



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

Issued by the Chief Inspector

Name of designated centre:	Camphill Community Kyle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	29 June 2026
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0049315

About the designated centre

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

Camphill Community Kyle provides long-term residential services for a maximum of 16 residents, over the age of 18, with intellectual disabilities, physical disabilities and autism. The centre is located in a rural setting and comprises four units of two-storey detached houses with each accommodating between one and five residents. All residents have their own bedrooms and other facilities throughout the centre include kitchens, dining rooms, sitting rooms, utility rooms, bathrooms and staff offices. In line with the provider's model of care, residents are supported by a mix of paid staff including social care staff and care assistants and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 29 June 2026	13:30hrs to 19:00hrs	Marie Byrne	Lead
Tuesday 30 June 2026	09:00hrs to 16:00hrs	Marie Byrne	Lead
Tuesday 30 June 2026	09:00hrs to 16:00hrs	Robert Hennessy	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by two inspectors over two days. It was completed to ensure residents were safe and in receipt of a good quality of care. This was the fourth inspection in this designated centre in a 12-month period.

In July 2025, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of this centre, due to continuous failure of the provider to implement actions to move into compliance with key regulations, which was impacting on the quality and safety of care for residents. The provider responded to this notice with a written representation outlining the actions they would take and two follow-up risk inspections were completed in September 2025 and December 2025. During these inspections several improvements were found, particularly relating to governance and management, safeguarding and risk management. However, several key actions were still in progress particularly relating to staffing and the premises. Following these inspections, the Chief Inspector applied an additional condition to the registration of this designated centre due to the provider's failure to demonstrate sufficient compliance in these areas as found on previous inspections. This restrictive condition required that the centre come into compliance with named Regulations by the 30 June 2026.

The findings of this inspection were that further actions had been taken by the provider since the last inspection such as the completion of the majority of premises works outlined in their compliance plan, and making further improvements to risk management and safeguarding. However, the centre was not resourced to meet the number and needs of residents and there were a number of key posts vacant in the local management team. This continued lack of staffing resources impacts on the provider's ability to achieve and sustain progress in other areas when providing care and support. The inspector was informed and shown documentary evidence that a team lead post had been offered and accepted and that the candidate was in the process of onboarding at the time of the inspection.

There was one action still in progress from the provider's previous compliance plan relating to the external painting of premises. It was reported that painting works had been delayed due to weather conditions and subsequently contractor availability. While doing the original works, the provider self-identified that further premises works were required and these works were scheduled. The provider was found to be in breach of the additional restrictive condition of registration as they had failed to move into compliance with Regulations 17: Premises and Regulation 15: Staffing by the 30 June 2026. These areas will be discussed further in the body of the report.

Camphill Community Kyle is a residential service providing care and support for up to 16 residents with an intellectual disability. The centre comprises five houses on a

rural campus in County Kilkenny. One house is single occupancy, and the other houses are home to between two and four residents. There were 14 residents living in the centre at the time of this inspection and one resident had self-discharged since the last inspection. Inspectors reviewed documentation relating to the resident's discharge and found that it had been completed in line with the provider's policies and procedures. This included meeting the relevant personnel from the Health Service Executive (HSE) to discuss the proposed care package prior to their discharge.

During the inspection, inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting 13 residents, 9 staff supporting them, the person in charge, the provider's national health and safety officer, two members of the provider's quality and compliance team, two clinical support officers and the area service manager who is a person participating in the management of the designated centre (PPIM). One resident was in hospital so inspectors did not have an opportunity to meet them.

On the first day of the inspection, an inspector completed a walk around each of the five premises with the person in charge. During this time, they had an opportunity to meet residents, speak with them and observe as residents went about their afternoon and evening routines. They appeared comfortable and content in their homes. Residents communicated in a number of ways and staff were observed to be very familiar with their communication styles and preferences. Staff who spoke with inspectors were also found to be very familiar with safeguarding procedures and residents' care and support needs. Residents spoke about their favourite things to do, upcoming events and about the important people in their lives.

Overall, during the walk around of the premises, improvements were noted to each of the premises and to the grounds. Residents showed an inspector the works that had been done to their homes. For example, one resident brought an inspector to the kitchen in their home, their bedroom and their sitting room where a number of works had been completed. This included the double doors from both their sitting and bedroom, the push buttons to open their bedroom door, their remote control blinds, their en-suite bathroom, and their wardrobe which had been designed to meet their needs. Another resident showed the inspector their apartment which had been freshly painted. They said their bedroom had doubled in size. They also showed them the bathroom which had been renovated, their new built in wardrobe and their new furniture. Their kitchen and storage presses had also been painted and new flooring had been installed in their apartment.

One resident spoke with an inspector, the person in charge and the PPIM about their planned transition from the centre. They said it was "going on for two years now" and that they were really looking forward to moving. They said they were hoping the move happened before their birthday as they would like to have a housewarming and a birthday party in their new home. They showed an inspector pictures of the apartment they were hoping to transition to and discussed picking paint colours, fixtures and fittings, white goods and furniture. They spoke about shopping for items for their apartment, visiting it and meeting with the local

management team there. They also showed an inspector some of the items they had purchased for their new apartment. They asked the inspector and PPIM if they had any update on the application to register the centre including asking the inspector how long it would take to register. The PPIM informed them that the application had not been submitted to the Chief Inspector, and the inspector spoke with them about the average time it takes to progress an application to register a new designated centre and the decisions that had to be taken.

In line with the findings of previous inspections, inspectors reviewed documentation and were told that one resident's care and support needs could no longer be met in the centre. Since previous inspections, the provider had responded to this residents' changing needs and implemented additional unfunded staffing supports while submitting a business case to the HSE. This will be discussed further under Regulation 15: Staffing. Several meetings had been held with the resident and the relevant professionals from the Health Service Executive (HSE). This included a meeting that had already been scheduled for the second day of the inspection. The inspector was informed by the PPIM that the funding had been agreed by the HSE for their transition at that meeting and that further meetings were planned to progress their transition.

On the second day of the inspection, both inspectors had an opportunity to visit some of the houses, to meet and speak with residents and staff, and to observe residents spending time in their homes. They were observed relaxing in their homes, taking part in the upkeep of their homes, doing arts and crafts, watching movies, listening to music, and spending time with each other and staff. They were also observed spending time walking around the grounds and leaving their homes to engage in their community. For example, they were going to attend day services, going shopping, to go out for meals and coffees, to attend appointments, to visit family and friends and to have a massage by a massage therapist who was on site. There were a number of vehicles to support them to access their community. However, two further vehicles were due to be sourced, and this will be discussed further under Regulation 23: Governance and Management. In the interim, there were two rental vehicles in place until such time permanent vehicles were procured.

One resident spoke about their recent graduation from college. They showed the inspector pictures and talked about how much they had enjoyed it. They spoke about how proud they were of their results and how they had been successful at securing a place to complete the second year of the course.

Inspectors also reviewed documentation in the houses and in an office on site about how care and support is provided for residents and relating to the day-to-day management of the centre. This included reviewing documentation relating to the actions detailed in the provider's audits and reviews, their compliance plan and their quality improvement plan.

In summary, while improvements had been made to the premises, risk management and safeguarding it remained the case that improvements were required in relation to oversight and monitoring, the premises and staffing.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found the systems for oversight and management of the centre were not effective in addressing ongoing identified issues within the centre, particularly those relating to resources and staffing.

As discussed in the opening section of the report, inspectors found that while there had been further improvements in several key areas since the last inspection such as the premises, risk management and safeguarding. They found that the provider had self-identified that further works were required to some of the premises. However, overall they found that the provider continued to fail to demonstrate effective governance and bring about some of the required improvements. For example, the provider's stated actions relating to resources/staffing remained incomplete and as a result they were in breach of the restrictive condition on the registration of this designated centre.

The high number of staffing vacancies remained as did vacancies in the local management team. Inspectors found that this was having an impact on the continuity of care and support for residents and the ability of the local management team to implement the required actions from the provider's audits and reviews in the stated timeframes.

Regulation 14: Persons in charge

The provider had employed a new person in charge since the last inspection. The inspector reviewed the Schedule 2 information for the person in charge in advance of the inspection and found that they had the qualifications and experience to fulfill the requirements of the regulations. They were full-time and had sole responsibility for the operation of this designated centre.

During the inspection, the inspector reviewed the systems they had for oversight and monitoring in this centre and found that they were effective in identifying areas of good practice and areas where improvements were required in this centre. Vacancies in the local management team was impacting on their ability to complete some actions from audits and reviews and this will be discussed further under Regulation 23: Governance and Management.

They had worked in the centre for a number of years, in a variety of different roles. Throughout the inspection, residents were observed to be very familiar with them and appeared very comfortable and content in their presence. Inspectors found that they were focused on ensuring that each resident was happy, safe and taking part in activities they enjoy. They were focused on ensuring continuity of care and support for residents and on implementing a human-rights based approach in this centre.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found that the provider was not clearly demonstrating that the centre was resourced to meet residents' care and support needs. Although some improvements were noted, in areas such as improved oversight of and maintenance of rosters, it remained the case that the provider had failed to ensure there were enough staff employed in line with residents assessed needs. The heavy reliance of agency staff also remained.

During the last inspection, inspectors were informed that there were eight whole time equivalent (WTE) staff vacancies; however, based on a review of the WTE vacancies at the time of this inspection, inspectors were not assured that this figure was accurate. Inspectors requested a breakdown of the WTE numbers for the centre, the number of staff employed since the last inspection and the number of staff who had resigned/left. The documentation presented indicated that there was a requirement for 46.2 WTE for this centre, that three new staff had been employed, that five staff had resigned/left and that there were 18.9 WTE staffing vacancies at the time of this inspection. Inspectors acknowledge that there had been a 4.2 WTE increase in the overall WTE for the centre since the last inspection in line with one residents' changing needs. The provider had implemented these additional unfunded supports for the resident while submitting a business case to the HSE. One resident had also self discharged and was no longer in the centre.

This level of staffing vacancies on the day of the inspection (18.9 WTE) equated to approximately 40% of the required WTE. Inspectors reviewed records relating to agency usage, agency induction, and rosters. These demonstrated that efforts were being made to ensure agency staff had a comprehensive induction and that the same agency staff were completing shifts where possible. However, an average of 1250 hours per fortnight were being covered by an average of 22 different agency staff.

Inspectors were told that efforts had been made to recruit staff such as local recruitment drives and interviewing overseas applications. They were told that four people were successful at recent interviews and were onboarding at the time of the

inspection, and that people from the provider's overseas recruitment drive would be assigned to this designated centre.

A sample of three staff, two agency staff and two short-term volunteer files were reviewed. They were well-maintained and the information required under Schedule 2 of the regulations was present.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, inspectors found that the provider had not ensured that effective systems were in place for governance and management in this centre. The centre was not fully resourced in terms of transport and staffing. As previously mentioned, there were two rental vehicles in place until such time permanent vehicles were procured. As described earlier, the provider was now in breach of the restrictive condition on the registration of this centre.

Inspectors reviewed the provider's latest six-monthly and annual review. The six-monthly review completed over five days between January and February 2026 was found to be comprehensive in nature and reviewed a range of areas. It self-identified areas for improvement in line with the findings of this inspection. However, a number of actions had not been completed in line with the provider's identified timeframes. In addition, there were outstanding actions from the annual review (annual review period September 2025 to June 2026) including those relating to staffing, the completion of actions from audits and reviews, resident transitions and staff supervision.

Inspectors were shown the quality improvement plan (QIP) for this centre which combined the actions from the provider's compliance plans, area specific audits and the provider's annual and six-monthly reviews. This showed that most actions were recorded as ongoing or overdue for completion. There were 91 actions on the QIP, with 67 marked as in progress, 13 overdue and 11 where the date for completion had passed but an update had not been provided on their status. For a large portion of the actions marked as in progress, the date for completion had passed. These outstanding actions related to areas such as governance and management, staffing, reducing the reliance on agency staff, closing actions from the provider's six-monthly review, sourcing two vehicles and staff supervision.

There were three vacancies in the local management team which were found to be impacting their ability to carry out their roles and responsibilities. This included the completion of actions from audits and reviews as described above. While the inspector was informed and shown documentary evidence that a team lead post had been offered and accepted and that the candidate was in the process of onboarding at the time of the inspection. They were not in post on the day of the inspection.

As mentioned in the opening section of the report, two residents were due to transition from the centre. For one person, this was in line with their changing needs and for another it was in line with their wishes and preferences. In line with the findings of previous inspections, these transitions were not progressing in a timely manner. For example, one resident's transition commenced in July 2024 and the other commenced in April 2025. The transition plans were reviewed for both residents and while they showed progress including meetings with the relevant stakeholders and improved levels of consultation with residents. However, there were no concrete plans or dates for their transitions on the day of the inspection.

Judgment: Not compliant

Regulation 30: Volunteers

There were two live-in (short-term) volunteers in the centre at the time of the inspection.

Their files were reviewed which demonstrated that they had their roles and responsibilities in writing. They were also in receipt of training and regular formal supervision and support. There was garda vetting and police vetting from their country of origin in place.

Judgment: Compliant

Quality and safety

Overall inspectors found that improvements had been made to the quality and safety of care and support for residents since previous inspections. These improvements included environmental enhancements, and improved oversight and utilisation of the provider's systems in relation to risk management and safeguarding. In addition, improvements were noted in relation to positive behaviour support and restrictive practices. The provider had identified that some further works were required to the premises and these will be discussed under Regulation 17: Premises.

Residents were being supported to enjoy best possible health. They were supported to access the relevant health and social care professionals. In line with the findings of previous inspections, the provider was recognising that they could no longer meet one resident's care and support needs. As described earlier their transition remained in progress at the time of this inspection.

Residents, staff and visitors were protected by the safeguarding and risk management policies, procedures and practices in the centre. There was a system for responding to emergencies and for reporting safeguarding concerns. Staff had completed training to ensure they were aware of their roles and responsibilities.

Regulation 17: Premises

Overall further improvements had been made to the premises since the last inspection. This was found to be having a positive impact for residents. As previously mentioned, while doing the original works outlined in the provider's previous compliance plans, the provider had self-identified that further premises works were required and these works were scheduled. These works will be outlined below.

The majority of actions outlined in the provider's compliance plan from the last inspection had been completed. The last action included painting the outside of the houses which was reported to be delayed due to weather conditions and contractor availability. A painter was onsite during the inspection.

Some of the works that had been completed since the last inspection included the following:

- The replacement and repair of a number of floor coverings.
- The kitchens were replaced in two houses.
- Two bathrooms were renovated.
- New furniture was sourced for a number of the houses.
- A tracking hoist was installed into one of the houses.
- A new shed had been purchased for one of the houses.
- Paths were installed around one of the houses.
- A laundry room had been renovated.

The additional works mentioned above included the following:

- While completing premises works outlined in the provider's compliance plan, a leak had been found. Remedial works had been completed. Further external works were now planned and included on the maintenance schedule for completion.
- Work was planned to a laundry room in one of the houses. The contractor was booked to complete this at the end of August 2026.
- Remedial works had been completed following a leak in the roof of one of the buildings and further works were now scheduled.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Inspectors found that residents', staff and visitors were protected by the provider's risk management policies procedures and practices.

The provider's risk management policy met regulatory requirements. There were detailed emergency plans in place which were regularly reviewed.

The risk register, and a sample of residents' individual risk management assessments were reviewed. Individual and centre specific risks had been identified with appropriate controls measures put in place to manage these risks.

The provider had an electronic system in place to record incidents, accidents and near misses. These were being reviewed by the relevant member(s) of the clinical/management team and follow-ups were completed, as required.

Overall, inspector found that risk was well managed in the centre.

Judgment: Compliant

Regulation 6: Health care

Residents were being supported to enjoy best possible health.

Appropriate assessments in place in relation to the changing needs of the residents. Residents have access to a general practitioner and have access to other healthcare professionals such as a psychiatrist and psychologist.

There was evidence that residents were supported to attend medical appointments. These appointments were documented to keep staff up to date. There was evidence that residents were consulted about these healthcare appointments and provided consent for these medical interventions.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors found that residents had their needs assessed and had the required supports in place to support them to manage any anxiety or distress they may experience.

Residents were accessing the support of a behaviour specialist, psychologist and psychiatrist. Their risk assessments and plans contained proactive and reactive strategies to support them to reduce any distress or anxiety they may be experiencing. These plans provided comprehensive guidance to staff and documented such actions as proactive interventions and their communication needs.

Staff were provided with training in the management of behaviour that is challenging including de-escalation and intervention techniques. Staff who spoke with inspectors were aware of the content of these plans and described how to best support residents in line with their plans and preferences.

There had been a number of restrictive practices and these had been reduced and then removed in the months before this inspection. For example, a number of doors and presses that were previously locked were now open and a keypad lock had been removed from a door. This demonstrated that the provider was regularly reviewing restrictions to ensure they were the least restrictive for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

Based on a review of documentation and discussions with the person in charge and staff members, inspectors found that residents were protected by the safeguarding policies, procedures and practices in this centre.

There had been a number of safeguarding incidents notified to the Chief Inspector since the last inspection. These had been followed up in line with the provider's and national policies. Safeguarding plans were developed and reviewed as required. Inspectors reviewed the safeguarding tracker for the centre which was accurate and well maintained. It demonstrated good oversight of safeguarding in this centre.

From a review of the staff training matrix, 100% of staff had completed online and in-person training in relation to safeguarding. Staff who spoke with inspectors were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. They spoke about the reduction of risks relating to safeguarding since previous inspections.

Inspectors reviewed a sample of financial records for four residents and found that they were well managed. Inspectors reviewed the contents of residents wallets and cash boxes against the balance recorded online and found that they matched. Receipts were maintained for residents spending and these were cross referenced against their statements of account in financial institutions. A sample of four residents' personal property inventories were reviewed and items from these lists were found to be present. For example, one resident showed an inspector some of the items from their list including their wallet and electric razor. Inspectors also saw

some of the larger items from these lists such as televisions and music systems while the visited the houses.

Overall, inspectors found that the provider's systems for safeguarding residents had improved since previous inspections.

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
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0049315

Date of inspection: 30/06/2026

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 provider will ensure that the designated centre is resourced with the number, qualifications and skill mix of staff required to meet the assessed needs of residents and to provide continuity of care and support by April 30, 2027. The staffing establishment has been reviewed following the transition of one resident in August 2026 whose assessed needs had previously required 4.2 WTE staffing allocation. The current approved staffing establishment is now 42 WTE. Our current contracted staffing stands at 27.9 WTE The provider will complete recruitment to the approved staffing establishment and will ensure that staffing levels, qualifications, skill mix and residents' assessed needs are reviewed and reconciled on an ongoing basis. Seven Social Care Assistants are currently completing pre-employment onboarding, and one regular agency staff member has accepted an offer of permanent employment, subject to completion of pre-employment requirements. The provider will progress these appointments that all those currently onboarding will be in post by October 31, 2026 Human Resources (HR) will continue targeted national and international recruitment until the approved staffing establishment is achieved. Recruitment activity will include engagement with relevant education providers, recruitment events and direct recruitment campaigns with a view to the full WTE being recruited by April 30, 2027. The Person in Charge (PIC) and Area Service Manager (ASM) will review staffing levels, vacancies, skill mix, resident dependency and roster requirements on a weekly basis. This has already commenced. Any staffing deficit identified through this review will be escalated to the ASM and appropriate contingency arrangements will be implemented to ensure residents' assessed needs continue to be met notably using agency staff with experience of the community. Recruitment progress, vacancies, roster consistency, agency utilisation, staff turnover and onboarding will be reviewed monthly by HR, the ASM and PIC and this has already commenced. Staffing will remain a standing agenda item at the weekly CEO/Head of Services/Area Services Manager meetings until the approved staffing establishment has	

been achieved. These meetings have already commenced.
Any risk to continuity of care identified in the above meetings will be documented, escalated and addressed through the local management and governance arrangements. All agency staff will complete the provider's induction requirements before working independently in the centre. Regular agency staff will receive formal supervision by September 30 2026 and quarterly thereafter in accordance with organisational policy.

Regulation 23: Governance and management

Not Compliant

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

The provider will ensure that Camphill Community Kyle is appropriately resourced to deliver safe, appropriate and consistent care and support in accordance with the Statement of Purpose.

Local management resources have been strengthened through the appointment of a Team Lead who commenced on July 13 2026 and a House Coordinator who commenced on July 10 2026. A second Team Lead has accepted an offer and is progressing through the onboarding process and is expect to be in post by September 30, 2026

Staffing resources will be addressed through the Regulation 15 action plan. The PIC and ASM will monitor staffing levels, vacancies, skill mix and resident dependency weekly and will escalate any resource deficit requiring management action. These meetings have already commenced.

Resource requirements, including staffing, management capacity and transport, will be reviewed monthly by the ASM, Team Lead and PIC and reported through the local governance and reported to the CEO-Head of Service-ASM weekly meeting. These meetings have already commenced.

By April 30, 2027, the provider will demonstrate that the centre has the staffing, management and transport resources required to deliver care and support in accordance with the Statement of Purpose. Evidence will include staffing records, rosters, management structure records, transport arrangements and documented governance reviews.

Through our weekly CEO/HoS/ASM weekly meetings, the provider has implemented an effective governance and management system to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

All outstanding actions on the Quality Improvement Plan (QIP) will have a clearly identified responsible person, risk rating, required action, completion date and documented status. The QIP will distinguish between actions arising from HIQA inspections, provider audits, local audits and health and safety audits and will identify related or duplicate actions to ensure that actions are not unnecessarily duplicated.

There are currently 37 actions on our QIP, with 9 currently in progress. These actions primarily relate to staffing and physical works with associated completion dates up to April 30, 2027.

The PIC and TL supported by the ASM, will review the QIP fortnightly. The QIP will remain a standing agenda item at weekly local management meetings involving the PIC, TLs and House Coordinators (HCs). These meetings have already commenced.

Progress against high-risk and overdue actions will be reviewed at monthly governance meetings and barriers to completion will be escalated through the SMT.

Where an action is not completed within its agreed timeframe, the responsible manager will document the reason for the delay, identify the corrective action required and agree a revised completion date. Escalated actions will remain under management review until completed and verified.

Transport resources will continue to be monitored through the governance arrangements. Two rental vehicles remain available to support residents' access to healthcare, community activities and social opportunities while procurement of permanent vehicles progresses.

In relation to resident transitions:

- One resident has successfully transitioned from the designated centre to a nursing home following a comprehensive reassessment of their changing needs. The provider worked collaboratively with the resident, their representatives and the multidisciplinary team to facilitate a planned discharge to a service better suited to meeting their assessed care needs.
- One resident hopes to transfer to a proposed designated centre. The provider will progress the registration application for the proposed designated centre by September 30 2026 and will maintain a documented transition plan for the resident, including identified actions, responsible persons and target dates. Progress will be reviewed through the local governance process until the transition is completed.
- Residents will continue to be actively consulted throughout transition planning, with regular multidisciplinary meetings to review progress.
- One resident was discharged due to wish to return home to live with their family. CCOI in consultation with the HSE completed the transition process and was discharged on March 31 2026.

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

The provider will complete all outstanding premises works identified through the inspection and subsequent maintenance review and will ensure that the premises are maintained in a good state of repair internally and externally.

The Tigh Eoin laundry refurbishment was completed on 7 August 2026.

The remaining works are:

- remedial external works associated with previously identified water ingress;
- remediation of the identified roof-related/external defects; and

- completion of the external painting programme for Tigh Eoin.

All external outstanding works (except the external painting) will be completed by October 31 2026.

We await approval of funding and appointing of a contractor for external painting works. A contractor will be appointed by October 31 2026. It should be noted that seasonality and weather may impact the external painting and as such we expect it to be completed by April 30 2027.

Completion will be verified by the PIC and Property & Housing (P&H). Evidence of completion, including contractor records and photographic or other appropriate evidence, will be retained.

The PIC will complete weekly environmental walkarounds and outstanding premises actions will be reviewed weekly with P&H and the ASM. Monthly environmental audits will continue to ensure that completed works remain effective and any newly identified premises issues are risk assessed and addressed.

The provider will ensure that the premises remain in good repair and that identified defects are addressed within defined and risk-appropriate timeframes.

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	30/04/2027
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	30/04/2027
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/04/2027

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2027
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/04/2027