



# 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:	Announced
Date of inspection:	08 December 2025
Centre ID:	OSV-0007754
Fieldwork ID:	MON-0040267

## 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 four residents with intellectual disability. 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 and social care workers.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	4
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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 (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	09:00hrs to 17:00hrs	Linda Dowling	Lead

## What residents told us and what inspectors observed

The purpose of this announced inspection was to monitor the designated centre's ongoing compliance with relevant regulations and standards and inform a decision on the renewal of the registration of the centre. The inspection took place over one day and was completed by one inspector. Overall, the findings of the inspection indicated residents were in receipt of a good standard of care. Although, improvements were required to ensure effective oversight of residents' personal finances which is discussed further under Regulation 12: personal possessions.

At the time of inspection the centre had capacity to accommodate four residents. Four residents were living in the centre on the day of inspection, two of these residents had transitioned into the centre in the weeks prior to the inspection from another designated centre operated by the same provider. The inspector had the opportunity to meet with all four residents who lived in the centre. In addition to meeting with residents, the inspectors spoke with staff members and the management team. The inspector also reviewed documentation in relation to the care and support needs of the residents in the home. The inspector spent time at the kitchen table in the afternoon as residents returned home and observed interactions between residents and staff members. Residents appeared comfortable in the communal spaces available and were observed to move around with ease.

On arrival to the centre, three residents were being supported to get ready to leave for day service, these residents were observed to be well dressed. A day service staff arrived to support with the transition, one resident was observed to be very happy when they seen them, smiling and waving their hands. The other two residents were relaxing in their wheelchairs and were content when staff told them they were leaving to go on the bus. One resident remained in the centre and was watching their preferred show on their electronic device. They were observed to make verbal sounds and body movements to communicate with their support staff. They were supported to get ready at their own pace and go out for lunch and visit the local library.

As part of the inspection process the inspector completed a walk around of the designated centre. The centre comprises a large bungalow style house located on the outskirts of Waterford city. The centre was clean and well maintained, each resident had their own en-suite bedroom with suitable storage for their belongings. Residents' bedrooms were seen to be decorated in line with their individual preferences and had preferred items on display.

In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and residents' feedback about what it was like to live in this designated centre and were presented to the inspector on the day of the inspection. Four surveys were returned to the inspector from residents, all four residents had been supported by family or staff

members to complete the survey. The feedback was positive, and indicated satisfaction with the service provided to them in the centre, including; the staff, activities, people they live with, food and the premises.

The next two sections of the report presents the findings of this inspection in relation to governance and management of this centre and, how the governance and management arrangements impacted on the quality and safety of the service being provided.

## Capacity and capability

This announced inspection was completed to inform a decision on the registration renewal of this designated centre. The findings of this inspection were that the residents were in receipt of good quality of care and support.

The provider was identifying areas of good practice and areas where improvements were required in their own audits and reviews.

A review of a sample of rosters indicated that there were sufficient staff on duty to meet the needs of the residents and ensure their health and social care needs were suitably supported. From reviewing the staff training records for the centre, the inspector found that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents.

## Registration Regulation 5: Application for registration or renewal of registration

The purpose of the inspection day was to inform a registration renewal decision.

The registered provider had submitted an application seeking to renew the registration of the designated centre to the Chief Inspector of Social Services. The provider had ensured information and documentation on matters set out in Schedule 2 and Schedule 3 were included in the application. This included submitting information in relation to the statement of purpose, floor plans and submitting fee to accompany the renewal of registration.

Judgment: Compliant

## Regulation 15: Staffing

The provider had ensured that a core staff team was present in the centre that was consistent and in line with the statement of purpose and the assessed needs of the residents.

There was a planned and actual roster in place, the inspector reviewed the last two months of rosters and found them to be reflective of the staffing arrangements in place. While there were two staff vacancies and one long term statutory leave requiring cover on the roster, local management were utilising familiar relief and agency staff to fill these gaps.

As mentioned previously two residents had moved to this centre from another centre operated by the same provider. The transition was planned in advance and their familiar staff team also transitioned with them to ensure consistency of care and support. From speaking with team members this has been very positive for all residents. Team meetings were held bi-monthly and a specific team meeting was held prior to the transition with all staff members involved to plan and prepare for the transitions.

The inspector reviewed three staff personnel files and these were reflective of the necessary documents required under Schedule 2 of the regulations. For example they all had up-to-date photo identification, complete employee history inclusive of two references and in-date Garda Vetting all stored on file.

Judgment: Compliant

## Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The inspector reviewed the staff training matrix that was present in the centre. It was found that the staff team in the centre had up-to-date training in areas including safeguarding, medication management, fire safety and manual handling.

The staff team were also provided with additional centre specific training including, epilepsy training, Feeding Eating Drinking and Swallowing (FEDS) training and safe administration of medication.

All staff were in receipt of two supervision meetings per year as per provider's policy. From review of the minutes, the inspector could see discussions were held on job description, statutory leave, training, care planning and management support. Local management also completed additional staff support and supervision meetings in line with the transition of two residents and the changes to the staff team. Staff reported to the inspector that they felt supported and could approach management if they had any concerns.

Judgment: Compliant

## Regulation 22: Insurance

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance and found that it ensured that the building and all contents were appropriately insured.

Judgment: Compliant

## Regulation 23: Governance and management

The management structure defined in the statement of purpose was in line with what was in place in the centre during the inspection.

The centre had a full time person in charge who also had responsibility for four other designated centre's operated by the same provider. The inspector was made aware this remit was an interim arrangement and the provider was currently engaging in recruitment for the role of person in charge. The person in charge for this centre had support from a social care worker and staff nurses within the staff team who were assigned delegated duties. The lines of authority and accountability were clearly identified and these were known by the staff team. The person in charge reported to an assigned senior manager who reports to the director of services.

The provider's last two six-monthly audits and the latest annual review were reviewed by the inspector. These reports were detailed in nature and captured the lived experience of residents living in the centre. They were focused on the quality and safety of care and support provided for residents, areas of good practice and areas where improvements may be required were identified in these reports.

The person in charge ensured local audits were being completed regularly, these audits included medication, food and nutrition, record keeping and infection prevention and control.

Judgment: Compliant

## Regulation 3: Statement of purpose

The provider had submitted a statement of purpose (SOP) which for the most part accurately outlined the service provided.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre. Although it did not include information on the fire precautions and associated emergency procedures in the designated centre as specified in the regulations. The inspector requested an updated SOP with all information included to be submitted to the Chief Inspector of Social Services.

Judgment: Substantially compliant

## Quality and safety

From what the inspector observed, speaking with the residents, staff and management and from review of the documentation it was evident that good efforts were being made by the provider, person in charge and the staff team to ensure that residents were in receipt of a good quality and safe service. Residents were afforded good opportunities to engage with their community and complete activities of their choosing. However, improvement was required in the effective oversight of residents' personal finances.

The inspector completed a walk around of the centre, it was found to be warm, clean and in a good state of repair. There was evidence of recent work completed to ensure the centre was suitable for all residents with consideration taken into recent transitions. The centre had been decorated in a homely manner and residents were seen to move freely around the centre with ease.

There were a range of systems in place to keep residents safe, including audits, risk assessments and safeguarding procedures. For the most part these systems were utilised in an effective manner ensuring that adequate guidance was available for staff.

## Regulation 10: Communication

Residents were assisted to communicate in accordance with their assessed needs and wishes. Residents had communication support plans on file that guided staff on how best to communicate with the residents. The plans detailed the individual and specific ways on how residents communicated their needs and wishes. The plans were found to be in date and available to staff.

Residents were also supported with the use of visual supports these included social stories. Residents who recently transitioned to the centre had social stories on file that supported them to understand the transition. These social stories included photos of the centre, the garden and communal areas of the centre. Visual supports were also utilised at residents meetings. For example, meal planning was completed with photos of various dinner options to support all residents to choose what they would like to eat.

Residents were supported to have access to media sources such as television, electronic devices, Internet and mobile phones.

Judgment: Compliant

## Regulation 12: Personal possessions

On review of one resident's personal possessions it was evident that improvement was required to ensure effective oversight of their finances.

One resident had been overpaying rent for number of years and this had not been identified in a timely manner by the provider's own audit systems. There was a lack of effective oversight in relation to this aspect of care and support. When this overpayment was identified the provider had taken steps to reimburse the resident and evidence of this was seen on the day of inspection including a review of an up to date bank statement. However, a systematic review of how this lack of oversight had managed to be in place for a number of years had not occurred. Therefore it was unclear if any learnings or other improvements in this area of care and support had been identified or put in place.

While a record was maintained of residents' cash and debit card purchases it was noted that on a regular basis this was only signed by one staff member when the provider's policy states two staff signatures are required for each expenditure item. This was also the case for the twice daily balance checks that are required to be completed and the start and end of each day and signed by two staff.

No reviews were taken place in relation to quality of spend for residents. One resident was seen to be spending a considerable amount of their personal finances on private prescriptions and other pharmaceutical items such as cough syrup and specialised toothpaste. No review or exploration had taken place to alternative schemes that may cover private prescription costs for this resident. This required review.

Judgment: Not compliant

## Regulation 17: Premises

As previously mentioned the premises comprised a bungalow style house located on the outskirts of Waterford city.

The centre was very well maintained and in a good state of repair both externally and internally. On the walk around of the premises it was noted that residents had access to their own en-suite bedrooms and there was sufficient communal spaces available for residents to relax including a kitchen / dining area and two sitting rooms. Each bedroom had suitable storage in place, this allowed for residents to store their personal belongings. Additionally, each room was appropriately decorated to meet the needs and interests of the residents.

The provider had completed a reconfiguration to the internal layout of the centre in preparation for the transition of two residents to the centre. It was evident on the day of inspection this new layout was suitable to the residents needs and while it was early days it appeared to be working well. Residents were seen to move around the centre with ease, in the evening residents were seen to gather in one of the sitting rooms with a staff member to relax and watch TV.

Judgment: Compliant

### Regulation 20: Information for residents

The inspector reviewed a resident's guide which was submitted to the Chief Inspector prior to the inspection taking place. This met regulatory requirements. For example, the guide outlined how to access reports following inspections of the designated centre.

Judgment: Compliant

### Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. The risk register and risk log reviewed were found to be reflective of the presenting risks and incidents occurring in the centre. The inspector reviewed the risk assessments for three residents and a sample of the organisational risks and found that they were up-to-date and regularly reviewed.

There were systems in place to record incidents, accidents and near misses. The inspector reviewed the incidents recorded on the system and all relevant follow up had been completed including the identification of safeguarding concerns and submission of information to relevant authorities where required.

Local management had identified the use of restrictive practices in the centre, each restrictive practice had an associated risk assessment in place and were last reviewed by the individuals multi-disciplinary team in July 2025. It was evident that reviews were considering residents' rights and clinical advice was sought where restrictions were in place to monitor medical conditions.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

The provider was actively reviewing residents' needs, developing support plans and offering support in line with these plans.

The inspector reviewed three of the residents' assessments and personal plans and found them to be up -to -date and person-centred. They were detailed and it was clear from review of the plans residents' strengths and needs were clearly reflected.

Residents were supported to set out goals they would like to achieve through annual person centred planning meetings. Goals included places they would like to visit, activities residents would like to engage in along with a focus on developing skills such as dressing independently.

From review of records, residents were seen to engage in both community and in house activities, these included visiting festive light displays, nights away, going to the cinema, meals out, visiting the library, hand massage, movies and foot spas. Additionally, there were a range of table top activities available in the centre for residents such as jigsaws and games.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents were supported to have choice in their daily lives. From review of minutes from residents' weekly meetings, they were provided with information in relation to meal planning, social activities and opportunities in day service. Residents were supported to choose and plan their week ahead and arrangements were put in place to ensure these activities and opportunities happened.

Residents were observed to be comfortable in the presence of staff and the staff were observed to be person centred in their approach to residents. From review of documentation, the use of professional and respectful language was used throughout residents assessments and plans.

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
<b>Capacity and capability</b>	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Bluebell Lodge OSV-0007754

Inspection ID: MON-0040267

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 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:  The provider will submit an updated statement of purpose, to include the required information on fire precautions and associated emergency procedures in the designated centre as specified in the regulations. To be completed by Monday 9th February 2026.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The provider has updated SD-01 Admissions and Discharges to include a requirement for new residents to have applied for rent supplements within 14 days of admission, and that the Person in Charge reviews how the application is progressing every 14 days. The council will be formally contacted by WIDA, and requested to write to tenants to inform them that their application for rent supplement has been successful. The housing association will be contacted by WIDA and asked to notify their tenant in writing when their rent supplement is received, and if it changes. The housing association will also be asked to contact all current residents to inform them of the current monies being received. The person in charge of designated centres will ensure that quarterly audits are completed by themselves or a suitably trained nominee who is qualified to follow up on issues identified. Staff training in SD-10 Service User's Finances will be undertaken with all staff at team meetings. The Person in Charge will ensure that there is a review of the service user's finances on a weekly basis to ensure that all checks are being completed correctly. SD-10 Service User's Finances will be updated to include the monitoring of the quality of spending so that residents are supported to access alternative schemes to cover the cost of things such as private prescriptions. The updates of all procedures will be communicated with staff at team meetings. Where	

individuals are not fully implementing procedures, the Person in Charge will follow up through staff supervision meetings.

To be completed by 31st March 2026 |

## 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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31/03/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	09/02/2026