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 Kyle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	03 July 2025
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0047556

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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	09:40hrs to 17:50hrs	Marie Byrne	Lead
Thursday 3 July 2025	09:40hrs to 17:50hrs	Conor Brady	Support
Thursday 3 July 2025	09:40hrs to 17:50hrs	Tanya Brady	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. It 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 findings of this inspection were poor. Inspectors were not satisfied with the standard of governance and management (provider and local), levels of staffing and continuity of care and support to residents, safeguarding residents' finances and implementation of risk management procedures.

Camphill Community Kyle is a large residential service providing care and support for up to 16 residents with an intellectual disability. The centre comprises five houses on a rural campus based setting in County Kilkenny.

Inspectors reviewed morning, midday and evening routines as part of this inspection. Inspectors had the opportunity to meet with the 12 of the 15 residents who lived in this centre, and 14 staff including three member of the local management team over the course of the inspection. Inspectors spent time observing residents' routines, engaging with residents and observing them engaging in activities. Throughout the inspection, documentation was also reviewed 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.

This provider and centre has a very poor history of compliance in ensuring the safeguarding and protection of residents' finances. This inspection found that this area remained poor with inadequate systems of managerial oversight and supervision in place to adequately protect residents' finances and belongings.

Residents had a variety of communication support needs and used speech, sign language, vocalisations, facial expressions, and body language to communicate. Some residents told inspectors what it was like to live in the centre, others used sign language, vocalisations, facial expressions and body language to communicate. In addition, inspectors used observations, discussions with staff and a review of documentation to capture to lived experience of residents. Over the course of the inspection, inspectors completed a walk around each of the five premises on the campus and reviewed documentation in an office base.

A number of residents showed inspectors around their homes. A number of necessary premises works had been completed since the last inspection, including painting some kitchens, the installation of a number of paths, the renovation of a number of bathrooms and bedrooms, and converting a room to a sensory room. However, a number of necessary works remained outstanding including those relating to making areas of residents' homes and the grounds more accessible. One

resident showed inspectors their bedroom and what appeared to be black mould in a number of areas. They told inspectors that this had been reported. In another part of the house, inspectors were shown works that had been completed to the kitchen and a resident's bedroom. However, it remained the case that they could not access all part of their home. Their was an open resident complaint about this issue. In addition, there was an open resident complaint about the footpaths and this was also documented in a recent residents' and staff meeting.

Two residents told inspectors they were transitioning out of this centre; one was moving to a nursing home and another stated they were moving to a new house and had purchased all of their new house ware and utensils. This resident stated they had been told by the provider that their planned move was 'being delayed by HIQA'. Inspectors informed the resident this was not the case as HIQA had received no application (to register a new centre) from the provider and assured the resident HIQA would prioritise it when/if it did.

Overall, inspectors found that improvements were required in governance and management arrangements, the premises, safeguarding residents' finances and continuity of care and support for residents. 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, the findings of the inspection were that the provider did not have effective governance and management systems in place and this was having a negative impact for residents particular relating to safeguarding their finances, ensuing the premises were well maintained and accessible and ensuing continuity of care and support.

There was a disconnect between the provider's national governance team and this centre's local management. This was having an impact on resourcing, managerial support, planning, implementation of action plans/targets and the overall culture in this centre.

The provider had failed to ensure that the management systems were effective and supported in monitoring the quality and safety of care and support for residents in the centre.

Inspectors found that lines of accountability and authority were not clear in line with recent changes in senior management. These included the departure of the head of service and area manager, three vacancies at House Coordinator level, and team leaders having to work on the floor at the expense of completing their other duties such as supervising staff teams.

The centre was not resourced to meet residents' needs as staffing numbers were not based on up-to-date assessments. There were 12 whole time equivalent (WTE) vacancies and inspectors found this was impacting on the consistency of care and support for residents.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge who had the qualifications, skills and experience to fulfill the requirements of the regulations. They were knowledgeable in relation to residents' care and support needs and motivated to ensure they were happy and safe living in the designated centre. They were also focused on ensuring residents were taking part in activities they found meaningful on a regular basis. They were identifying areas of good practice and areas where improvements were required and escalating these concerns and required actions to the provider. The person in charge/centre support structures and connection with the provider needed improvements. This is a large designated centre with a very large managerial remit - residents' changing needs, finances, premises and estates and fire safety. This will be discussed further under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 15: Staffing

The centre was operating below the staffing requirement outlined in the statement of purpose. Staffing levels were not based on up-to-date assessments. This did not provide an assurance that the provider could sustain assessment systems previously in place.

There were 12 whole time equivalent vacancies in the centre at the time of the inspection which equated to 28% of the total staffing requirement outlined in the centre's statements of purpose. In addition, two staff were not reporting for duty and this had been escalated to the provider's human resource team. The provider had taken steps to maintain service delivery through the use of agency staff. However, staffing shortfalls were not being addressed by recruitment efforts to date. There were times when the staffing complement dropped below the prescribed staffing need due to the providers inability to fill shifts.

Inspectors found that staffing vacancies were having an impact on continuity of care and support for residents. Inspectors were informed by a number of staff and reviewed documentation to demonstrate that for some residents it was paramount that they required support from regular staff.

Inspectors reviewed records relating to agency usage in the centre in 2025. In the

first six months in 2025, on average 900 hours per month were being covered by agency staff. Parts of the centre were averaging 700 hours a fortnight with agency staff. This was not which providing continuity of care.

On the week of the inspection, in one of the houses five shifts were being covered by five different agency staff, only one of whom was regular. This meant that unfamiliar people were working/supporting complex residents as a regular occurrence. The person in charge stated the location of the centre made it challenging to attract people to work there.

Inspectors reviewed documentation which demonstrated that over a six week period four incidents occurred when agency staff not familiar in the areas, were on duty. Two of these related to residents engaging in behaviours of concern and two related to omission of prescribed medicines. In addition, from a review of incidents over a three month period, one resident requested a change in staff supporting them on seven occasions.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not have effective governance and management systems in this centre. Inspectors found systems failures, particularly relating to safeguarding, continuity of care and support for residents and the premises.

This inspection found that the designated centre was not adequately resourced to ensure effective delivery of care and support in line with resident need and its statement of purpose. This directly contributed to challenges in relation to delivering consistent, person-centred, and safe supports to all residents.

The organisation structure was not in line with the centre's statement of purpose due a number of vacancies in senior management posts. Inspectors found that recent changes to senior management meant that lines of accountability and authority were not clearly defined.

Other examples of the impact of resourcing issues included;

- Behaviour support plans not reviewed in line with the timelines identified in the provider's policy due to personnel changes,
- Limited access to transport. While a business case had been submitted for two additional vehicles, staff informed inspectors that there were ongoing issues with vehicles breaking down,
- There were limited drivers available in this remote site,
- The provider's restrictive practice committee were not available to review restrictive practices due to key/continued personnel changes,
- There were delays in training staff members to complete medication competency assessments for staff and as a result 12 staff were out of date.

Inspectors were informed that this was impacting day-to-day operations in the centre as there were now limited staff trained and competent to complete medicines administration.

- A number of staff raised concerns about the provider's policy relating to supporting residents to go on holidays and had raised their concerns to the management team.
- Inspectors were informed that due to lack of resources, a number of staff could not take their full annual leave entitlements for 2024.

Inspectors found that despite efforts by the local management team, a lack of senior management input was resulting in an inability to bring about the required changes. There were three house co-ordinator vacancies and team leaders had been redeployed to directly support residents. This was having an impact on the daily operational oversight in the centre. The two team leaders had not been fully engaged in the day-to-day running of the designated centre for a period of approximately five months prior to the inspection. As a result, they were not in a position to carry out their roles and responsibilities, particularly relating to oversight and monitoring and staff supervision. For example, team leaders reported they had not completed 80% of planned staff supervisions.

Inspectors were informed that the latest annual review by the provider had been completed in January 2024; however, this had not been made available to the person in charge and was not available in the centre on the day of the inspection. Inspectors also reviewed the latest six-monthly review by the provider. The person in charge was tracking the completion of actions and uploading the required evidence to demonstrate this. However, actions remained open as they had not been reviewed or closed off by the provider's senior management team.

In 2024 there had been a funded plan submitted to the Chief Inspector for premises works in the centre, including those relating to improving accessibility, but the majority of these works had not been completed. In addition, one resident was due to move to another designated centre. However, due to the protracted nature of sourcing and completing works to another premises owned by the provider, the residents' transition plan had been significantly delayed. During the inspection, they asked staff and inspectors for timelines for when they would be moving into their new home, but this information was not available to give them at the time of the inspection.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that the local management team were experiencing significant challenges to deliver a safe and consistent care and support for residents

in this centre due to lack of resources.

Formalised current assessments of need were not used to inform staffing supports. As described earlier in the report, the environment was not fully meeting some residents' needs. As a result, residents could not access parts of their homes and in some cases restrictive practices were used to manage this situation. Some risks, had not been appropriately assessed which did not adequately safeguard and protect residents. This is discussed further under Regulation 26: Risk Management Procedures, and Regulation 8: Protection.

The provider was recognising that they could not meet one resident's needs and were supporting another resident to move in line with their preferences. However, plans to support both residents to transition from the centre were not progressing in a timely manner.

The provider's systems for oversight were ineffective in safeguarding residents' finances. This included the occurrence of a serious financial safeguarding concern which was notified to the Chief Inspector in May 2025. Investigations were ongoing at the time of the inspection; however, it was evident a serious systems failure had occurred in terms of the provider's managerial oversight of this matter.

Regulation 26: Risk management procedures

The provider's systems for oversight and monitoring of risks relating to safeguarding residents' finances had not been effective. This is discussed further under Regulation 8: Protection.

Inspectors reviewed the centre's operational risk register which contained 20 recorded risks. This included risks relating to safeguarding, infrastructural deficits, premises not meeting residents' needs, impact of restrictive practices, residents going missing, errors and omissions due to staff practices, risks relating to insufficient staffing resources to support residents, and accidents.

Risks relating to required premises works were red risk rated and had been highlighted on the risk register since 2020. Inspectors observed some environmental risks relating to the premises and grounds over the course of the inspection including, mould in a residents' bedroom, moisture damage to wooden floor, areas of the farm and grounds that could pose a risk for residents who were unsupervised, uneven paths and uneven areas of the grounds. A number of environmental restrictive practices were in place at the time of the inspection due to risks associated with the premises. For example, there was a locked door due to a bathroom not being fit for purpose, and one resident was restricted from accessing areas of their home as they were not accessible. Following the inspection, inspectors were informed that the bathroom door was locked on a short-term basis to facilitate maintenance works. None of the provider's intended actions identified to the Chief Inspector at the last inspection of this centre had been completed.

As previously mentioned, inspectors were not assured that staffing levels and arrangements were based on up-to-date assessments. This was found to impact the quality and safety of care and support for residents. For example, in a house where staff complete sleepover shifts, a resident had sustained a fall during the night and it was reported that there had been a significant delay in getting the required support - despite the resident using their call-bell. In another house with sleepover staff, the risk associated with a resident requiring the support of two staff for manual handling/supporting with personal care had not been clearly documented with relevant guidance in place.

Overall, inspectors found that the provider was not demonstrating their ability to manage a number of identified risks, particularly those relating to safeguarding, staffing resources and infrastructural deficits.

Judgment: Not compliant

Regulation 8: Protection

The provider's oversight systems had not proved effective in safeguarding residents' finances.

A serious safeguarding concern had occurred regarding the protection of residents' finances. This was a provider systems failure which had a very real, direct and negative impact on residents. Furthermore this centre has a very poor history in this regard (financial safeguarding) with previous systems failures occurring that negatively impacted residents and subsequent assurances submitted to the Chief Inspector that highlighted that such financial safeguarding breaches would or could not happen again. This was not the case and residents in this centre were failed again by the absence of an effective system of oversight.

Inspectors found there were delays in commencing trust in care/safeguarding investigations in this centre. For example, it had been identified that a trust in care investigation was required following an significant incident involving a resident in March 2025, and this investigation had not commenced at the time of this inspection.

In addition, in line with the findings of previous inspections the provider did not have full oversight of one residents' finances and it remained the case that a number of residents had limited access to their own finances in line with a historical restriction implemented by a financial institution. It was evident that the provider had taken some steps to address these restrictions such as open accounts for residents in different financial institutions, however, it remained the case that residents had restricted access to their finances.

In addition, significant improvements were required to ensure that a formalised plan was in place to safeguard all residents' finances and to ensure their asset or personal possession lists were verified, updated and maintained - particularly after

residents made financial purchases with staff support.
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	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0047556

Date of inspection: 03/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A full review of staffing levels in Kyle Community is underway by the Provider and the Person in Charge (PIC). This will be completed by 31/08/2025. • The PIC, with support from the Team Leaders, has re-reviewed all residents' assessments of need to ensure they reflect current requirements. Further reviews are ongoing and will be completed by 31/10/25. • The PIC appointed one House Co-ordinator on 16/07/2025 and another on the 20/08/26. • The House Co-ordinators will undergo a robust induction plan with the PIC, supported by the Team Leaders and this will be completed within 6 weeks from their commencement date. • One Social Care Worker has been appointed in a full-time role since the inspection, with a further 1.5 Social Care Workers currently onboarding. An offer for an additional Social Care Worker position was made on 19/08/2025, and two further interviews are scheduled for the week commencing 18/08/2025. • The Registered Provider has engaged a new recruitment agency since the inspection to assist in filling all vacant positions within the community. The PIC is actively working with the agency and the HR department to screen applicants and progress candidates through the recruitment process. • HR and the Digital Marketing Lead in CCoI is supporting the PIC with recruitment for Camphill Kyle through advertising campaigns on local radio stations, newspapers, and social media platforms (commenced on 13/08/2025). • The PIC is working closely with staffing agencies to ensure that consistent agency staff with the required skills and knowledge are deployed in the community. A meeting was held with one agency on 18/08/2025, and collaboration will continue. • The PIC retains overall responsibility and oversight of all staff rosters, ensuring that care standards are consistently upheld. Where staffing levels temporarily fall below assessed requirements, a structured support plan is promptly implemented to maintain continuity of care and safeguard service quality. During such periods, oversight is maintained by either a Team Leader or the PIC to ensure adequate staff coverage at all	

times.
• The PIC, with support from the Team Leaders, is ensuring that all agency staff receive a robust induction to Camphill Kyle. This will be completed by 30/09/25.
• The PIC, with support from the Team Leaders, is ensuring that all agency and core staff receive supervision in line with CCoI policy. This will be completed by 30/09/25 and agency staff will continue to receive supervision every three months in line with policy.
• The Statement of Purpose has been reviewed and temporarily updated to reflect increased staffing levels required to support residents transitioning from Camphill Kyle or experiencing periods of dysregulation. This was submitted to HIQA on 30/07/2025.
• The Registered Provider and HR have engaged with staff members who were not reporting for duty. HR processes have been concluded as of 08/08/2025.
• Conclusion:
Although staffing shortfalls remain, significant progress has been made since the inspection, and robust interim measures are in place to ensure continuity of care. CCoI is fully committed to achieving compliance with Regulation 15. The workforce plan will continue to be reviewed and updated to reflect residents' evolving needs and regulatory requirements. Ongoing internal audits and oversight mechanisms are in place to monitor 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:
· The Registered Provider has appointed an Area Services Manager for Camphill Kyle who commenced in the role on 05/08/25. The ASM has visited Kyle Community on 11/08/25 to meet with the PIC and has received the induction to the residents and the Community. The Area Services Manager is undergoing a comprehensive induction process, guided and supported by the CEO. This induction includes familiarisation with the communities the manager will be supporting as part of their responsibilities. Supervision has been scheduled with the Person in Charge on the 01/09/25.
· From 11/08/25, the ASM will be present on site every week and will check in via teams daily.
· The registered provider has appointed a Clinical Support officer in the Behaviour Support Role, and they commenced in the role on 01/08/25 also, visiting Kyle on the 15/08/25 to review all current behaviour supports. The Clinical Support Officer is undergoing a comprehensive induction process, guided and supported by the CEO. This induction includes familiarisation with the communities the CSO will be supporting as part of their responsibilities.
· All Behaviour Support Plans have now been reviewed and updated and the Person in Charge will work with the new Clinical Support Officer to continually ensure that this is completed within the timelines of the organisational policy. This was completed on the 08/08/25.

· The Clinical Support Officer met with the funder's Clinical Psychologist to support the Person In Charge on the19/08/25 to review Behaviour Support Plans further with a follow up appointment for a Psychology review on 16/09/25.
· The Registered Provider is actively recruiting to fill the vacant Head of services role. The Chief Executive Officer is currently fulfilling all Head of Service functions on an interim basis, ensuring continuity of leadership and operational oversight until a successful appointment is made to the role. Interviews starting on the 28/08/25.
· The Person In Charge followed up with the funder in relation to the business case submitted in May 2025 regarding application for funding for 2 vehicles for the community on the 15/08/25 and funding is being made available following quotes that will be submitted to the funder on the 21/08/25. The provider will also ensure that funds will be made available to purchase a vehicle for the community on or before the 30/09/25 from the National Fundraising.
· As an interim measure to make sure that the community is adequately resourced the provider has ensured that rental cars have been organized for the community which were collected on the 19/08/25 until the purchase of a vehicle on or before the 30/09/25.
· The Person in Charge will continue to ensure that each house is resourced daily with staff who are safe qualified drivers.
· The Restrictive Practice Committee convened on Tuesday 12/08/25 to conduct a comprehensive review of all restrictive practices in line with the current policy.
· 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. Feedback from reviews will be reported to the Quality & Safety Committee for oversight.
· Restrictive practices will be reviewed and discussed at team meetings monthly to ensure continuity of care and support and to contribute to staff development and safe service for our residents. The Person In Charge has ensured that this was implemented from the 18/08/25 and will review and sign off on all Team Meeting notes.
· The Restrictive Practice Panel met on the 20/08/25 to discuss all financial restrictions in detail in Camphill Kyle.
· All staff outstanding medication assessments will be completed by the 31/08/25, with Training for the Team leader to be an Assessor will be completed before 31.08.2025 with the first assessment being completed on the 20/08/25. The Team Leader will complete assessor training on 27/08/25 which will complete this training. This will result in a medication assessor being on site in Camphill Kyle to prevent this from occurring again.
· A recruitment drive is underway for the appointment of House Co-ordinators to the community, presently we have two house co-ordinators onboarded who commenced in their role on 16/07/25 and 20/08/25. The Person in Charge is ensuring that they are receiving a comprehensive induction, and this will be within 6 weeks of their commencement.
· The Team Leaders remain in a supernumerary capacity of 40 hrs to support the Person in Charge to fulfil the regulatory responsibilities.

· Supervision for all staff and agency staff are underway in Camphill Kyle in line with organisational policy and this will be completed by the 31/08/25. Staff will be also receiving supervisions from their appointed House Co-ordinators who will undergo HSEland supervision training as part of their induction. A supervision workshop will be completed with the supervisors to ensure there are providing effective supervision in line with CCOI policy. This workshop will be completed by the 30/09/25. Further dates will be determined depending on the appointment of additional House Co-Ordinators. The Person in Charge will continue to oversee the quality of the supervisions conducted and ensure follow up on any issues that arise.
· The appointed Area Services Manager in conjunction with the Provider will complete the Annual Review for Camphill Kyle by 01.09.25. This will be overseen by the Provider.
· The newly appointed Area Services Manager in conjunction with the Person In Charge will review all actions on the 6 monthly unannounced provider audit to ensure that they are reviewed and closed out by the 31/10/2025.
· The Provider has initiated a comprehensive review of all premises which has been carried out by the Person in Charge. Findings have been discussed during weekly maintenance and daily calls and logged on Affinity for oversight and completion by the Properties and Housing Department. A detailed plan, including timelines, is in place for all scheduled works. While timelines may require occasional adjustment, the objective remains to complete all identified works in full. All works are projected to be completed by the end of Q1 2026
· The Registered Provider has approved the funding for the replacement of 3 kitchens in Camphill Kyle and the Person In Charge met with the kitchen company on the 23/07/25 to confirm the start date of the 23/09/25 for House 1, 20/10/25 for House 2 and the 17/11/25 for House 3. The kitchens have been designed to ensure that they are accessible for residents living in their homes. The OT is visiting on Camphill Kyle on 21/08/25 for a final evaluation for the plans for the kitchens. The expected date for the completion of all kitchens is 15/12/25.
· Renovation of 1 Bathroom is completed with another in progress, with 3 more scheduled to be completed by no later than February 2026.
· Works on the footpaths began on 05/08/25, with the current projected completion date set for no later than the end of Q1 2026.
· The provider has ensured that the Compliance, Safeguarding and Risk Manager has been provided with the schedule of works for completion and they will conduct monthly checks based on this commitment and report directly back to the Provider. Any issues that arise will be immediately addressed to ensure that timelines are met as agreed. The ASM will also be onsite weekly in support of escalating any concerns arising regarding maintenance works.
· The transitions continue within Camphill Kyle and the Person in Charge is liaising with the Provider and funder regarding both. Updates are given to both residents by the Person in charge regarding their transitions.
· An environmental assessment of 1 residents' bedroom was completed by the OT and has been subsequently reviewed by the Person in Charge with the support of the Provider to progress with works. A structural engineer has completed an assessment of the environment in April 2024 approving the required works and will return again on the 21/08/25 to re-review and a work schedule has been agreed by the provider. The planned date of construction is 15/09/25 with a completion timeframe of 6 weeks.
· The funder has committed to monthly engagements specifically to Camphill Kyle as part of assurance and support to the Local Community. The first meeting was on the

08/08/25 and are scheduled monthly thereafter.
· The SOP was reviewed on 12/08/2025 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 (x2) → House Coordinators (x2) → Social Care Team
· A Quality Improvement Plan has been completed for Camphill Kyle and all actions will be reviewed weekly to monitor progress.
· The Quality & Compliance Officer has completed a six-monthly provider audit and feedback was provided to the PIC on 20.08.25 with the finalised reported being submitted to the PIC on 22.08.25.

· Review of the finance Policy / Safeguarding Resident Finances.
The organisation has taken proactive steps to strengthen the governance and oversight of all resident finances within CCoI. We have actively reflected on the learnings to date and are committed to addressing any identified gaps.
The Registered provider circulated an organisational learning MEMO

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A comprehensive review of all risk assessments in Camphill Kyle, local and operational is underway starting on the 18/08/25.
• A subsequent review is being undertaken on all individual risk assessments pertaining to the residents residing in Camphill Kyle.
• These reviews will be completed on or before the 10/10/25.
• All needs assessments are being re-reviewed in Camphill Kyle supported by the Provider. This will be concluded by 31/10/25
• The Person In Charge is meeting with Agency's that support Camphill Kyle to review the current agency staff that are working with the centre. First Meeting on the 18/08/25. The objective of this meeting is to obtain a core agency cohort to support the community until we can appropriately appoint CCOI staff. The Agency have communicated back with the Person In Charge on the 20/08/25 about their staff taking consistent lines until such a time as the vacant positions are filled in Camphill Kyle.
• There has been a review of the induction process for Agency staff that has been updated to include a robust site-specific induction. This is in process of being rolled out to be concluded by the 30/09/25.
• Agency staff will be provided with supervision as per CCOI policy for completion with current agency staff being completed by 31/08/25.
• The Provider and the HR department are supporting the Person in Charge with a recruitment drive to hire suitable and qualified Social Care staff to the centre. This will be discussed further in the Staffing section of this report.
• The registered provider has approved the funding for the replacement of 3 kitchens in

Camphill Kyle and the person in Charge met with the kitchen company on the 23/07/25 to confirm the start date of the 23/09/25 for House 1, 20/10/25 for House 2 and the 17/11/25 for House 3.
• Renovation of 1 Bathroom is completed; Bathroom 2 is underway and on schedule of completion with 3 more scheduled to be completed by February 2026. This is being completed in Order of priority across the community.
• Works on the footpaths began on 05/08/25, with the current projected completion date set for the end of Q1 2026. For all pathways and farm areas identified in the Premises Review.
• The Mould has been removed from the residents ceiling, and the bedroom has been repainted. In order to enhance air circulation and overall ventilation, the provider has initiated a review of current room layout. Plans are being developed and the Person In Charge met with the contractor on 15/08/25 to outline the specific requirements in terms of the works to be completed. These works will be completed by the end of Q1 2026.
• The provider has ensured that the Person in Charge in conjunction with the Properties and Maintenance Team has completed a comprehensive review of all premises in Camphill Kyle and re-reviewed all logged maintenance concerns. A work plan has been completed and there are weekly progression meetings where the registered provider and Compliance, Safeguarding and Risk manager is supporting the person in charge to ensure that all works are being completed in line with the agreed works schedule. The end date for all identified works is the end of Q1 2026.
• The Registered Provider and Person in Charge recognise that certain areas of the farm and surrounding grounds could pose potential risks to residents due to uneven grounds and pathways and contractors have been appointed to complete works identified by the end of Q1 2026.
• The provider has completed training of an identified Health and Safety Representative in Camphill Kyle who will complete a weekly walk around to identify and report any new risks to the National Health and Safety officer this was put in place 15/08/25.
• The Provider has completed a risk assessment on the 15/08/25 specifically for the identified risk area pertaining to the grounds of the community which will be reviewed monthly as per Risk Management Framework or following the weekly walk around if required. This will also be updated if there is any issues identified on a daily basis.
• The Provider has ensured that the Farm Manager and the Property and Housing Department have supported the Person In Charge to improve signage and place physical barriers where identified works are required, this was completed on the 15/08/25 and this will be monitored closely and dynamically risk assessed with additional measures being implemented if required and will be reviewed daily by the Health and Safety Representative and or the Person In Charge.
• The Provider has ensured that farm has been secured with limited access to assigned key holders which include the farm manager, maintenance personnel for Camphill Kyle and the Person in Charge. Completed on the 15/08/25.
• The Provider has organised that an independent Health and Safety audit to be carried out in Camphill Kyle and this will be carried out on the 4th and 5th of September 2025.
• The Person in Charge has notified an environmental restriction but works are due to begin on the 23/09/25 to replace a kitchen which will mean that this restriction can be reviewed by the restrictive practice committee and closed. The Provider has ensured that there is an alternative kitchen made available to the residents, and all residents will have the appropriate communication regarding the works being completed. They will be overseen by the OT. An environmental assessment of 1 residents' bedroom was

completed by their OT and has been subsequently reviewed by the Person In Charge with the support of the provider. A structural engineer has completed an assessment of the environment in April 2024, and a work schedule has been agreed by the provider with a contractor that has been identified and visited the community on the 15/08/2025 with an anticipated start of the 01/10/2025. The Provider has arranged for a flooring contractor to complete works on the floor that is identified as having moisture damage and the works will begin on Monday the 18/08/25 with a completion date of 01/09/25.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
CCoI Actions Taken:

The organisation has taken proactive steps to strengthen the governance and oversight of all resident finances within CCoI. We have actively reflected on the learnings to date and are committed to addressing any identified gaps. The Registered provider circulated an organisational learning MEMO to all communities on the 08/08/25.

• The Registered Provider has commissioned an independent reviewer has been engaged to support the organisation in identifying areas for improvement, implementing best practices, and addressing any shortcomings that may require action. Terms of reference have been agreed with the Provider. This process begun on 18/08/25 with a projected timeframe of 3 months for completion.

• Following the finalisation of the finance policy review as addressed in the Governance and Management section above an additional audit will be implemented whereby the ASM will complete finance audits on a 6 monthly basis in their respective communities to be completed by the 31/10/25.

• The Provider will arrange staff will be trained by the Finance Policy once this is implemented and will be a standing agenda at the Team Meetings to be completed by 31/10/25

• The expected date for draft review of the finance policy is 30/09/25. This will be conducted by the Compliance, Risk and Safeguarding Manager with a nominated PIC and the support of the Finance Team and a nominated person of the HSE with the final sign off by the Provider. Following the outcome of the independent review of the financial safeguarding concern the Policy will be further updated to include recommendations.

• An inventory list has been implemented across the Camphill Kyle in addition to the asset register as per Finance Policy. This is reviewed as and when a purchase occurs.

• The funder have appointed member of the QSSI (Quality, Safety and Service Improvement Team) in the Southeast to support the provider in the review of the safeguarding incident and to identify learning and protective measures to prevent any such incidents from occurring again. The Person In Charge met with them on the 19/08/25 and will meet again on the 26/08/25.

• All financial restrictions in Camphill Kyle were re-reviewed by the Restrictive practice panel on the 20/08/25

• The PIC will continue to liaise with the ADM lead in the SPT regarding financial

restrictions.
• The Person in Charge is liaising with all relevant agencies in relation safeguarding and will continue to do so. A meeting was held on the 19/08/25 to discuss progress.
• The HR Department in CCoI have initiated the outstanding Trust in Care Investigation with the latest follow up being the 20/08/25
• The Provider has committed to refunding the residents any monies owed to them following this safeguarding concern, a review of this will be completed on 30/11/25 once information is gathered.
• A safeguarding review was conducted by the funder on 09 July 2025 regarding Camphill Kyle following the financial safeguarding incident.

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.	Not Compliant	Orange	31/08/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/03/2026

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/10/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2025
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	01/09/2025
Regulation	The registered	Not Compliant	Orange	22/08/2025

23(2)(a)	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 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.	Not Compliant	Orange	31/08/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/08/2025