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 Community Dingle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	03 July 2025
Centre ID:	OSV-0003609
Fieldwork ID:	MON-0047545

About the designated centre

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

The designated centre is a large detached two-storey house located in a rural area outside a small town. The centre can provide residential services for a maximum of eight residents of both genders, over the age of 18. Residents with mild to moderate intellectual disabilities, physical disabilities, sensory disabilities and autism are supported. Support to residents is provided by the person in charge, a team leader, social care workers, social care assistants and volunteers. Each resident has their own bedroom. Other facilities in the centre include bathrooms, a sitting room, a dining room, a kitchen, a utility room and a staff office.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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	14:30hrs to 23:30hrs	Kerrie O'Halloran	Lead
Thursday 3 July 2025	14:30hrs to 23:30hrs	Lucia Power	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 Chief Inspector of Social Services.

This designated centre had recently been inspected in March 2025, which found a high level of non-compliance with the regulations. This inspection reviewed a number of the regulations to ensure the provider had put the agreed measures in place to come into compliance in the agreed time lines.

This centre is registered for a maximum of eight adults to live in the centre. On the day of the inspection seven residents lived in the centre. The inspectors had the opportunity to meet six of the residents on the day and evening of the inspection. The inspection was completed by two inspectors over the course of one day. The inspectors commenced the inspection in the afternoon in order to meet the residents and staff in the designated centre and observe practices in the centre to gain insight into the daily routines for the residents.

On arrival the inspectors were greeted by a member of staff. The inspectors signed into the visitor's book and asked the staff on duty if residents would like to meet them. The inspectors sat and spoke to one of the residents who had come to greet the inspectors. The resident informed the inspectors that the person in charge had changed since the last inspection. The resident spoke about the high number of changes to the person in charge over the past few months and said this had effected them at times. The resident told the inspectors that visitors came to the centre to complete audits. The inspectors asked the resident if they were happy and safe in their home, they informed the inspector that they were happy most of the time but they had made a complaint to staff about a resident in the house making noise at night. The resident told the inspectors the staff were nice and treated them well. The resident had recently enjoyed a day trip on a boat and spoke about going to the local town for food and shopping which they enjoyed.

The inspectors were informed that one resident was relaxing in their bedroom. The inspectors asked the staff member if they could ask the resident if it was ok to meet with them. The inspectors observed the staff enter the resident's bedroom without knocking on the resident's door. The inspectors followed and knocked on the door and introduced themselves to the resident. The staff informed the inspectors the resident was going to the local pub later in the day. The resident had chosen an outfit for their trip. The resident had limited verbal interaction with the inspectors but did inform them with some gestures and words that they were happy. The resident told the inspectors they were feeling sore, the inspectors informed the staff

on duty. The person in charge later informed the inspectors that the recent had been unwell recently and had been support to see their general practitioner.

The inspectors had the opportunity to meet the person in charge of the designated centre. This person had been recently appointed to the position and commenced the role on the 17 June 2025. The person in charge assisted the inspectors for the duration of the inspection and were found to be knowledgeable of the residents and their needs. The person in charge had a remit of this designated centre and also had oversight and management duties of the day service located nearby the centre. The person in charge was committed to ensuring oversight would be in place to ensure compliance with the regulations in the future. However, during this inspection it was note that the provider had not come into compliance with regulations from the last inspection within the agreed time lines from the compliance plan. The person in charge was aware of this, however on this inspection it was seen that not all information had been provided to the newly appointment person in charge to ensure this could happen. For example, the person in charge had not been provided with updated action plans as a result of provider audits that the provider had committed to oversee see the last inspection, these audits formed part of the assurances given to the Chief Inspector.

Later in the inspection the inspectors had the opportunity to meet other residents who had returned from their day service. One resident was relaxing in the sitting room when an inspector greeted them. They informed the inspector that they were happy in their home, felt safe and liked the staff. They also spoke to the inspector about farming which they enjoyed.

An inspector spent some time in the evening observing residents in their home environment. During this time one resident began to become vocal. The staff member began to assist and support the resident. The inspector observed the staff member request assistance promptly from another member of staff and they supported the resident. This resident has a behaviour support plan in place which the inspector had reviewed. It was observed that the resident was not supported as per the guidelines on their behaviour support plan, this included abruptly assisting the resident to a standing position while not using hand over hand techniques as identified.

In summary. From what residents told us and what the inspectors observed, residents engaged in activities they enjoyed and appeared overall happy in their home. Ongoing improvement was required in relation to governance and management, staff training and development, statement of purpose, individualised personal plans and care plans, health care, protection and residents rights. Overall on this inspection it was found that the provider had not come into compliance with a number of regulations. Urgent actions were issued to the provider under regulation 23 governance and management and regulation 34 complaints. This will be discussed in the next two sections of the report.

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

This risk inspection was carried out following the receipt of solicited and unsolicited information and to monitor the providers compliance with the regulations from the previous inspection in March 2025.

The provider did not have good management systems in place and on the day of inspection were found not to have monitoring systems in place that were being reviewed to ensure residents care was monitored effectively. There was also no evidence that the newly appointed person in charge was given a handover in relation to the identified actions and updates that formed part of the providers assurance given to the Chief inspector to comply with the regulations.

This designated centre had recently been inspected in March 2025. During this inspection a high level of not compliance was found with the regulations, with two urgent actions issued. Following the inspection in March the provider had submitted assurances in March and April to the Office of the Chief inspector, as to how the provider was going to come into compliance with the regulations within an identified time frame.

From the findings in this inspection the provider had not come into compliance with a number of regulations, the provider also failed to implement a number of actions identified in their response to the Chief Inspector. The provider had been issued with a warning letter as a result of the findings on the last inspection. The provider's response to the chief inspector was also reviewed on the day of inspection and actions identified on this were noted and observed not to have been implemented.

Due to the findings on this inspection the registered provider was requested to submit an urgent compliance plan with regard to the governance and management and complaints of the designated centre. This will be discussed under Regulation 23 and Regulation 34.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 14: Persons in charge

There was a full-time person in charge employed. The person in charge was responsible for this designated centre and the day service located nearby. The person in charge was in their post since June 2025 and knew the residents very well due to their previous roles with the provider.

The person in charge met with both inspectors during the inspection and assisted the inspectors for the duration of the inspection. The person in charge described the residents social, health care needs and supports required as per their assessed needs. The person in charge discussed with the inspectors supports they had requested from the provider to assist them in their roles and they were aware of the progress that was required to improve the designated centres compliance with the regulations. It was clear that the person in charge was knowledgeable and clear in the skills that were required in leading a team and ensuring residents received a high quality service.

The person in charge was supported in their role by a house coordinator. The local management structure in place at the time of the inspection had vacancies and this was not supporting or ensuring effective governance, operational management and administration of this centre. This will be discussed under Regulation 23, governance and management.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the centre was resourced and a consistent staff team was in place based on the assessed needs of the residents. The inspectors reviewed a sample of rosters from April until the end of July 2025. The centre had vacancies of just over half of the whole time equivalent, however the provider was recruiting for these positions and had ensured these vacancies were covered with regular and familiar internal relief staff and agency staff. The rosters viewed had been maintained and clearly indicated the staff on duty. On the day of the inspection there was four staff on duty and the person in charge.

The centre also had volunteers in the centre. The centre could accommodate up to two volunteers, at the time of the inspection one volunteer was in place. The volunteer also covered shifts in the centre and these were clearly identified on the roster.

The inspectors reviewed the induction records for staff in the centre. These were in place and had been completed with new staff working in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix for the centre. On the last inspection in March 2025 the provider had identified a number of trainings would be completed. On this inspection it was found that some of these training had not been completed by all staff such as:

- Applied safeguarding training. Some staff were still outstanding on this training. All staff had completed safeguarding training.
- Key working skills and risk assessments; the inspectors were informed this had been rescheduled and due to take place in July.

Other training courses had not been completed by all staff working in the centre to support the assessed needs of the residents. This included:

- Four staff required behaviour support training
- Two staff required medication training.

Overall inspectors did note improvement in the staff training records since the previous inspection. The staff team had all completed supervision

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre had been previously inspected in March 2025, during this inspection an urgent action was issued under regulation 23. Following the inspection a warning meeting took place with the provider and a warning letter was issued. This was due to the high level of non-compliance with the regulations. The provider submitted a response to each which outlined how they would come into compliance with identified time lines. During this inspection it was found this required review as the provider had not achieved a number of the actions they had provided to the Chief Inspector as assurances. For example:

- The provider outlined they would be in compliance with regulation 23 by the 21/03/2025, ensuring management systems would be in place with the head of services on site each week to review actions and in their absence a suitable nominated person would be present. This was not found to be in place on the day of the inspection.
- A dedicated person in charge in a full time role. The designated centre had a person in charge in place in a full time position, however they also had responsibility of a day service located nearby.

- The provider had identified an unannounced provider audit would take place, this had not taken place since the last inspection in March 2025.
- A number of regulations found not compliant in the March 2025 inspection were again found with compliance issues during this inspection, this included, regulation 3 statement of purpose, regulation 16 staff training and development, regulation 8 protection, regulation 5 individual assessments and personal plans, regulation 5 health care, regulation 28 fire precautions and regulation 9 residents rights.
  Further improvement was required.

The provider had lines of authority and accountability and a structure in place for governance and management identified and outlined, however due to changes in staff personnel not all positions were currently filled. This has resulted in, out of necessity, an altered and reduced management structure which weakened the stated governance plans and oversight of the designated centre and organisation. At the time of the inspection the person in charge of the designed centre was reporting to the CEO of the organisation.

The person in charge was supported in their role with a house coordinator. The house coordinator assisted the person in charge with delegated duties. Since the person in charge commenced their role they had requested a number of audits to be completed in the centre. On the day of the inspection the centre was undergoing a medication audit by the providers clinical support officer. The day prior to the inspection the centre had undergone a fire door audit by an external contractor in the area of fire safety. The person in charge discussed with the inspector that these reports would be available in the coming days or weeks after the inspection with action plans to be completed.

The centre had a reliance on the current person in charge to fulfil multiple roles such as, oversight over the day service and the designated centre. Given the high level of non-compliance's found repeatedly in this designed centre in March and June 2025 inspections and the lack of governance oversight this needed to be improved and reviewed. The role of the person in charge had undergone a number of changes this year. Since January 2025 there had been four person in charges in the designated centre. This included the current person in charge, who was identified as covering the position for an interim period until the role would be permanently. The provider was actively recruiting for this position.

The provider had put in place a schedule of audits for 2025. Inspectors found that some audits had occurred since the last inspection. These included an annual health and safety audit which was completed in April 2025 and Quarterly care and support audits in April and May 2025. These audits contains actions plans with assigned time lines and a person responsible to complete. However, a number of actions in place from these centre audits had not been completed within the providers own identified time line. For example, the health and safety audit identified a number of risk assessments to be completed such as lone working. This had been completed on the centres risk register but was still highlighted as overdue for completion since 30

April 2025. This required review to ensure action plan were being reviewed and monitored.

The inspectors reviewed the centre's staff meetings. These were occurring weekly. Residents were being supported weekly with community meetings. The inspectors reviewed minutes of two management meetings that had taken place in April and May 2025. These meeting included review of weekly reports such as incidents and notifications of events, goals and supports for residents, complaints and compliments, audits.

The absence of a governance structure had hampered the compliance plan response, warning response and urgent action response previously presented to the Chief Inspector by the provider after the March 2025 inspection. As stated actions for improving the compliance with the regulations had not been achieved in the time lines identified. As mentioned, the provider had not ensured appropriate actions had been taken in line with the compliance plan response from the inspection completed on 21 March 2025. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose and function for the designated centre. This is an important governance document that details the care and support in place and the services to be provided to the residents in the centre. This required review to ensure the organisational structure was correct.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the designated centre and this was reviewed by the inspectors. The Office of the Chief Inspector had not been notified of the occurrence of all incidents in line with the requirement of the regulations. An incident that took place in June 2025 had not been notified, this incident was of an allegation, suspected or confirmed, of abuse to a resident. The inspectors had also reviewed all notifications submitted since the previous inspection in March 2025, two of these notifications had been submitted over the required time frame of three working days.

Judgment: Not compliant

Regulation 34: Complaints procedure

On the day of the inspection the inspectors reviewed the complaints log for the centre. The designated centre had a complaint policy in place, this had been reviewed in April 2025. The centre had one open complaint relating to the care of a resident, which had been received on the 16 May 2025. On the 19 May 2025 the complaint had been recorded on the centres complaint analysis record, however details of any findings, recommendations and actions taken were not completed. This did not provider assurance that this complaint had been addressed. The registered provider had not ensured that all complaints were investigated promptly. A record of all details of any investigation into the complaint, outcome of the complaint and action taken was not present on the day of the inspection.

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk as it related to a concern expressed about a resident. The provider's response post inspection did provide assurance that the risk was adequately addressed.

Judgment: Not compliant

Quality and safety

Overall the residents in this centre appeared happy and content in their home. Residents spoken with complimented the staff saying they were nice to them and treated them well. The staff team appeared to be committed to delivering good care and support to the residents. Although as mentioned earlier in the report some incidents that occurred were not managed as per the assessed needs of residents and this required review to ensure staff in the centre were provided with additional training and support where required.

Inspectors also viewed some good care practices in the centre such as staffing ratios in place as per residents assessed needs. Along with staff engaging with residents in conversations. Areas required improvement such as residents' rights, individual assessments and personal plans, fire precautions and health care to ensure residents were receiving a high quality service.

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. For example, risks were managed and reviewed through a centre specific risk register and individual risk assessments. The centres risk register had been recently reviewed on the 24 June 2025 by the provider's safety officer. The centre had identified risks in a number of areas such as risk of injury, falls and harm to visitors, staff and residents. The provider had two risks in place for the non-compliance with regulatory standards due to recruitment and retention of staff and insufficient resources. These risks had identified action in place such as ongoing recruitment.

Individual risk assessments were in place for residents and had been reviewed. The person in charge had identified risks in areas such as behaviour supports, fire safety, abuse and non-compliance with the regulations.

The health and safety audit identified a number of risk assessments to be completed such as lone working. This had been completed on the centres risk register.

Judgment: Compliant

Regulation 28: Fire precautions

Fire-fighting systems were in place to include a fire alarm system, fire doors, fire extinguishers, and emergency lighting/signage.

The inspectors noted a number of fire doors appeared to have gaps or did not close fully. Some doors were also distressed in appearance. The person in charge informed the inspectors that a fire safety audit had taken place the day prior to the inspection and this audit reviewed the fire doors in the centre. This audit had not yet been furnished to the provider on the day of the inspection. The person in charge informed the inspectors that actions identified in relation to these fire doors would be completed promptly.

There was a procedure in place for the evacuation of the residents, volunteers and staff on duty in the centre.

The inspectors requested to review the fire drills that had taken place in the centre since the previous inspection. Planned fire drills had taken place in the centre. However, the time of one fire drill reviewed took over four minutes to complete. The inspectors reviewed the provider's fire safety policy however this did not confirm a time duration for the safe evacuation of the premises. In the following days after the inspection, the person in charge confirmed that the safe evacuation time for Camphill Dingle is four minutes. No action had taken place after this fire drill had been completed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed four residents' personal plans. Personal plans were kept in a locked press in the office. The person in charge informed the inspectors that since the previous inspection they were in the process of reviewing and updating all personal plans to a new format.

As per the findings on the previous inspection, the residents personal plans reviewed by the inspectors had not all been fully updated to reflect support needs or changes in the residents lives. For example, goals were not evident for all residents and some goals reviewed were not meaningful for residents. Not all residents' personal plans were available in accessible format as not all information had been updated and placed in resident's accessible plans.

One resident's personal plan had been updated to the new format. This plan was seen to be updated regularly, containing information regarding the resident's goals they had completed this year along with pictures. The inspector spoke to the resident and they discussed these goals, such as attending marts and farming achievements. The resident appeared happy about achieving these. This personal plan contained detailed information about the resident such as likes, dislikes, method of communication and intimate care plan.

Some improvement had taken place since the last inspection and residents were now completing regular keyworker meetings with residents. However, some of these meetings reviewed identified aspirations for residents and these had not been clearly documented as goals in the personal plan.

Judgment: Not compliant

Regulation 6: Health care

The inspectors reviewed the health care supports in place for residents, having regard to that in the resident's personal plans.

As per the findings on the previous inspection, from the four personal plans reviewed the inspectors found that the residents were not fully being supported with their identified health care needs.

The inspectors reviewed the daily notes for one resident, this resident had been advised by their physiotherapist to complete daily exercises. The inspectors reviewed a sample of record from June 2025 and it had not been documented that the resident had completed these exercises. This had been a finding on the previous

inspection. This resident did have a support plan in place which also identified daily exercises to be completed as per physiotherapist recommendations.

One residents file had been updated did reflect health care plans for identified needs such as a diabetes health care plan. This plan contained details for staff on how to support the resident such as attend chiropody ever six to eight weeks. This was seen scheduled for the resident on a health care planner and these appointments had taken place and were planned for the year. However some improvement was required. This resident was in the process of managing their weight which had been identified in their diabetes health care plan. The resident was prescribed medication to assist them, monthly weight charts were also being completed. The resident had a dietitian guidance plan in place but this support plan had been completed in August 2022. Although the resident had phone consultations with a dietitian the dietitian plan had not been updated to reflect the resident current health care needs and supports. The resident had no weight management health care plan in place to support staff or the resident with their assessed need and goal.

Judgment: Not compliant

Regulation 8: Protection

The inspector reviewed the safeguarding plans in place for the designated centre. The centre had an open safeguarding plan in place. The interim safeguarding plan had been completed in May 2025 and identified control measures in place with time lines for these to be completed and/or reviewed. However on the day of the inspection the interim plan reviewed did not have evidence that further review had taken place as it was not documented or a status update had not been completed. This required review to ensure interim safeguarding plans were being reviewed.

The person in charge spoken with during this inspection demonstrated an awareness of how and who to report safeguarding concerns to. Training records provided indicated that staff had completed safeguarding training, however not all staff had completed applied safeguarding training. This was discussed under regulation 16 staff training and development.

During this inspection, a resident informed the inspectors that they have been woken during the night by another resident living in the centre. When inspectors spoke to the person in charge and some staff on duty regarding this it was identified that a resident may wake at night or go to sleep later some nights but they were unaware that this had effected other residents living in the centre. From a sample of daily notes reviewed for one resident in June it was documented on one daily note that the resident had been vocal and active during the night and disturbed other residents. It also recorded that the resident had been to their general practitioner due to illness. This required review to ensure residents had not been impacted.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider ensured residents were consulted and encouraged to participate in how the centre was run. Residents meetings were taking place regularly where health and safety, rights, safeguarding meal planning and activities were discussed. Residents were also supported with regular key worker meeting to discuss any upcoming plans or plans for the further.

The inspectors found that some practices did not always respect resident's privacy and dignity. For example, when the inspectors requested to greet a resident who was in there bedroom, the inspectors observed the staff member entering the room without knocking on the residents door first. A sideboard located in the hallway contained documents relating to one resident. This contained personal information for the resident. This required review to ensure the residents autonomy.

As mentioned the inspectors reviewed the compliant records for the centre. While reviewing these records it had been documented on a complaint analysis that a resident lacks capacity. There was no other evidence in place that this resident capacity had been assessed that they lack capacity, therefore this required review to ensure the rights of the resident were supported and promoted.

The inspectors did hear staff verbally interacting with residents in a kind and caring manner. Such as, asking resident if they would like a drink or snack and discussing their day with them. Residents had intimate care plan in place to support and guide staff on residents needs and wishes.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Camphill Community Dingle OSV-0003609

Inspection ID: MON-0047545

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Monthly Meetings with Dingle Admin and National Training officer are taking place where training needs for each community are discussed. Meeting minutes are available on SharePoint.

• Quarterly meetings are held with the organisation's Training Officer, Admin, ASM and PiC where progress of training and feedback on compliance of training tracker is discussed.

• Training is a standing agenda item at the Community Management Meetings where training needs are discussed including the status of staff training needs and provision.

• Admin completing Bimonthly Schedule 2 Training and Supervision Audits on viclarity for assigned departments within the community every 2 months where clear actions are set out with timeframes for completion.

• Applied Safeguarding Training; As of 02/08/2025, All staff inclusive of Agency have completed Applied Safeguarding Training.

• Key working Skills; As of 15/07/2025, All fulltime residential staff have completed this training.

• Risk Assessments Training; As of 15/07/2025, All fulltime residential staff have completed this training. This will be rolled out to the remaining staff and completed by 30.09.2025

• Person Centred Care (PCP) Training for all fulltime residential staff will be completed by 30/09/2025. As of the 05/06/2025, All full-time residential staff have completed this training. This will be rolled out to the remaining staff and completed by 30.09.2025

• Low Arousal Behavioural Support Training: All staff, with the exception of 3 have completed Low arousal training. These 3 outstanding staff will have this completed by 31/10/2025.

• Medication Training: The staff who require medication training have been booked to completed on the 22/10/2025. In line with policy, they will not be administering medication until trained to do so.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Area Services Managers (ASM)
• The ASM commenced on 05/08/2025 and will be onsite in Dingle once a month to support the new PIC in the role.

The Area Services Manager (ASM) will be inducted into facilitating weekly Regional Huddles with their respective communities. These forums will address, but are not limited to, incident and accident trends, resident updates, identified learning, maintenance concerns, and any additional supports required by the community. The ASM will be responsible for escalating relevant matters to the appropriate departments and to the Senior Management Team.

o In addition, the ASM will participate in weekly Senior Management Team meetings, where cross-service matters—including maintenance, finances, compliance, risk and safeguarding, and human resources—are reviewed. This process will support the promotion of shared organisational learning and continuous improvement across services.

The ASM will have governance and oversight through the named action points below:

o Community Engagement & Oversight
Attend each community's management meeting on a monthly basis to ensure governance and oversight in terms of the running of the designated centre. The monthly management meeting includes an in-depth discussion on each resident including their needs and supports the require regarding MDT support. Discussions occur in relation to safeguarding, risk management and restrictive practices within the community as well as any maintenance issues requiring action. Additionally, during the monthly management meeting, a full review of any audits that occurred in the previous months is undertaken ensuring any identified actions are being closed off within the specified timeframes.

• Conduct in-person visits to the community at least once per month. A full walk around will be completed by the ASM on visits to the centre to ensure the centre is working in line with the regulation and following the inspection actions in terms of premises upkeep. Conducts professional supervision with the PIC in line with CCOI policy.
• ASM will liaise via teams with the PIC daily to provide support and to ensure they are attuned to the daily operations within the centre.

Conduct in-person visits to the community and Review:

o Incident Review & Risk Monitoring
o Regional huddles & Information Sharing implementation
o Resident Finance Reviews
o Data Collection & Reporting
o Audit Oversight & Compliance

Person in Charge (PIC)

• New PIC appointed expected start date 01/09/2025. A structured handover period will be implemented to facilitate a seamless transition from the outgoing Person in Charge (PIC) to the newly appointed full-time PIC. This process will ensure the incoming PIC is fully supported in becoming familiar with the operations of the designated centre, as well as with all ongoing actions and the established compliance plan.

The PICs will have governance and oversight through the named action points below:

• Leadership & Oversight
Provide day-to-day operational leadership, ensuring high-quality, person-centred care and support. There will be a permanent PIC in post within the centre who is present in the community Monday to Friday on a weekly basis. The PIC will be available to the staff and residents offering support and guidance.
Safeguarding & Protection
• Implement and monitor safeguarding measures to protect residents from harm, ensuring prompt action on concerns.
Incident Management
• Oversee the reporting, investigation, and follow-up of incidents via ViClarity, ensuring timely closure and trend analysis. Any corrective actions following incidents will be promptly implemented.
Staff Management & Supervision
• All new staff will be appropriately inducted into the community by the PIC and House Co-ordinators including but not limited to induction to the residents, the guidance documents on how best to support the residents – behavioural support plans, care plans, risk assessments, restrictive practices and live safeguarding plans.
Audit & Quality Assurance
• Conduct and follow up on audits, ensuring corrective actions are implemented and evidenced.
Resident Rights & Advocacy
• Promote and protect residents' rights, autonomy, and participation in decision-making by ensure residents meeting occur weekly, residents are involved in their annual review, circle of support meetings and subsequent contribution to their person-centred plan (PCP).
Care Planning & Reviews
• A full review of all residents needs assessments is currently underway. This will be completed by 29.08.2025.
• Following the completion of the needs assessments, support plans will be reviewed and updated in line with the assessed needs. This will be completed by 22.09.2025. Once complete all support plans will be regularly reviewed and updated where required within a timeframe not exceeding twelve months.

• Maintain effective communication with residents, families, staff, the Provider, and external agencies, and provide accurate reports as required.

• The Person in Charge is also supported by:
o The National Safeguarding Lead
o The Compliance, Safeguarding and Risk Manager
o The Quality and Compliance Officer
o The Health and Safety Officer
o Clinical Support Officers
to ensure quality care is provided to the community.

• Community Management Meeting CMM will take place monthly with PIC, HC/TL, ASM, CSO, BS, RSL.

• 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) and/or DO. This process will ensure that all statutory notifications to HIQA and SPT are submitted in full compliance with regulatory timeframes.

• The Chief Executive Officer is currently fulfilling the Head of Service functions on an interim basis, ensuring continuity of leadership and operational oversight until a successful appointment is made to the role.

Through a structured governance and oversight framework, the CSO Behavioural and Clinical Support Team ensures that local services are supported to maintain compliance, uphold quality and safety standards, and deliver care that reflects the values and rights of each person supported.

• Out of hours escalation and Oversight
Camphill Communities of Ireland (CCoI) has had a Person-in-Charge (PIC) On-Call Roster in place for a number of years, providing consistent and reliable managerial oversight outside of standard business hours. This system operates across both the North and South regions, ensuring that staff always have access to senior managerial support for the escalation of incidents, safeguarding concerns, or urgent operational matters. The on-call rota is maintained and monitored to ensure full regional coverage and continuity of governance across all services.

Camphill Communities of Ireland (CCoI) remains fully committed to upholding the highest standards of governance, leadership, and accountability across all designated centres. 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 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: A review of the Statement of Purpose and Function has been completed and now reflects correct organisation's structure chart. This will be reviewed again once HOS is appointed to reflect changes.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All incidents and accidents are reviewed by the PIC and ASM on a daily basis. Depending on the incident the Health and Safety officer, Complaints officer, Regional Safeguarding Officer, Clinical Support Officer or Behavioural Specialist may also review same incident within a timely manner and provide feedback or actions to the communities. Additionally, to support further oversight in terms of regulation 31, the Compliance Department will ensure that all incidents for the preceding 6 months are reviewed as part of the unannounced six-monthly provider audit process. Any notifiable incidents are notified to HIQA in line with regulatory requirements. Safeguarding, Governance and Oversight CCOI are committed to safeguarding the rights and wellbeing of all residents. The following safeguarding structures are in place: Area Services Manager Commenced on 05.08.2025 Person in Charge (PIC) Interim PIC in place – A structured handover will commence on 01.09.2025 to 15.09.2025. New permanent PIC commencing on 01.09.2025 Designated Safeguarding Officer In place Compliance and Safeguarding Risk Manager In place Quality and Compliance Officer In place National Safeguarding Lead In place Team Lead Currently recruiting House Coordinator In place • The Person in Charge (PIC) commencing on 01.09.2025 is the identified Designated Officer for the centre and they will be supported by the House Coordinator who is also a Designated Officer. They will ensure that all safeguarding concerns are promptly reported and appropriately notified to the Health Information and Quality Authority (HIQA) and the Safeguarding and Protection Team (SPT), in full compliance with	

statutory requirements. The PIC will prioritise the immediate safety of all residents and will implement appropriate safeguarding measures as required. This includes immediate protective actions, interim control measures, and longer-term safeguarding strategies, as identified through risk assessment and multidisciplinary review.
• In circumstances where the PIC is on leave, the House Co-ordinator is currently trained as a Designated Officer and will also ensure policy and procedure is followed and residents are appropriately safeguarded.
• All staff are trained in safeguarding vulnerable adults at risk of abuse. In addition, CCOI facilitate Applied Safeguarding Training to all staff members, to ensure all staff in Dingle Community are knowledgeable with respect to the safeguarding policy and their responsibilities within their role.
• All incidents are reported in real time through the ViClarity module and where safeguarding concerns are present these are reported to the PIC / DO immediately who notifies the National Safeguarding Lead and their respective ASM.
• All residents are educated in terms of safeguarding through discussions at resident meetings and residents are encouraged and supported to raise any concerns. The PIC will ensure that all safeguarding is discussed at each resident meeting in the centre.
• Discussions regarding live safeguarding plans and the safeguarding policy and procedures and staff responsibility under the legislation is now a standing agenda for the house team meetings to ensure safeguarding practices are embedded in daily care. Staff are supported to raise any safeguarding concerns with their PIC / HC who is the identified designated officer for the centre presently.

This structure ensures that safeguarding concerns are escalated appropriately and addressed in a timely and transparent manner, in line with the National Standards for Adult Safeguarding.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
New National Complaints Officer has been appointed and handles and oversees all complaints from start to finish to ensure in line with policy guidelines.

CCoI wish to provide assurance that the Person in Charge (PIC) and all relevant staff are fully informed of all complaints received within the designated centre. The organisation has clear procedures in place to ensure that:
• All complaints are promptly recorded, acknowledged, and communicated to the PIC and relevant staff members.
• Appropriate input is sought from all involved parties to ensure a thorough understanding of the issues raised.
• Actions arising from complaints are tracked and monitored to ensure they are implemented effectively and within agreed timeframes.
• The outcome of each complaint is reviewed to confirm that it is satisfactory and that

the complainant is informed of the resolution.
• Learning from complaints is discussed with the team and incorporated into service improvement plans where appropriate.

These measures are designed to safeguard residents' rights, promote transparency, and ensure that every complaint is managed to achieve a fair and satisfactory resolution for all parties involved.

With regards to the complaint received on the 19.05.2025. This complaint was escalated and actioned with immediate effect. The complainant was contacted on the 20.05.2025 and a meeting was arranged and took place on the 21.05.2025. The provider was required to submit an urgent action response by the 16.07.2025. A comprehensive report was submitted on the 15.07.2025 and noted within the report that the provider's response post inspection did provide assurance that the risk was adequately addressed

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A schedule for fire evacuations is in place to ensure fire evacuations are occurring at least quarterly and at least one of these planned evacuations occurs with minimum staffing in place during and during "nighttime hours".

• All fire drill reports are forwarded to Health and Safety Officer and Safeguarding, Risk and Compliance Manager for oversite.

• A full review of Fire Doors within the Designated centre took place on the 01.07.2025. Required works is schedule to take place by external contractors on the 03/09/2025.

• A full review of Fire releasers took place on 08/08/2025

• Dingle Fire Department has been invited onsite to review safe evacuation times of the designated centre and also fire plans and procedures. Date of onsite visit is to be confirmed.

• Dingle is planning to be fully fire compliant in all areas by 30th Sept 2025.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• All CMSN files were previously reviewed and audited by the outgoing PiC in accordance with the prior compliance plan. To ensure accuracy, continuity, and up-to-date compliance, the current PiC has commenced a secondary review of these files and is actively addressing any gaps or areas requiring improvement to ensure the needs of each resident, and the associated supports are accurately outlined.

• Reg 23 Internal Audit took place on 31st July and 1st Aug by the Compliance, Safeguarding and Risk Manager and the Quality and Compliance Officer. Areas of improvement were identified and provided to the community on 08/08/2025. All associated actions have been clearly outlined coupled with a definitive timeline for completion. The PIC in conjunction with the Area Service Manager will oversee completion of identified actions.

• Plans are currently being updated in consultation with the residents to ensure their plans accurately reflect the information pertaining to each resident. Each resident's support plan is being updated to ensure staff are aware of how best to support the resident in line with their assessed needs.

• Plans are also being updated to ensure they are in an accessible format for all residents in line with their needs.

• Monthly key working for each resident is taking place in the centre and will continue to be consistently completed going forward. This will be overseen by the PIC in conjunction with the Area Services Manager.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• An appointment schedule is in place for each resident, outlining all appointments required for the year with different healthcare professionals appropriate to each resident and this is included in their individual files.

• Reg 23 Internal Audit took place on 31st July and 1st Aug by the Compliance, Safeguarding and Risk Manager and the Quality and Compliance Officer. Areas of improvement were identified and provided to the community on 08/08/2025. All associated actions have been clearly outlined coupled with a definitive timeline for completion. The PIC in conjunction with the Area Service Manager will oversee completion of identified actions.

• Each resident support plan is being updated to ensure staff are aware of how best to support the resident in line with their assessed needs, and updates from MDT's or Health Care Professionals are added based on appointments attended or when

recommendations are received.

• Where professionals e.g. Physio or Dietician will not engage in providing detailed plans. Dingle will develop said plans based on recommendations and seek GP approval or sign off.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• As of 08/07/2025 Further enhanced training; Applied Safeguarding Training has been provided by the National Safeguarding Lead with all designated centre staff inclusive of agency. This has provided staff with guidance on the processes involved identifying, reporting and responding to any concerns relating to the welfare of any resident.
• All safeguarding concerns are reported via ViClarity and also through internal reporting forms in place which are escalated to the Area Service Manager and Regional Safeguarding Lead by the Person in Charge and or DO and measures to safeguard all residents are implemented as a priority.
• All measures are reviewed at local house meetings and also at Monthly Community Management meetings.
• National Safeguarding Lead will complete onsite audit and review at least on a 6 monthly to ensure compliance.
• Monthly staff meetings are scheduled, which will incorporate all aspects of each resident's life and will also review all safeguarding plans in place. This will also ensure all closed safeguarding plans have all relevant measures in place documented in the support plan and an appropriate risk assessment relevant to the residents associated with the plan. This will be overseen by the DO, Person in Charge and ASM.
• Safeguarding Plans (Matrix) is available for all staff within CMSN personal files. These Safeguarding plans are discussed at weekly house meetings and also are noted with brief description on daily handovers.
• DO and PIC in conjunction with Area Service manager and the National Safeguarding Lead to complete full review of all SG plans within personal files against tracker and supporting documentation on online tracking system and portal. This will be completed by 30.09.2025.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Provider Response:
We acknowledge the inspectors' findings regarding the lapses in upholding residents'

privacy and dignity. We take these concerns seriously and are committed to ensuring that all staff adhere to best practice standards in line with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations and the National Standards for Residential Care Settings for Older People in Ireland.

Specific query re CMSN belongings in hallway:
• The sideboard belongs solely to the CMSN and with his prior knowledge and in agreement, he has an additional sideboard directly across from his room which he has chosen what items he would like to keep there.
• Promoting Residents Rights and Dignity is a point that will be discussed at the weekly house meeting from 01.09.2025 when the PIC commences in the role.

Actions Taken / Planned:
1. Immediate Staff Re-Education:
o All staff have been reminded of the importance of respecting residents' privacy and dignity at all times, including the requirement to knock and wait for permission before entering any resident's private room.
2. Policy Review and Reinforcement:
o CCoI's Privacy and Dignity Policy provides clarity and alignment with current HIQA standards.
o Additional guidance on appropriate conduct when entering resident spaces has been circulated and reinforced through team briefings and supervision sessions.
3. Document Security and Confidentiality:
o The storage of resident information in communal areas has been addressed immediately. The documents identified on the hallway sideboard have been removed and securely stored in accordance with data protection policies.
4. Ongoing Monitoring and Accountability:
o Spot checks and audits on staff interactions and information handling are conducted by the PIC and management team on a regular basis.
o Any non-compliance will be followed up with corrective action plans and individual staff accountability measures.
Commitment to Continuous Improvement:
We are committed to creating a culture of dignity, respect, and safety within the centre. These findings have served as an important reminder to remain vigilant and proactive in upholding residents' rights. The management team will continue to work closely with staff to embed these standards into everyday practice and to ensure that the centre remains compliant with all regulatory expectations.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2025
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	01/09/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Not Compliant	Red	01/09/2025

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/09/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	11/08/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	15/09/2025
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Red	15/09/2025
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Red	15/09/2025

Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Red	15/09/2025
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	30/09/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/09/2025
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Not Compliant	Orange	30/09/2025

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2025
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	30/09/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and	Not Compliant	Orange	15/09/2025

	personal care, professional consultations and personal information.			