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:	08 December 2025
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0048633

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	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
Monday 8 December 2025	10:10hrs to 14:45hrs	Marie Byrne	Lead
Monday 8 December 2025	10:10hrs to 14:45hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed by two inspectors of social services over the course of one day. The purpose of the inspection was to ensure residents were safe and in receipt of a good quality of care and support. This was the third inspection of this centre in the last six month period.

Following a regulatory programme of inspections with the provider in July 2025 and poor inspection findings in this designated centre, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of this centre. This was issued due to the continuous failure of the provider to implement actions to come into compliance with key regulations, which was having a direct impact on the quality and safety of care provided for residents.

In August 2025 the provider responded to the notice of proposed decision to cancel the registration with a written representation outlining the actions that they would take to address the areas of concern. A follow-up risk based inspection was completed in September 2025 and during that inspection a number of improvements were found particularly relating to governance and management and risk management. However, at that time a number of key actions were still in progress and required further time to be implemented in order to bring about improved levels of regulatory compliance.

The findings of this inspection were, that actions taken by the provider since the last inspection, such commencing premises works and safeguarding measures, had brought about improved levels of regulatory compliance. However, a number of actions were still in progress at the time of the inspection, particularly those relating to ongoing premises works and renovations, and staff recruitment

In addition, it was found that residents had been reimbursed monies following the conclusion of an investigation into a serious safeguarding concern.

Camphill Community Kyle is a residential service providing care and support for up to 16 residents with an intellectual disability. There were 15 residents living in the centre at the time of the inspection.

At the time of the current inspection there were four houses registered as part of the designated centre. One house, which had previously been registered, was in the process of significant renovation works. At the time of the inspection this house was not registered and no residents were living in this part of the centre. The provider had recently submitted an application to vary the current registration conditions to add this house back onto the floor plans of the designated centre bringing the total number of houses back to five. This application was in progress at the time of inspection.

Due to these works a number of residents in the centre had relocated to other homes located in the designated centre and one resident had temporarily moved back to their family home. The works to this part of the centre were essential in ensuring the home was accessible, meeting residents' assessed needs and kept in a good state of repair. The renovation works included installation of a new kitchen, renovation of bathrooms, installation of an over head hoist and making rooms larger to accommodate residents with mobility needs.

During the inspection, inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting five residents, five staff, the person in charge, the provider's national health and safety officer and the area service manager who is a person participating in the management of the designated centre (PPIM). The provider's head of services (PPIM) attended feedback via video-conference at the end of the inspection.

Inspectors completed a walk around each of the four premises that made up the designated centre on the day of the inspection with the person in charge and documentation was also reviewed throughout the inspection about how care and support is provided for residents, and related to the actions detailed in the provider's representation and the compliance plans following the inspections in this designated centre in July and September 2025.

Over the course of the inspection, residents and staff spoke about some of the improvements that had occurred since the last inspection. For example, they showed inspectors the tarmac and paths that had been laid outside the houses, the new guttering, the new flooring in a number of areas within the houses, rooms that had been painted in their homes and the new furniture, curtains and other soft furnishings. Inspectors found that these improvements had resulted in residents' homes and the grounds being more accessible and in their homes appearing more homely and comfortable. These works had also resulted in a reduction of some presenting risks for residents. Further works were scheduled, and these will be discussed further under Regulation 17: Premises.

Inspectors met one resident as they were getting ready to go on the bus with staff. They took inspectors by the hand and showed them around their home. Another resident was at the kitchen table playing board games and their housemate was sitting in the living room knitting.

Inspectors had an opportunity to meet and speak with a resident. They spoke about all the works that were currently in progress to renovate their home. They expressed how excited they were to move into their newly renovated bedroom which was now twice the size. They asked the person in charge to show inspectors the pictures of their new bedroom and other parts of their home that had also been renovated and decorated. They told inspectors the house was "like a hotel". They spoke about the newly renovated kitchen and their involvement in picking furniture and paint colours.

One inspector met a resident as they spent time with staff in their home. They were in the process of drying dishes and putting them away when the inspector and person in charge arrived. They appeared very content and comfortable in their home and smiled at the inspector and staff throughout the visit. They asked why the inspector was visiting and once this was explained they said they were "happy" and felt "safe" in the centre. After this they said goodbye to the inspector and person in charge as staff had put one of their favourite programmes on television.

Overall, while improvements had been made in relation to oversight and monitoring, and safeguarding it remained the case that improvements were required to ensure all premises works were completed as required and staffing numbers were in place to ensure continuity of care and support for residents.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

The findings of this unannounced risk-based inspection were that improvements in regulatory compliance had been made since the last inspection. Inspectors found that the actions outlined in the provider's quality improvement plan (QIP) demonstrated a clear trajectory towards achieving compliance in the areas where further improvements were needed such as the premises and staffing.

Some actions from the provider's representation and compliance plans remained outstanding at the time of the inspection. These will be discussed further under Regulation 23: Governance and Management.

The centre was not fully staffed in line with the statement of purpose. The inspectors found that efforts were being made by the local management team to ensure continuity of care; however due to the number of shifts that needed to be covered, this was not always proving possible. The provider had recruited to fill some vacancies. However, it remained the case that the a high volume of shifts were covered by different agency staff.

The person in charge was supported with the day-to-day management of the centre by two team leaders and two house co-ordinators. The provider was in the process of recruiting a third house co-ordinator at the time of the inspection. The person in charge reported to and received supervision and support from an area service manager (PPIM). They both reported to a head of services.

Regulation 15: Staffing

The registered provider had not ensured that there were enough staff employed in this centre to support the number and needs of residents living in this centre.

The centre was not fully staffed in line with the statement of purpose. As previously mentioned, the provider had recruited to fill a number of staff posts since the last inspection. There were 12.93 whole time equivalent (WTE) vacancies at the time of the inspection in September 2025 and there were eight whole time equivalent vacancies at the time of this inspection. Inspectors acknowledge and were informed that three people had recently accepted offers of employment and were onboarding at the time of the inspection.

The inspectors reviewed a sample of two months of rosters and found that they were well-maintained. There were a number of regular agency staff completing shifts in the centre, especially in two of the houses where continuity of care and support was of particular importance to the residents living there. However, based on a review of rosters and records relating to agency usage, it remained the case that there were a high volume of shifts being covered by different agency staff. For example, over a two-week period 18 agency staff covered 1,140 hours across the four houses. Therefore continuity of care was not afforded to all residents within the designated centre.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that further improvements were noted to oversight and monitoring since the last inspection. There were clearly defined management structures as detailed in the statement of purpose for this centre.

The person in charge, team leaders and house co-ordinators were engaged in the day-to-day management of the designated centre. They received supervision and support from two persons participating in the management (PPIM) of this designated centre. There was an on-call roster in place to ensure that support was available out-of-hours.

Inspectors found that the provider's systems for oversight and monitoring were now being utilised to identify, track actions and to bring about improvements. Regular planned meetings were occurring, as were provider-led and area-specific audits and reviews. Inspectors reviewed the latest six-monthly and annual review by the provider. These identified areas of good practice and areas where improvements were required.

The provider had developed a quality improvement plan (QIP) for this centre. It captured planned, in progress and completed actions. In line with the findings of this inspection, the majority of outstanding actions detailed on the provider's quality improvement plan related to filling staff vacancies and planned premises works. The

QIP was divided into four sections which were governance and management, protection, risk and staffing. Inspectors reviewed and verified the actions completed and the actions outstanding. 55% of actions were completed at the time of the inspection and 45% were in progress. This indicated that progress had been made since the previous inspection in September 2025.

The actions outstanding mainly referred to premises works and staffing requirements which were in line with the findings of this inspection. There were actions in place to address these areas of improvement. For example, in relation to staffing, information gathering had commenced in relation to improving staff retention within the centre.

Since the area service manager (PPIM) had commenced in post they were present in the centre on a regular basis and meeting with the person in charge regularly to review actions and measure improvement.

Inspectors reviewed the actions from the provider's representation submitted to the Chief Inspector in August 2025 and the compliance plans submitted following the inspections in July and September 2025. Of these actions, 80% were completed and 20% were in progress. Again the outstanding actions were in line with the provider's QIP, and findings of inspection.

The completion of all premises works and ongoing actions in relation to staff recruitment remained outstanding or in progress at the time of inspection. Inspectors acknowledge that the date for some of these actions, particularly those relating to premises works were not due for completion until the end of March 2026. The successful conclusion of these areas of improvement were essential in ensuring compliance with relevant regulations.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that residents were supported to take part in activities they enjoyed on a regular basis. They were also supported to keep in contact with and spend time with their family and friends and supported to make decisions about their care and support. Each of the premises were found to be warm, very clean and homely during this unannounced inspection. Improvements were noted in relation to both the premises and safeguarding since the last inspection. Further improvements were planned to the premises and these will be discussed further under Regulation 17: Premises.

The provider had further strengthened their policies, procedures, practices and systems relating to safeguarding and protection since the last inspection. The provider had commissioned an independent investigation following financial

safeguarding concerns in the centre. Arrangement had been completed to reimburse residents.

Regulation 17: Premises

The provider had completed a comprehensive review of the premises following the inspection in July 2025. These findings were being discussed during weekly maintenance meetings and were tracked on the providers quality improvement tracker. A number of maintenance personnel and contractors had been on site since then and had completed maintenance, repairs, grounds and premises works. Works were also ongoing at the time of this inspection. The inspectors saw works in progress on the day of inspection.

The inspectors reviewed works that had been completed which included the following:

- The installation of one new kitchen.
- The installation of tarmac and paths across the campus.
- Painting and decoration in all of the premises.
- The renovation of a number of bathrooms.
- The installation or repair of flooring in a number of premises.
- Door saddles were removed and electronic hold open devices were installed in a number of key areas to make residents' homes more accessible.
- New guttering was installed on a number of premises.
- New furniture, curtains and soft furnishings were purchased in line with residents wishes and preferences.

Some of the works in progress/outstanding included the following;

- Works to replace and/or repair flooring in one of the houses.
- The kitchens were due to be replaced in two of the houses.
- Renovations were due to be completed in two bathrooms.
- The installation of a tracking hoist in one of the houses.
- External painting of some of the houses.

Ensuring all the works were completed was essential in maintaining the residents' living environment to a suitable standard.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors found that the provider's systems for safeguarding residents had further improved since the last inspection.

Prior to the inspection in July 2025, a serious safeguarding concern had occurred regarding the protection of residents' finances and this had a negative impact for residents. The provider had commissioned an independent investigation which was now complete. Inspectors reviewed the findings of this investigation and documentary evidence to show that residents had been reimbursed. In the investigation report, a number of recommendations were made to further strengthen the provider's policies, procedures and systems to safeguard residents' finances. The provider was in the process of implementing these actions at the time of the inspection. For example, the provider was reviewing their policy in relation to residents' finances at the time of inspection.

There had been a number of safeguarding concerns since the last inspection and the provider's safeguarding tracker and documentation relating to these was reviewed. These demonstrated that the provider was responding to allegations or suspicions of safeguarding concerns in a timely and thorough manner. Overall, improvements were noted in relation to how timely and responsive the provider was to safeguarding concerns. For example, a safeguarding concern reported to the Chief Inspector the week before the inspection had been screened and reported in line with National policy. In addition, steps had been taken to commence an investigation. The provider had taken appropriate steps to safeguard residents and a safeguarding plans was developed.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0048633

Date of inspection: 08/12/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Person in Charge continues to oversee all rosters to ensure that there is continued continuity of care. This is monitored on an ongoing basis until the full staff compliment can be reached by 30/06/26. • All rosters continue to be based on the current needs of the residents. • Recruitment drives are ongoing for Camphill Kyle with collaboration with the HR Department and CCOI Digital Marketing Lead. • The Registered Provider continues to engage with recruitment agencies since the inspection to assist in filling all vacant positions within the community. • The PIC is continuing to work closely with staffing agencies to ensure that consistent agency staff with the required skills and knowledge are deployed in the community. There is established continuity with the agency staff that are supporting the staffing deficits in the community. This is monitored continuously and the skill mix is reviewed on a daily basis by the Person in Charge with the support of the Team Leader. • 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. • Interviews are ongoing with 3 scheduled for completion by the 10th of January 2026. Interviews will continue to be planned after the selection process. The Provider is supporting Camphill Kyle with recruitment initiatives such as scheduling attendance at recruitment fairs, college open days, advertising on local radios and social media. • Camphill Kyle is currently onboarding 2 Social Care staff which will further reduce the gap in the WTE. • Conclusion: Although staffing shortfalls continues to remain, progress is being made with regards to recruitment. • 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	Substantially Compliant

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

• With regards to retention CCOI have committed to a 3-year road map by partnering with the Great Place to Work (GPTW) institute in an effort to put in place a strategy to drive staff retention. CCOI has commenced an organisation wide employee survey on December 1, 2025, to gather anonymous feedback from all employees to ensure action planning reflects the needs.

• In collaboration with the HR department the Provider has committed to launching many initiatives in 2026 to improve recruitment and retention such as:

• Pay and Benefits Review
• Workplace culture framework
• Career Development
• Recognition Programme
• Work-Life Balance
• Onboarding
• Leadership Communication

• Interviews are ongoing with 3 scheduled for January 2026 to date. Interviews will continue to be planned after the selection process. The provider is supporting Camphill Kyle with recruitment initiatives such as scheduling attendance at recruitment fairs, college open days, advertising on local radios and social media.

• Camphill Kyle is currently onboarding 2 Social Care staff which will reduce the gap in the WTE.

• The Registered Provider continues to engage with a recruitment agency since the inspection to assist in filling all vacant positions within the community.

• Weekly maintenance calls are in place where the outstanding maintenance actions are reviewed and remain on target for completion at the end March 2026.

• All upgrades to properties are being completed in line with the residents' needs and accessibility and following recommendations from an OT and the Housing Guidelines that were developed by Senior OTs.

• The Quality Improvement Plan is being reviewed weekly with the ASM and PIC. This is to review progress and maintain traction on the action plan and to support the PIC with progressing outstanding actions.

• The Area Services manager is visiting the community regularly to support the Person in Charge in their role and escalates any requirement for additional support.

• The compliance department has introduced a new system for auditing and are rolling

this out in January 2026. They will provide training and guidance through a standard operating procedure to Persons in Charge.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Provider has replaced the floor in the house identified. This was completed on 15/12/25
• Both outstanding kitchens will be replaced by the end of March 2026.
• Outstanding renovations in the two bathrooms will be completed by March 2026
• Ceiling track hoist was installed on the 18/12/25.
• External painting on the houses is scheduled for completion by the end of June 2026.
• Weekly maintenance calls are in place where the outstanding maintenance actions are reviewed and remain on target for completion at the end March 2026.
• All upgrades to properties are being completed in line with the residents' needs and accessibility and following recommendations from an OT and the Housing Guidelines that were developed by Senior OTs.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2026
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	06/01/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/03/2026

	are of sound construction and kept in a good state of repair externally and internally.			
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.	Substantially Compliant	Yellow	06/01/2026