



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

Issued by the Chief Inspector

Name of designated centre:	Bluebell Lodge
Name of provider:	Waterford Intellectual Disability Association Company Limited By Guarantee
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	30 September 2021
Centre ID:	OSV-0007754
Fieldwork ID:	MON-0029557

About the designated centre

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

Bluebell Lodge is a four bedroom bungalow situated in its own grounds on the outskirts of Waterford City. It is registered to provide a full time residential home for up to three residents with intellectual disability, although currently is home to two individuals. The house comprises of a kitchen-dining room, and has two sitting rooms, all bedrooms are en-suite. Externally there is a large decked area and well maintained garden. Transport is available to the resident who lives here. The service is staffed at all times when a resident is present and the staff team comprises of healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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 - 2015 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 30 September 2021	9:00 am to 6:00 pm	Leslie Alcock	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, completed to assess the centre's ongoing compliance with regulations and standards. The inspection took place during the COVID-19 pandemic and therefore appropriate infection control measures were taken by the inspectors and staff to ensure adherence to COVID-19 guidance for residential care facilities. This included the wearing of personal protective equipment (PPE) and maintaining a two metre distance at all times during the inspection day.

The centre was a large bungalow situated on the outskirts of a city. It was comfortable, homely, well maintained and clean. There were pictures of the residents and the residents' artwork observed on the walls around their home. Three residents lived in this centre and the inspector had the opportunity to meet all three over the course of the day. Each resident had their own bedroom which was personalised to suit their preferences and had space to store personal belongings. The house had large communal areas and the inspector observed the residents use these throughout the day. The centre also had a large, well maintained garden with a large deck in the back.

On arrival, the inspector met two residents who were having their breakfast and was advised the staff were assisting the third resident in their bedroom. The inspector later met the third resident who allowed the inspector to see their bedroom. The inspector spoke with the residents over the day to determine their views of the service, observed where they lived, observed care practices, spoke with staff and reviewed the resident's documentation.

In general, the inspector found that the residents appeared very happy, relaxed and comfortable living in the centre. They were supported through-out the day by their support staff. The residents appeared very relaxed in the company of staff and in their environment. The residents enjoyed personalised activation schedules. On the day of the inspection, one resident went to their day service until lunch time and later went for a walk and the other two residents went for a walk in the morning and swimming in the afternoon. The residents also appeared interested to meet the inspector and curious about the inspection process.

The inspector observed respectful, warm and meaningful interactions between staff and the residents during the day. Staff spoken with on the day of inspection spoke of the residents in a professional manner and were keenly aware of their needs. Staff spoken with were clear on what to do if in the event of a concern and who the designated officer was. Staff were observed to adhere to guidelines and recommendations within individualised personal plans to support the residents to achieve a good quality of life.

In summary, based on what the residents and staff communicated with the inspectors and what was observed, it was evident that the residents received good quality care and support. The next two sections of this report outline the inspection

findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. Some improvements were required to ensure that the service provided was safe at all times and to promote higher levels of compliance with the regulations. This was observed in areas such as; fire safety and health care.

Capacity and capability

Overall, the inspector found that the registered provider demonstrated the capacity and capability to support the residents in the designated centre. There were management systems in place to effectively monitor the quality and safety of the care and support delivered to the residents. On the day of inspection, there were sufficient numbers of staff to support the residents assessed needs.

The centre had a clearly defined management structure in place consisting of a person in charge, who worked on a full-time basis in the organisation. The person in charge was found to be competent, with appropriate qualifications and experience to manage the designated centre. This individual also demonstrated good knowledge of the residents and their support needs. While the person in charge had responsibility for two centres, they were supported by the staff team and an assistant director of nursing. The assistant director of nursing demonstrated good oversight as they also had a regular presence in the centre and was familiar with the staff and residents. Regular audits had taken place such as the annual review and the six monthly unannounced provider audits. Actions plans were developed as a result of the audits to address areas in need of improvement.

Overall, the staff team were found to have the skills, qualifications and experience to meet the assessed needs of the residents. There was some staff vacancies and where cover was required, it was found that a bank of regular agency staff were used to cover absences. This ensured consistency of care for the residents. All staff were in receipt of regular support and supervision provided by the person in charge and mandatory staff training and refresher training was facilitated by the provider. However, not all training and refresher training was up-to-date for staff.

Regulation 15: Staffing

There was a planned and actual staff rota in place and it was reflective of the staff on duty on the day of the inspection. There was appropriate skill mix's and numbers of staff to meet the assessed needs of residents. The staff rota highlighted which staff member was responsible for administering the medication on each shift. The staff were knowledgeable about how to meet the residents needs and were seen to interact with the residents in a warm, respectful and dignified manner. The provider ensured continuity of care through the use of an established staff team and a small

group of regular agency staff where required.

A sample of personnel files were reviewed against the regulations to ensure they contained the required documentation and found that photographic identification for two staff member's was out of date.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Arrangements were in place for the staff team to receive training to support them in meeting the assessed needs of the residents. The inspector viewed evidence of mandatory and centre specific training records. However, not all training and refresher training was up-to-date for staff. While a number of the identified gaps in training were scheduled for the coming weeks in areas such as first aid and medication management, there were a number of staff due fire safety training which had not been scheduled. Similarly, there were a number of staff due training in centre specific areas that the register provider identified as a requirement, such as food safety. Staff on duty on the day of the inspection communicated that their training was up to date with the exception of one staff member who was in the process of completing training in medication management.

Supervision records reviewed and discussions with staff highlighted that one to one formal supervision was taking place regularly. Staff who were on probation received formal supervision more regularly than those who completed their probationary period.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that there were appropriate governance and management structures in place with clear lines of authority and accountability. The registered provider had arrangements in place to monitor the service provided to residents. The registered provider had appointed a suitably qualified and experienced person in charge to the centre who had regular oversight of the centre. They were in a full time position and also had responsibility for one other designated centre. This individual was due to finish up their position in the centre the day after the inspection. However, the provider demonstrated appropriate arrangements for the oversight and management of the centre until the new person in charge is appointed. The annual review for the previous year and six-monthly provider unannounced audits were occurring in line with the requirements of the regulations and where improvements were identified, plans were in place to address these. In

addition, the person in charge was completing regular audits in areas such as, record keeping audits, food and nutrition audit and staff hand washing audits. There was evidence that the staff team were meeting regularly and that regular house meetings were taking place with the residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose and function is a governance document that outlines the service to be provided in the designated centre. The statement of purpose was available in the centre and contained the majority of the information required by the regulation. However, the statement of purpose required review in order to ensure it met the requirements of the regulations. For instance, the staffing levels including that of the person in charge required to be updated to reflect the current staffing levels required in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had an up to date and effective complaints policy and procedure in place. The inspector reviewed a number of closed complaints as there were currently no open complaints and found that they were dealt with in line with the centres' policy.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre provided a comfortable home and person centred care to the residents. The management systems in place ensured the service was effectively monitored and provided appropriate care and support to the residents. However, there were some improvement required in relation to health care and fire safety.

The inspector reviewed a sample of residents personal care plans and they had an up-to-date assessment of need which appropriately identified residents health, personal and social care needs. The assessments informed the residents personal support plans which were up-to-date and suitably guided the staff team in

supporting the residents with their assessed health, personal and social care needs. The review of the person centred plans looked at areas such as significant events, advocacy, finances and activities.

Overall, the designated centre was decorated in a homely manner. The residents bedrooms were decorated in line with their preferences and pictures of the residents and samples of their artwork were located throughout the centre.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. Risks were managed and reviewed through a centre specific risk register and individual risk assessments. The risk register outlined the controls in place to mitigate the risks. The centre had suitable fire safety equipment in place, including emergency lighting, detection systems and fire extinguishers which were serviced as required. The residents had personal emergency evacuation plans (PEEP) in place which guided the staff team in supporting the residents to evacuate. There was evidence of regular fire evacuation drills taking place in the centre however the most recent drill with minimal staffing took significantly longer than drills with the optimal level of staffing. Similarly, a number of containment measures in place required review as they did not ensure adequate containment in the event of a fire. The register provider attempted to address this issue on the day of the inspection but some equipment needed to be replaced. The provider made the necessary arrangements and advised that the issue would be addressed the following week.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment (PPE), including hand sanitizers and masks, were available and were observed in use in the centre on the day of the inspection.

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of residents; it presented as a warm and homely environment decorated in accordance with the residents' personal needs and interests and it was well maintained. The designated centre was a large bungalow situated on the outskirts of a city. The centre had a large well maintained garden with a large deck that had an accessible ramp to the side of the house allowing ease of access to the garden. The provider had ensured the provision of all requirements set out in Schedule 6 including adequate storage, and adequate social, recreational spaces as well as kitchen, bathroom and dining facilities.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had detailed risk assessments and management plans in place which promoted resident's safety and were subject to regular review. There was an up to date risk register for the centre and individualized risk assessments in place which were updated regularly. There was an effective system in place for recording incidents and accidents which included an incident analysis that recorded actions taken and whether the action taken was effective and if further action was required.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and person in charge had taken steps in relation to infection control in preparation for a possible outbreak of COVID-19. The person in charge ensured regular cleaning of the premises, sufficient personal protective equipment was available at all times and staff had adequate access to hand-washing facilities and or hand sanitising gels. The centre was visibly clean and there was ample signage throughout the centre. Mechanisms were in place to monitor staff and residents for any signs of infection. Risks associated with residents and staff contracting COVID-19 had been carefully considered and risk assessed with appropriate control measures in place. An up to date COVID-19 preparedness and service planning response plan was also in place.

Judgment: Compliant

Regulation 28: Fire precautions

In general, fire safety systems were in place which included daily checks that involved a visual check on the fire fighting equipment, emergency lighting and evacuation routes. Fire detection and containment measures in place in this centre including fire doors, fire fighting equipment and an appropriate fire alarm system. An issue regarding the effectiveness of a number of fire doors was noted on the day of inspection and this was promptly followed up with maintenance who fixed all but two doors to ensure they closed properly. Two fire doors required replacing. These doors were ordered on the day of the inspection and the provider assured the inspector they would be fitted the following week. This meant that appropriate containment measures were not fully in place at the close of the inspection day.

Evidence of regular evacuation drills which simulated both day and night time conditions were taking place. However, the most recent drill that took place with the

minimal staffing levels indicated that it took significantly longer than drills with the optimum staffing level. The documentation in place relating to evacuation drills did not allow for full identification of potential evacuation issues and learning from these drills. From a sample of drills reviewed, the documentation indicated that alternative evacuation routes were not demonstrated and therefore potential issues relating to alternative evacuation routes were not identified.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Comprehensive needs assessments were in place for residents and the designated centre was found to be suitable to meet their assessed needs. Appropriate personal plans had been put in place and contained suitable goals and were subject to regular review with input from the multi-disciplinary team. The review of the person centred plans looked at areas such as significant events, advocacy, finances and activities. The personal plans also included how to best support the residents with areas such as personal care, nutrition, mobility, health and safety and their social needs.

Judgment: Compliant

Regulation 6: Health care

The inspector found that all aspects of resident's health-care were not met in this designated centre. While an appropriate weighing scales had been identified and approved for purchase, this was not in place on the day of the inspection and therefore the provider had no access to an appropriate scales to monitor the residents' weight on a regular basis. Records indicated that while attempts were made earlier in the year which were unsuccessful, the monthly weight charts had not been completed in a number of months and resident's weight had not been recorded and monitored since the beginning of the year. It was communicated that the previous scales was shared with another provider and could no longer be shared as a result of COVID-19.

It was also noted on the day of the inspection that a resident's wheelchair was assessed by staff and a member of the provider's multi-disciplinary team as not meeting that resident's most current needs. For instance, it was identified by the provider that the foot plates and the sides of the wheelchair needed adjusting. Documentation indicated that resident displays signs of discomfort when seated and a multi-disciplinary review was arranged. The person in charge arranged for the community occupational therapist (O.T) to conduct an assessment which took place and the community O.T agreed to review. The staff communicated and it was

observed that they minimize the resident's time in the wheelchair to promote the resident's comfort. However, they were required to use the wheel chair for meals as directed in the resident's swallow care plan and for transport. The provider assured the inspector on the day of the inspection that they will follow up this matter to address the issues with this residents wheelchair.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that staff had up to date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. The inspector observed the staff implementing the proactive strategies during the inspection which was in line with resident stress support plans. The stress support plans for resident's had input from a multi-disciplinary team. Where restrictions were in place, they were implemented in line with best practice and efforts were made to ensure that the least restrictive method was employed. There were risk assessments in place for the use of restrictive practices which identified the rationale for the use of same and they were subject to regular review.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to ensure that residents were safeguarded from abuse in the centre. Staff had completed training in relation to safeguarding and protection and were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. Staff were also familiar with who the designated officer for the centre was. There were no open safeguarding concerns and there was evidence that previous concerns were monitored, reviewed and dealt with appropriately. Residents had intimate care plans in place which detailed their support needs and preferences.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bluebell Lodge OSV-0007754

Inspection ID: MON-0029557

Date of inspection: 30/09/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The HR Department will include the checking of staff photographic identification in the annual audits of personnel files. The process will be completed by 17th December 2021 ensuring that all staff have valid/current photographic identification on file.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There is a training plan in place to ensure that all required training is completed by 28th January 2022.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of purpose will be reviewed to reflect the current service provided in the designated centre and to ensure that it meets the requirements of the regulations. This will be completed by 17th December 2021.	
Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The two fire doors which would not close on the day were replaced. A review of fire documentation is being completed with the assistance of a fire safety consultant and staff will be trained in all updates. This will be completed by 28th January 2022.

Regulation 6: Health care

Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
A suitable weighing scales has been ordered and will be available in the centre by the 30th November 2021.
The resident's wheelchair was assessed by the community OT on 24th May 2021 and the chair was deemed appropriate with some minor repairs which were completed. It was then reviewed again by the WIDA OT on 12th August following an internal referral as residential staff had a concern that the person may be uncomfortable in the chair at times. Recommendations were made by WIDA OT to promote the service users comfort while an external referral was made. There was a delay with the external referral because the resident was now in a different county and a new OT had not yet been assigned. A further referral has now been sent to the Central Remedial Clinic for a full review of the chair and this has been highlighted as being urgent. In the meantime, the service user is being supported as per the recommendations made by WIDA OT to reduce the time spent in the chair and minimise any possible discomfort.
The disability manager in the county where the resident previously resided has been contacted to provide assistance with the prioritisation of this referral.
WIDA OT will continue to advocate weekly for this person to have her wheelchair reviewed by the 17th December 2021.

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	17/12/2021
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	28/01/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	28/01/2022
Regulation 03(1)	The registered provider shall prepare in writing	Substantially Compliant	Yellow	17/12/2021

	a statement of purpose containing the information set out in Schedule 1.			
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	17/12/2021