service and one waking night shift.

However, the inspectors found that there was a significant reliance on agency staffing to maintain the assigned staffing complement. For example, throughout the month of May and June 2025 there was a total of 67 shifts covered by agency. The assessed number of staff required to run the centre was 18.5 whole time equivalent (WTE). At the time of inspection the centre was operating with 13.9 WTE. From review of the roster there were 28 occasions over the two month period where the staffing levels fell below the planned staffing complement. The staffing arrangements required further review to ensure the planned staffing complement levels were maintained at all times to ensure safe and quality care was being delivered to residents.

In addition, it was not demonstrable that the staffing levels were in line with all residents assessed needs and control measures identified in residents risk assessments. From review of a sample of risk assessments, some residents had control measures in place to identify where they required full supervision or full support from staff. From a review of the roster and the significant number of times the staffing levels were below the planned complements, demonstrated that these control measures could not always be implemented. For example 2:1 supervision/support of residents.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, improvements were required to ensure there was an effective and sustainable governance arrangements in place to support the centre.

The inspectors were informed that the staff team were reporting directly to the Chief Executive Officer (CEO) of the organisation due to leave, absences and vacancies. This was not determined to be an effective system of local governance for this centre.

There had been recent changes in the senior management of the service which meant the lines of authority and accountability were unclear on the day of the inspection. For example, the staff team were advised to utilise the on-call system for out of hours and contact the CEO in the absence of the person in charge and area manager. According to the statement of purpose the person in charge reported to the area manager, who in turn reported to the head of service. The head of service then reported to the CEO. On the day of the inspection, the roles of the area manager and head of service were vacant.

While inspectors reviewed evidence of emerging structures to manage the centre, with the changes, the management systems in place did not ensure sustainable,

consistent and effective monitoring. This issue was ongoing at the time of the inspection with inspectors informed of a number of managers that were handing in their resignations in this providers services.

There was evidence of quality assurance audits including the annual review and six-monthly provider visits. These audits identified areas for improvement and developed actions plans to address same. The inspectors found that improvement was required in the timeliness of the annual review, as it was overdue.

Judgment: Not compliant

Quality and safety

Overall, the staff team and person in charge of the centre were striving to provide a person centered care and support to residents. Residents' homes were found to be clean and in good state of repair.

There were a number of systems in place to identify, manage and review risks in the centre and keep residents safe from abuse. From review of the risk register including both centre specific risks and residents individual risks overall risk was being managed in this centre. While in some cases the control measures identified referring to staffing levels was not always possible with current vaccines, this has been reflected in regulation 15: Staffing.

There were systems in place to keep residents safe. The staff team had been appropriately trained in safeguarding. From a review of incidents and accidents logged, it was demonstrable that they were being recorded and reviewed by the person in charge, with appropriate action taken and recorded where required. From speaking with and spending time with residents they reported they were happy living in the centre, they had opportunities to engage in activities of their choosing and were observed as comfortable and relaxed in the presence of other residents and staff members.

Regulation 26: Risk management procedures

The provider had systems in place to identify and manage risk. The inspectors reviewed the risk register and found that general and individual risk assessments were in place. From the sample of risk assessments reviewed, they were all in date and had been updated post incident of adverse event to reflect new control measures in place. Residents had a variety of risk assessments in place from money management, gardening, slips, trips, falls, medication management, attendance at workshops and swimming to name a few. Risk assessments were detailed and

offered good guidance to staff in management of risk for each resident.

Staff spoken to throughout the inspection were aware of each resident's risks and the control measures in place. One staff member spoke to the inspectors about a audio monitor in place for one resident who required supervision while in bed due to the risk of seizure activity. The staff was aware this was a restrictive practice and should only be used for the times specified in the resident's plan.

Judgment: Compliant

Regulation 8: Protection

The provider had a number of control measures in place to safeguard residents and ensure they were kept safe. Inspectors found that there were clear systems in place for reporting and following up incidents. There was one open formal safeguarding plan in place on the day of inspection. This was a result of a negative interaction between two peers. The action that has been taken to mitigate the risk of such incidents happening again was seen to be in place on the day of inspection and both residents were aware of the new arrangements in place to keep everyone safe.

The staffing team had all received safeguarding training and were seen to be actively reporting incidents of concern.

Residents had intimate and personal care plans in place which gave clear guidance to staff on the level of support each resident needed, this ensured each residents right to autonomy, privacy and dignity were promoted and upheld during these care routines.

The inspectors reviewed a sample of residents finances and found that that there were appropriate local systems in place to provide oversight of monies held by residents physically in the centre. For example, local systems included day-to-day ledgers, storage of receipts and regular
checks on the money held in the centre by the staff team. In addition, there was evidence of monthly reconciliation of the residents' bank statements with the provider's internal ledgers and an up-to-date asset register recording residents' belongings.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Camphill Jerpoint OSV-0003624

Inspection ID: MON-0047555

Date of inspection: 03/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The PIC will conduct a full review of all the community members needs assessments which will determine an updated account of Jerpoint's WTE. This will be completed by the 31.10.25 • As of the 04.08.25, Jerpoint community have appointed a House Coordinator who is now in the post. The House coordinator is currently being inducted by the PIC into all operational systems, risk management and the support needs of each individual resident. • A second House coordinator is currently onboarding and is scheduled to commence the role on the 02.09.25. The PIC will also provide a full induction into all the organization's operational systems, risk management, individual support plans to ensure she is well attuned to the needs of all the community members. • All agency shifts covered are completed by regular agency staff who have knowledge of the community members and are trained in line with CCOI Policies. All agency staff training will be monitored by the PIC and community administrator to ensure all agency staff we roster are working in line with CCOI's Training policy. • All agency staff and CCOI staff are supervised by the PIC until the House Coordinator and Team Leads are fully inducted into her role and they are upskilled and trained to supervise staff. This will be completed by 30.11.25 • The Interview for Team Lead took place on the 12/08/25 and has since been accepted. The Team lead will receive a full induction into the role by the PIC upon commencement. This induction will cover all aspects of the community members assessed needs from their support plans to risk management, all operational systems, rosters. The Team lead role is 40 hours a week, the role will not exclusively be an office-based role. The Team lead will have the availability and flexibility to support community members for example supporting a community member who requires 2:1 support while attending a GP appointment. • There is currently one Social Care Assistant and one Social Care Worker onboarding due to commence these posts by the 06.10.25. • The PIC will liaise with the social media expert by 29-08-2025 to develop new ideas to increase engagement from potential candidates and ensure all social media outlets are	

being utilized effectively. A discussion will take place with residents as to whether they would like to be involved in social media recruitment videos by 10-09-2025.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A new Area Service Manager (ASM) started on 18th August 2025, providing regional oversight and leadership.
• First site visit to Jerpoint took place on 21.08. 2025 with a meet and greet with staff and residents, and a handover of resident needs.
• The new ASM will conduct fortnightly visits to the center to include a walk around, conversations with residents, staff and PIC providing for increased onsite oversight. This process commenced on 21-08-2025.
• A baseline regulatory audit (covering up to 30 regulations, including governance and management) will be undertaken in the centre by the PIC and the ASM by 30-09-2025. This audit will provide for development of an overall centre quality improvement plan by 30-10-2025.
• A Quality Enhancement Plan (QEP) will be developed based on the audit, to be completed by the ASM by the 30-10-2025.
• All staff in Jerpoint were informed of the new ASM and updated lines of authority via email on 18/08/2025.
• An accessible letter will be provided to each resident by the PIC by the 29-08-2025 to inform them of the new management persons in place and their contact details
• ASM will also attend the weekly Senior Management Team meetings, starting Friday, 22nd August 2025.
• The ASM will complete the annual service review for 2024 by 30-10-2025, feedback for this review will be gathered from the residents via the baseline audit process. Family and resident feedback questionnaires will be sent to families in January 2026 as part of the annual review for 2025, with a completion date for the 2025 review of 30-03-2025.
• A full-time Person in Charge (PIC) is currently in the post and actively fulfilling their statutory duties under the Health Act 2007.
• The Head of Services position is currently vacant and being advertised through a national recruitment process. Interviews are scheduled for Thursday 28.08.2025.
• In the meantime, the CEO is covering the responsibilities of the Head of Services to maintain continuity of governance.
• The SOP was reviewed on 19/08/2025 by the National Operations Support Officer and the PIC. The current management structure is as follows:
Board → CEO → Head of Services Vacant (Interviews Thursday 28th August 2025) → ASM → PIC → Team Leader (Role accepted and the candidate will commence on 15.09.2025) → House Coordinators (x2) → Social Care Team
• The PIC will be provided with formal supervision by the ASM on the 02-09-2025.
• HR Team re-engaged with recruitment agencies, shared updated job descriptions for

vacant posts, and requested relevant CVs. CV for review by PIC available on a Recruitment Tool.
• All agency staff have completed mandatory training as per CCoI policies and are fully inducted, with access to all required systems to ensure safe and effective care.
• Supervision for agency staff is in place, aligned with CCoI's supervision policy to ensure ongoing professional oversight. This is reviewed by the Compliance officer during review of staff files.
• Rosters continue to be reviewed daily to ensure adequate, qualified, and experienced staff are available to meet residents' assessed needs.
• An on-call roster is in place to support staff outside regular working hours.
• The SOP for On-Call, outlining the roles and responsibilities of the PIC, ASM, CEO, and Head of Services, reviewed by the CEO on the 15.08.25 and was shared with the staff team on the 22.08.25

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	30/09/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/10/2025
Regulation 23(1)(d)	The registered provider shall	Not Compliant	Orange	30/10/2025

	ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			