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 Ballymoney
Name of provider:	Camphill Communities of Ireland
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	09 July 2025
Centre ID:	OSV-0003633
Fieldwork ID:	MON-0047557

About the designated centre

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

Camphill Ballymoney consists of two units located in a rural community setting. Overall, the designated centre can provide residential services for a maximum of seven residents with support given by paid staff members and volunteers. The centre can accommodate residents of both genders, aged 18 and over with intellectual disabilities, Autism and those with physical and sensory disabilities including epilepsy. Facilities throughout the two units that make up this designated centre include kitchens, sitting rooms and bathroom facilities while each resident has their own bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 9 July 2025	09:30hrs to 18:30hrs	Marie Byrne	Lead
Wednesday 9 July 2025	09:30hrs to 18:30hrs	Conan O'Hara	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to provide assurance that residents were in receipt of a good quality and safe service 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 Chief Inspector of Social Services. The inspection was completed by two inspectors of social services over one day. Overall, the findings of this inspection were that residents appeared comfortable and content in their homes and were engaging in activities they found meaningful. However, improvements were required in relation to governance and management, staffing numbers, safeguarding and risk management and these areas will be discussed further in the report.

The designated centre consisted of two houses located a short distance apart in a small village, in close proximity to the sea. The designated centre provides care and support for up to seven residents with an intellectual disability. Inspectors had the opportunity to meet with the five of the six residents living in this centre at the time of the inspection. One resident was away from the centre on holiday with their family.

Inspectors spent time over the course of the inspection in both of the houses engaging with residents and observing aspects of their day. Inspectors also spoke with the four staff on duty, including a regular agency staff. In addition, they had an opportunity to briefly engage with two co-workers (live-in volunteers) and the newly appointed person in charge facilitated this inspection. The inspectors completed a walk around each of the three premises. In addition, inspectors reviewed documentation about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

Residents had a variety of communication support needs and used speech, sign language, vocalisations, facial expressions, and body language to communicate. Three residents told inspectors what it was like to live in the centre, and inspectors used observations, discussions with staff and a review of documentation to capture to lived experience of the remaining residents.

As noted, the designated centre consisted of two houses located a short distance from another. The first house was a two storey detached house which was home to three residents. The ground floor comprised of a kitchen and dining room, two sitting rooms, laundry and two resident bedrooms. The first floor comprised of an office, bathroom, two resident bedrooms, a sitting room and two spare bedrooms. Overall, the inspectors found that the centre was decorated in a homely manner and in line with the preferences of the residents.

On arrival to the first house, inspectors were informed that one resident was gone to day service, one resident was on holidays with their family and one resident was

having a lie on. In the afternoon, the inspectors had an opportunity to meet the two residents. One resident spoke with both inspectors briefly at lunchtime in the sitting room. They spoke about being happy living in the house and how important it was to them to continue to live there. They asked inspectors questions about their role and experience. They spoke about having a busy day the day before and their plans to relax today. They showed inspectors a knitting project they were working on. The second resident spoke with inspectors in the afternoon when they returned from day services. They were complimentary towards the staff team and spoke about their keyworkers and who they would go to if they had any worries or concerns. The resident informed inspectors that the same agency staff were supporting them on a regular basis.

The two residents showed inspectors around their home and showed them some of their favourite possessions. They showed inspectors their bedroom, bathroom and personalised sitting room. They spoke about activities they enjoyed on a regular basis and about the important people in their lives. They spoke about sharing their home with their peers and about feeling safe living in the centre. One resident spoke about experiencing difficulties sharing their home with one of their peers, at times; however, they stated they felt safe and could speak with staff if they had any worries or concerns. In the afternoon and evening, inspectors observed residents relaxing in the communal sitting rooms and spending time chatting to staff and a volunteer in the kitchen area.

The second house consisted of a two storey house and an adjacent apartment. The two storey house which could accommodate three residents comprised of three resident bedrooms, living and dining room, kitchen, utility, office and sensory room. The apartment was home to one resident and comprised of a living room bathroom and resident bedroom.

On arrival to the second house, one resident had left for day service, one resident was having a lie on and one resident had returned from a walk and was engaged in table top activities. One resident was planning to go to a local farmers market for a coffee. In the afternoon, the third resident had returned from day services. The inspectors observed the resident enjoying the sun on the patio engaged in sensory activities while the other resident was sitting with a volunteer in the sitting room while they read a book aloud to them.

The resident in the apartment invited an inspector into their apartment and showed them their home. It was decorated in line with their interests. The resident spoke of people important in their live and stated they were happy in their home. They informed the inspector of their healthcare needs and and upcoming procedure which they had been supported with. They spoke positively about the staff team and noted plans to exercise in the afternoon. Inspectors later returned to visit their home and they spoke about how much they enjoyed exercising with staff.

A number of premises works had been completed or were ongoing at the time of the inspection. There was a full-time maintenance staff working between this centre and a local day service. The provider had recognised that the premises of the second house was not fully meeting one residents' needs particularly relating to

their changing mobility needs. An assessment had been completed and additional equipment ordered. Inspectors were informed that the provider was in the early stages of exploring possible alterations to the premises to ensure the premises could meet the resident's mobility needs.

From speaking with residents and staff and reviewing documentation, inspectors found that activities residents were regularly taking part in included, attending a local active retirement group, attending adult education, going to a local gym, horse riding, spending time with their family and friends, attending a local knitting class, boxercise, karaoke, listening to music, completing puzzles and watching television and movies.

Two residents spoke about how important it was to them to be independent. They spoke about travelling and spending time at home and in their community independently, preparing and cooking their meals and taking part in the upkeep of their home. Residents were observed approaching staff when they required their support, and staff were observed to respond in a kind and caring manner. They were observed taking time to listen to and support residents in line with their wishes and preferences.

Staff were observed to respect residents' privacy in their homes. They were observed to knock on residents' doors before entering, to ask them before entering their rooms. They spoke with inspectors used person-first language and focused on residents' like, dislikes, strengths, talents. They also spoke about the ways in which residents contributed to their home and their community. A number of staff spoke about the staffing vacancies in the centre and the efforts made by the local management team to fill the vacancies.

Overall, inspectors found that residents were comfortable and content in their home and regularly taking part in activities they enjoyed. However, improvements were required in governance and management, staffing resources, safeguarding and risk management to ensure that residents continued to enjoy a good quality of care and a safe service.

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

Capacity and capability

Overall, inspectors found that improvements were required to governance and management. Inspectors found that improvements were required in relation to oversight by the provider, lines of accountability and authority, staffing numbers, safeguarding and risk management.

The local management team consisted of the person in charge and due to a number

of vacancies in the provider's senior management team, the person in charge was reporting directly to the Chief Executive Officer (CEO) at the time of this inspection. Inspectors were informed that a team leader had been recruited and were due to take up their post in the weeks after the inspection.

The centre was not resourced to meet residents' needs as staffing numbers were not in line with the required whole time equivalent (WTE)numbers detailed in the centre's statement of purpose. There were 7.5 WTE vacancies and while efforts were being made to ensure continuity of care and support, this was not sustainable.

Inspectors found that staff had access to training and refresher training in line with the organisation's policy. However, staff supervision was not being completed in line with the timeframes identified in the provider's policy.

Regulation 14: Persons in charge

Inspectors reviewed Schedule 2 documentation for the person in charge in advance of the inspection and found that they had the required qualifications and experience to meet the requirements of this regulation. During the inspection, inspectors found that they were full-time and present in this centre regularly since they had commenced in post two weeks before the inspection. Prior to this they had worked in this centre for a number of years as a member of the local management team in house co-ordinator and team leader positions.

Overall, inspectors found they were motivated to ensure that residents in receipt of a good quality and safe service, and where areas for improvements were identified they planned to follow up and bring about the required changes. It was evident from their interactions with residents on the day of the inspection that residents knew them well.

Judgment: Compliant

Regulation 15: Staffing

As previously mentioned, the centre was not fully staffed in line with the centre's statement of purpose at the time of the inspection. The WTE requirement identified in the statement of purpose was 14.5 WTE. There were 7.5 WTE vacancies at the time of the inspection which equated to 52% of the required WTE. Roles were advertised but there were no interviews scheduled for social care assistants or social care workers at the time of the inspection. Inspectors were informed the current vacancies were in place for approximately eight months.

Inspectors reviewed a sample of planned and actual rosters from May to July 2025. on in charge. These demonstrated that all the required shifts were covered and that

efforts were being made to ensure continuity of care and support for residents. However, 40% of shifts during that period were covered by agency staff. The rosters reviewed demonstrated that consideration was given to ensuring continuity of care and support for residents. For example, over an eight week period 35 shifts were covered by the same agency staff, and 17 shifts were covered by another agency staff.

Staff including the agency staff on duty, were complimentary towards the supports from the newly appointed person in charge. Regular staff also discussed the support they received from them during their time as a team leader. A number of staff spoke about the high levels of staffing vacancies and use of agency staff in the centre; however, they said that efforts were being made by the local manager to ensure that the same agency staff were regularly covering shifts in the same houses. The minutes of the may 2025 management meeting in the centre highlighted low staffing levels and the potential negative impact of this for residents if the situation continued.

Inspectors reviewed a sample of three staff files and the file of one live in volunteer (co-worker). These files contained the information required by the regulations. This included Garda vetting, reference checks and valid identification for staff.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, inspectors found that the designated centre was not adequately resourced to ensure effective delivery of care and support in line with residents' needs and it's statement of purpose.

There were recent changes in the senior management of the service which meant the lines of authority and accountability were not in line with the centre's statement of purpose. The statement of purpose outlined that 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 and the person in charge was reporting directly to the CEO.

In addition, the person in charge was supported in the management of this centre by a team leader. At the time of the inspection, the team leader position in this centre was vacant. The person in charge was in post two weeks and it was not clear who would be completing their supervision or induction. Inspectors were informed that interviews were scheduled for vacant management posts and that a team leader was due to commence in post in a number of weeks. However, the current structure did not provide assurances that there was adequate oversight and monitoring of this centre by the provider.

The provider's systems for oversight and monitoring not being utilised fully or

effectively in this centre. For example, the provider's Annual Review for 2024 had not been made available in the centre. In addition, for the six-monthly review completed in November 2024, 86% of actions remained outstanding. These actions were assigned to stakeholders who no longer worked in the organisation. The latest six-monthly review completed in May 2025 was comprehensive in nature and identified recurring areas for improvement in line with the findings of this inspection particularly relating to areas such as staffing numbers, an over-reliance on agency staff, staff supervision, the provider's annual review, risk assessment ratings, and restrictive practice reviews.

The impact of the vacant posts for (staff and senior management) in the centre included;

- Restrictive practices not being reviewed in line with the provider's policy due to personnel changes and quorum for the restrictive practice committee not being met,
- Incidents were not being reviewed by a member of the senior management team,
- Staff supervision was not being completed in line with the timeframes identified in the provider's policy. For example, no staff had received supervision in line with the provider's policy in 2024 and to date in 2025 one staff had supervision in line with the provider's policy,
- Delays advertising vacant role for administration staff for this centre,
- Management meetings for this centre not being attended by a member of the provider's senior management team since February 2025.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that residents were supported to take part in activities they enjoyed both at home and in their community. They were supported and encouraged to make choices and decisions and their independence was encouraged. However, inspectors found that improvements were required to ensure that incidents relating to allegations and suspicions of abuse were recognised and reported in line with the provider's and national policy, and to ensure that risk ratings were reflective of presenting risks in the centre.

For the most part residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. However, improvements were required in relation to incident trending and review and the risk ratings on risk assessments and this will be discussed under Regulation 26: Risk Management Procedures. There was a system for responding to emergencies and to ensure the vehicles were serviced and maintained.

The provider had safeguarding and protection policies and staff had completed safeguarding training. Staff who spoke with inspectors were knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse. However, inspectors identified two incidents which had occurred in the centre had not been recognised or reported as safeguarding concerns and this will be discussed further under Regulation 8: Protection.

Regulation 26: Risk management procedures

The provider's risk management policy contained the information required by the regulations. The risk register, general and residents' individual risk assessments were reviewed and found to be reflective of the presenting risks and incidents occurring in the centre. They were also up-to-date and regularly reviewed. However, the risk rating following implementation of control measures and additional control measures for some risk assessments required review. For example, the residual risk remained the same as the initial risk despite the implementation of a number of additional control measures.

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

Inspectors reviewed the systems to record incidents, accidents and near misses. The incidents trending report and a sample of incident reports for quarter one and quarter two 2025 were reviewed. Inspectors found that the majority of incidents were been reviewed and followed up on by the local management team; however they were not being reviewed by the provider's senior management team and this was captured under Regulation 23: Governance and Management. In addition, incident trending by the local management team was not identifying incidents which should be notified to the Chief Inspector of Social Services such as safeguarding concerns. This is discussed further under Regulation 8: Protection.

Judgment: Substantially compliant

Regulation 8: Protection

The provider's safeguarding policy clearly detailed staff roles and responsibilities should there be an allegation or suspicion of abuse. Staff had completed safeguarding training and three staff on duty spoke with inspectors about the open safeguarding plans in the centre. They spoke about the control measures in place and their responsibilities should there be an allegation or suspicion of abuse. They described the different types of abuse, some indicators of abuse and the reporting structures. For example, they told inspectors the newly appointed person in charge was the designated officer for this centre.

There had been a number of allegations or suspicions of abuse and inspectors reviewed documentation relating to these and found that they had been followed up on in line with the provider's and national policy. However, inspectors identified two incidents that could potentially meet the threshold requiring safeguarding reporting and follow up. These had not been recognised or reported by the staff team but had been picked up on in the provider's latest six-monthly review. However, that was completed in May 2025 and had not been followed up on at the time of the inspection.

Residents who spoke with inspectors stated they felt safe living in the centre. One resident spoke about experiencing some difficulties sharing their living environment with a peer but said they felt safe.

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 asset register recording residents' belongings.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Camphill Ballymoney OSV-0003633

Inspection ID: MON-0047557

Date of inspection: 09/07/2025

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: • ASM commenced in the role on 18.08.2025. • The PIC role was filled on 23/06/2025 • The vacant position of Team Leader has been filled on 28/07/2025. • 1 relief social care assistant commenced on 18-08-2025. This will provide for improved consistency in the centre. • An interview has been scheduled for a community admin for 26-08-2025. • A recruitment drive is underway nationally to recruit sufficient core staff. We continue to reach out to local education facilitators and promote positions in local newspapers, colleges and radio stations for maximum exposure. • 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. • Motion graphic videos and social media stories created and added to social media platforms and posted by lunchtime yesterday. • Social media platform sponsored campaigns are currently being set up and should go live by close of business on 29/08/25 • Emails have been sent to company covering 5 regional newspapers o request newspaper advertising rates and potential charity discounts. • Radio advertising has already been agreed, paid for, and is currently on air as of 19 August 2025 on three radio stations, with 36 prime-time on-air adverts/mentions scheduled. In addition to this - Radio advertising inquiries have been sent to an additional four radio stations, and we are awaiting their rate cards. • Two recruitment testimonials will be filmed next week featuring a representative of the community. This will be a 60-second testimonial video, shared across all social channels, an online social media platforms, including local groups for free. • We also plan to post ads in five relevant community groups 09/09/25. • Ballymoney Community in Camphill utilise a cohort of agency staff who are familiar with the residents' needs and consistent on the roster where possible.	

• All staff currently utilised via agency have been trained as per CCOI training requirements.
• All staff currently recruited via agency have access to CCOI systems and are inducted fully to meet the needs of all community members.
• All agency staff receive supervision in line with CCOI policy
• All agency staff have completed mandatory training as per CCoI policies and are fully inducted, with access to all required systems to ensure safe and effective care. As confirmed by PIC on 19/08/2025, there are currently no outstanding staff inductions. This is reviewed by the Compliance officer during review of staff files.
• Supervision for agency staff is in place, aligned with CCoI's supervision policy to ensure ongoing professional oversight. This is reviewed by the Compliance officer during review of staff files.
• Rosters continue to be reviewed daily to ensure adequate, qualified, and experienced staff are available to meet residents' assessed needs.
CCoI remains fully committed to achieving full compliance with Regulation 15 and will continue to review and update the workforce plan to reflect changing needs and regulatory expectations. Ongoing internal audits and oversight mechanisms are in place to ensure the effectiveness of staffing arrangements and their impact on residents' outcomes.

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 Ballymoney was conducted on 20/08/25
· An introductory meeting was held with the PIC on 20/08/25 to begin induction and agree on a short-term plan.
· 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 20-08-2025. The ASM will check-in daily via videoconference.
· The ASM will conduct a full audit of the Ballymoney Designated Centre. This will involve more frequent site visits initially.
· A Quality Enhancement Plan (QEP) will be developed based on the audit, to be completed by 31st October 2025.
· All staff in Ballymoney were informed of the new ASM and updated lines of authority via email on 19/08/25
· The ASM, National Safeguarding Lead, Medication CSO, and Behavioral CSO will attend the monthly Community Management Meeting (CMM), scheduled for the first Wednesday of each month. The first will be on 03/09/2025.
· ASM will hold weekly regional meetings with PICs, with the first one planned for 02/09/2025

· ASM will also attend the weekly Senior Management Team meetings, starting Friday, 22nd August 2025.
· A full-time Person in Charge (PIC) is currently in the post and actively fulfilling their statutory duties under the Health Act 2007.
· The Head of Services position is currently vacant, and interviews are scheduled for 28.08.2025.
· In the meantime, the CEO is covering the responsibilities of the Head of Services to maintain continuity of governance.
· The Health and Safety Officer is due to carry out a full audit as per schedule of audits.
· The Compliance Officer conducted a full-service review in May 2025.
· The Clinical Support Officer for Medication is scheduled to complete the annual medication audit on 09.09.2025.
· The Behavioral CSO commenced in the role on 05.08.2025. A site visit is organized for 21.08.2025 and will continue to visit the site monthly, or more frequently if needed. They attend team meetings each month where there are behaviors that challenge and provide 1:1 staff debriefs after incidents. They are available Monday to Friday, 09:00–17:00, by Teams or mobile. The staff team will utilize this support regularly.
· The National Safeguarding Lead is working with the PIC to analyze safeguarding trends to support learning during team meetings. To be completed and ready for shared learning for September's staff meetings beginning 03/09/2025.
· The SOP was reviewed on 19/08/2025 by the National Operations Support Officer and the PIC. The current management structure is as follows:
Board → CEO → Head of Services Vacant (Interviews Thursday 28th August 2025) → ASM → PIC → Team Leader x1 → Social Care Team
· The Learning and Development officer holds monthly meetings to support PICs and Admins in fulfilling training obligations for staff members, supporting booking and planning training. The next meeting will take place on 10/09/2025.
· The Compliance, Safeguarding and Risk Manager provided revised templates for risk assessments, and they will be completed by the PIC by 05.09.2025
· Supervision for PIC with ASM has been scheduled for 29/08/25
· Restrictive practices were reviewed by PIC and CSO on 21/08/25
· ASM was inducted into the incident management system 19/08/2025 and will begin reviewing incidents in real time.
· An on-call roster is in place to support staff outside regular working hours.

· The SOP for On-Call, outlining the roles and responsibilities of the PIC, ASM, CEO, and Head of Services, was shared with the staff team again on 21/08/25.
· The supervision schedule has been reviewed, and all staff have now been scheduled for their formal supervision. These will be completed by the PIC by the 19-09-2025.
· Provider review actions will be reviewed by the PIC and ASM on 29-08-2025 and an action plan for implementation will be agreed.
· The PIC and ASM will conduct fortnightly governance meetings to discuss issues impacting the service. This commenced with an initial meeting to discuss resident needs and current issues on 21-08-2025.

Camphill Communities of Ireland (CCoI) remains fully committed to upholding the highest standards of governance, leadership, and accountability across all designated centers. The actions outlined above reflect a targeted and strategic approach to strengthening local and national oversight, ensuring that services are both compliant with

Regulation 23 and responsive to the evolving needs of residents.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• A thorough review of the risk register and risk assessments will be undertaken as part of the baseline audit by the ASM by 30-09-2025.

• The new ASM was inducted into the incident management system 19/08/2025 and will begin reviewing incidents in real time. This provides for increased layers of oversight to ensure incidents are directed through the appropriate processes.

• The Compliance, Safeguarding and Risk Manager provided revised templates for risk assessments, and they will be completed by the PIC by 05.09.2025

• Where behaviours of concern from residents' impact on other resident's, appropriate risk assessments will be developed to capture and monitor this risk. Information for this review will be gathered by staff knowledge of the residents, the baseline regulatory audit, the residents feedback document, compatibility assessments, SVP and incident management data. The review and development of appropriate risk assessments will be completed by the PIC and ASM by 30-09-2025.

• All staff have resumed use of the digital incident management system which will support timely reviews, and trend analysis by all relevant professionals/management. Both the new PIC and ASM have been provided with access to this system and have been inducted into the system.

• A new Clinical Support Officer (CSO) – Behavioural Support has been appointed and commenced on 05.08.2025 in CCOI. This results in each CSO being able to concentrate solely on their associated centres within their regions.

• The Clinical Support Officer for Medication is scheduled to complete the annual medication audit on 09.09.2025.

• 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.The audit and quality improvement plan will identify areas for improvement in the centre, not just those highlighted in the inspection report, and actions to address those areas in a timely and efficient manner, thereby providing a path forward.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The incidents highlighted on the inspection date have since been processed in line with CCOI's policy on safeguarding, with regulatory notifiable requirements now completed.

• The new ASM will complete the Designated Officer training online by 26-08-2025.

• The new ASM will attend a meeting with the safeguarding lead on 26-08-2025 for a full induction into the services process.

• The new ASM will attend the Designated Officer safeguarding training provided by CCOI on 28-08-2025.

• The PIC is scheduled to complete the DO refresher on 26th and 28th August 2025.

• The Team lead is scheduled to complete the DO refresher on 26th and 28th August 2025.

• The PIC will ensure an accessible poster is readily available in communal areas of the designated center detailing who the designated officers are, along with the deputy designated officer by 29-08-2025 to contact in event of management absence. This updated information and the new poster will be discussed at the residents meeting by staff on 31-08-2025. Any resident who does not wish to attend the residents meeting will be informed individually of the change by 31-08-2025.

• The ASM will ensure all staff and PIC have read and signed the CCOI safeguarding policy by 30-09-2025, regardless of whether previously completed or not.

• The new ASM has read the CCOI safeguarding policy.

• ASM was inducted into the incident management system 19/08/2025 and will begin reviewing incidents in real time. This will ensure all incidents are subject to senior management review, improving layers of governance and oversight and ensuring appropriate processes are followed.

• Incident management and Safeguarding are a standing agenda on team meetings and governance meetings.

• The National Safeguarding Lead will be notified of all safeguarding incidents to ensure appropriate oversight and to facilitate joint review with the Person in Charge (PIC). This process will ensure that all statutory notifications to HIQA and SPT are submitted in full compliance with regulatory timeframes.

• A review of all safeguarding plans/NF06s will be undertaken by the PIC by 19/09/25 to

ensure all actions have been implemented and the effectiveness of same has been assessed.

• A full review of existing behaviour support plans will be undertaken by the PIC to ascertain if all are in date, in line with incident management data, and relevant to the current situation and needs. The PIC has enlisted the support of the CSO in relation to any outstanding reviews, outstanding interventions, new behaviours, increases in behaviours, and requirement for new strategies should current strategies be identified as ineffective. This process will be completed by 27/08/25.

• Where behaviours of concern from residents' impact on other resident's, appropriate risk assessments will be developed to capture and monitor this risk by the PIC with the support of the ASM. Information for this review will be gathered by staff knowledge of the residents, the baseline regulatory audit, the residents feedback document, SVP and incident management data. The review and development of appropriate risk assessments will be completed by the PIC and ASM by 31.09.2025.

• The Restrictive Practice Policy was reviewed on 18.08.25 and the Compliance, Safeguarding and Risk Manager is currently working with IT support to update the reporting flow on the system. The policy will be issued to staff when flow had been updated, and the policy has been signed off by the Provider. This will be completed no later than 10.09.25. Following the review of the policy, the Restrictive Practice Committee will convene by 30.09.25 and going forward will convene on a quarterly basis for review of all restrictive practices. In the event unplanned or emergency restrictive practices that require implementation, a process will be followed to ensure these are reviewed by the panel within a timeframe not exceeding 3 working days.

• Restrictive practices are now a standing agenda on staff team meetings and local governance meetings.

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	31/12/2025
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.	Substantially Compliant	Yellow	31/12/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/10/2025

	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	31/10/2025
Regulation 23(1)(d)	The registered provider shall 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.	Not Compliant	Orange	30/09/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a	Substantially Compliant	Yellow	30/11/2025

	written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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 responding to emergencies.	Substantially Compliant	Yellow	30/11/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/07/2025