



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

Issued by the Chief Inspector

Name of designated centre:	Mountainview
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	30 July 2025
Centre ID:	OSV-0007982
Fieldwork ID:	MON-0047419

About the designated centre

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

In Mountainview a full-time residential service is available to a maximum of four residents aged between 18 and 65 years. Residents may be autistic or have an intellectual disability, and may also have sensory and physical needs. The service operates 365 days a year. Supports are provided within a safe, homely environment, designed to promote wellness and quality care and support. The designated centre is a detached dormer bungalow located in a rural area, approximately 5km from the nearest town. There are four resident bedrooms, three of which have an ensuite bathroom. Residents also have access to communal facilities including a large kitchen, dining and sitting area, a separate living room and an upstairs games room. The centre is staffed at all times that residents are present, with two staff working in the centre overnight.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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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
Wednesday 30 July 2025	09:20hrs to 15:40hrs	Kerrie O'Halloran	Lead

What residents told us and what inspectors observed

This inspection was an unannounced focused regulatory inspection to review the arrangements the provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013) and the National Standards for Adult Safeguarding (2019). Safeguarding of residents is an important responsibility of a designated centre and fundamental to the provision of high quality care and support.

The inspection was facilitated by the team leader and the person in charge. The inspector had the opportunity to speak to both the team leader and person in charge and one staff member who worked in the centre. The inspector briefly met three other staff members who were on duty on the day of the inspection. Four residents lived in this centre and required support in the area of social care and positive behavioural support. Some residents had assessed needs in health care such as, elimination and dental care and had support from staff and health care support plans in place with these aspects of their care. The designated centre had an emphasis on promoting residents independence, positive risk taking and integration within their local community.

On arrival the inspector was greeted by the team leader and introduced to the staff on duty. The team leader facilitated a tour of the centre. The designated centre comprises of detached dormer bungalow located in a rural area. Each resident had their own bedroom, three of these bedrooms had an en-suite facilities. The additional bedroom had access to a bathroom, which could be used for communal use if required. The centre had a sensory room upstairs which contained items such as a bean bag, table top activities and seating. The centre was observed to be bright, homely, and had pictures displayed of residents enjoying various activities. Although the premises was generally clean and well-maintained some areas had been identified for improvement by the team leader and person in charge. These had been documented on the centres maintenance record to be completed. These included a number areas of the centre that required painting due to wear and tear. On the day of the inspection the centre had maintenance on site to put in place a new television.

The inspector had the opportunity to meet two of the residents living in the centre. These residents communication needs varied, one resident did not communicate verbally with the inspector, while another resident had limited verbal interactions. One of these residents came to greet the inspector as they spoke with a staff member. The resident appeared happy and relaxed in their home. The staff member spoke in detail about the supports in place for this resident and activities the resident enjoyed. A second resident was met with later in the day, this resident was being supported by staff to choose an activity for the day ahead. The staff supported the resident with this by showing the resident different activities in a picture format. The resident used the pictures to inform their choice of shopping. The resident and staff then headed out on their activity. Staff discussed with the

inspector that independence, choice and communication is promoted in the centre. Residents in this centre are supported with one to one, or two to one staffing as per their assessed needs. One resident was staying with family on the day of inspection, while another resident was out partaking in activities in their community and the inspector did not get the opportunity to meet them.

Residents were supported and encouraged to maintain connections with their family and friends. Visiting to the centre was facilitated. There was space for residents to meet with visitors if they wished. Some residents enjoyed regularly visiting their family members at home. Telephone calls, messages and letters were also used to stay in contact with family members.

Residents' rights were promoted and residents had access to information in a suitable format. Important information such as the complaints process, safeguarding information, advocacy services, assisted decision making information as well as staffing information was made available to the residents. These were displayed and discussed regularly with residents in monthly keyworker meetings. There was evidence of on-going communication with residents on a daily basis through activity planners displayed, as well as, through regular weekly house meetings. Residents were also supported with annual person centred planned meetings.

It was evident throughout the inspection that both staff and management were person centred in their approach to care and support, and that residents were supported to make their own decisions. Safeguarding of residents was balanced with their right to positive risk taking. The provider had system in place to protect residents from abuse, and that there were robust systems in place to respond to any allegations in a way that ensured the residents safety was maintained.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This section of the report describes the governance and management arrangements and how effective these were in ensuring a good quality and safe service.

There was a clear organisational structure in place to manage the service. The person in charge worked full-time and was responsible for the day to day operation of the service. The person in charge was supported in their role by a team leader.

The provider had ensured the staff numbers and skill mix were in line with the assessed needs of the residents and appropriate to meet the safeguarding needs of residents. The inspector noted adequate staffing levels were in place on the day of the inspection. The inspector reviewed rosters from May to August 2025.

Staff recruited to work in the designated centre completed an induction programme which included instruction and guidance on information regarding the centre, policy's and procedures, safeguarding and medications. The inspector reviewed the induction record for a staff member that had commenced employment in 2025.

Overall, this inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality.

Regulation 15: Staffing

The provider had ensured that the staff numbers and skill mix were in line with the assessed needs of the residents and appropriate to meet the safeguarding needs of residents.

There were sufficient numbers of staff to meet the needs of the residents both day and night. The roster reviewed showed that the planned numbers and skill mix of staff was maintained and that there was a consistent staff team who were known to the residents. The person in charge advised that there was one staffing vacancy in the centre but this position had been filled and the new staff member would be commencing in the coming weeks. This vacancy had been filled by part time staff working additional hours, so they were familiar to the residents.

Residents in this centre had 1:1 or 2:1 staffing in place as per their assessed needs. This was to ensure the safety of the residents.

The inspector spoke to the team leader, person in charge and one staff member and they were found to be knowledgeable in their role and the support needs of residents. They were also familiar and knowledgeable in questions relating to safeguarding of residents. They were also knowledgeable about the ways to respond to behaviours of concern.

During the course of the inspection the inspector observed and overheard staff interacting with residents in a caring and professional manner and in accordance with their assessed needs. It was evident that residents were comfortable with the staff supporting them and that they were familiar with them.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that all staff who worked in the centre received training in areas such as safeguarding, children's first, management of potential and actual aggression (MAPA), fire safety, positive behaviour support and manual handling to

reduce the risk of harm and promote the well being of residents. Other training was provided to staff to support them safely to meet the support needs of residents including infection prevention and control and administration of medications. Staff had also completed training in human rights.

One staff was awaiting positive behaviour support training, this had been scheduled in the coming weeks. Six staff had been scheduled for management of actual and potential aggression in the coming weeks as part of a refresher training.

Staff were provided with regular supervision meetings from their line manager to support their work practice and development. A schedule of supervision meetings was documented.

Judgment: Compliant

Regulation 23: Governance and management

There were effective leadership and management arrangements in place to govern the centre and to ensure the provision of a good quality, safe service and to ensure that residents were safeguarded. The provider had ensured that the designated centre was resourced in terms of staffing and other resources to ensure the effective delivery of care and support in line with the assessed needs of the residents.

The provider and local management team had systems in place to maintain oversight of the safety and quality of the service including an annual review of the service, which had taken place for 2024. There was evidence of ongoing consultation with residents and their representatives in this. The provider had ensured six-monthly unannounced audits had taken place in the centre. These had been completed in September 2024 and March 2025. Both the annual review and six-monthly unannounced audit contained action plans. For the most part these actions were seen to be completed. However, an action had been identified to be completed in June 2025 was found not to be fully completed on the day of the inspection. All staff were to receive a medication competency assessment, the full staff team had not completed these and from a review of the documentation five staff had completed these.

Where safeguarding incidents had taken place, investigations had commenced immediately, and immediate steps had been taken to ensure the safety of all residents. Some improvement was required to ensure reviews were recorded, this will be discussed under Regulation 8, protection. When required, safeguarding plans had been put in place following consultation with the designated officer. The centre also had the support of a positive behaviour support specialist. All the appropriate authorities had been informed, and the necessary notifications had been made to the Office of the Chief Inspector.

Support for staff had been made available, and communication with the staff team

was on-going. The inspector reviewed the regular monthly staff meetings for 2025 and safeguarding was a standing item at each of these meetings. This included a review of any incidents and any learning from them. Meetings also discussed different safeguarding scenarios.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of service for the residents living in the designated centre. This inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality. The provider and person in charge were endeavouring to ensure that residents living in the centre were safe at all times. Some review was required in Regulation 5: Individual assessment and personal plan and Regulation 8: Protection.

Staff and management spoken with were familiar with and knowledgeable regarding residents' health care and support needs. Residents had access to general practitioners, out of hours general practitioners service and a range of allied health services. The inspector reviewed the files of two residents. Support plans in place including those to guide the specific health care needs of residents were found to be informative, however one resident's health care support plan required further review to ensure it was reviewed on an annual basis. Residents had also completed annual person centred planning meetings. These meetings reviewed residents achievements for the previous year and planned goals and aspirations for the residents for the coming year ahead. This will be discussed more under Regulation 5: Individual assessment and personal plan.

Where some residents' required behavioural support, the provider had ensured these residents received regular multidisciplinary reviews, as and when required. A behaviour support specialist was accessible to the centre to review this aspect of residents' care. Each resident had a positive behavioural support plan in place. The inspector reviewed two of these, they were found to provide clear information for staff and had been recently reviewed.

Regulation 10: Communication

The inspector reviewed two of the resident's communication plans. These plans were clear and contained information specific to the communications needs of the residents. Residents in this centre presented with assessed communication needs. Residents used various methods to communicate including some words, gestures, pictorial communication aids and objects of reference. The team leader informed the

inspector that some residents had commenced over the past year using communication applications to support their communication. Staff and management of the centre discussed how residents were continuing to be supported to use this.

Residents had access to speech and language therapy. Recommendations made were available in residents support plans. These recommendations were clear and informative for staff. Staff spoke to the inspector about these recommendations, visual schedules were in place for residents. One resident had a communication dictionary developed in their personal plan, this clearly identified words the resident may communicate and what these words mean. The staff and team leader spoken with informed the inspector how informative this was and it supported staff in facilitating the resident's communication needs.

The inspector saw that communication of all forms was respected and responded to. The inspector saw kind and caring interactions between residents and staff, and staff were able to use their knowledge of residents and their routines to promote responses.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had systems and processes in place for risk management at this centre. The centre had a risk register in place and these risks had been reviewed by the person in charge and team leader. Resident's had individual risk assessments in place, where risks to their wellbeing and safety such as abuse were identified, assessed and in general kept under ongoing review.

Some review was required to ensure all control measures in place were identified for residents. For example, one resident had an open safeguarding plan in place, this resident had a risk assessment also in place; however not all control measures had been identified on this risk assessment, such as the safeguarding plan. To note the risk assessment had been updated after the safeguarding incident.

Other risk assessments reviewed were seen to have control measures in place to alleviate the identified risk. For example, one resident had a risk assessment in place for the use of transport, this identified the use of items that were clearly recorded on the center's restrictive practice log, along with a protocol in place to support the resident.

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Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall residents' health and social care needs were regularly assessed and care plans were developed, where required. These plans reviewed by the inspector were found to be individualised, clear and informative. Staff spoken with were knowledgeable regarding the care and support needs of residents. For example, one staff member discussed the supports required for one resident while using the centres transport. The resident has a protocol in place which had been recently reviewed and updated along with a risk assessment in place which identified specific controls to support the resident.

One resident had a bowel management plan in place. This identified how to support the resident and was found to be clear and informative. The resident was being supported actively with this and attending general practitioner appointments. However, the health care plan for bowel management required review to ensure it was reviewed on an annual basis or as required. The care plan had last been reviewed in June 2024

Residents were supported to identify and achieve personal goals. Annual person centred planning meetings were held with residents and regular meetings took place to review and discuss progress of identified goals. Residents had monthly keyworker meetings in place. The documentation reviewed for two residents was found to clearly identify meaningful goals for the residents. The inspector noted that goals set out for 2024 had been achieved, with pictures in place. However, some review was required to ensure residents goals that had been achieved were not ongoing goals. For example residents had achieved goals such as attending swimming regularly and local GAA matches, however these remained ongoing goals for 2025. Residents had a New Directions file in place which recorded activities residents completed during their weekdays. These were found to be clear and informative and documented such activities residents were completing regularly.

Residents had been supported to complete a number of goals including using public transport, day trips and nights away. One resident was taking steps to progress to a holiday abroad.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents that required support with behaviours that challenged were being supported appropriately, had access to specialists in behaviour management and behaviour support plans were in place. Staff had received training in order to support residents manage their behaviour. The behaviour support plans in place outlined supportive strategies, detailed information about situations which might trigger distress for residents and guidance for staff on managing difficult situations.

It was evident that there was sufficient detail in the positive behaviour support plans that staff were familiar with these plans to ensure that residents were protected and supported. The inspector reviewed two of these plans and both had been recently reviewed in April and June 2025.

The local management team regularly review restrictive practices in use. This meeting had taken place in June 2025. There were some restrictive practices in use for residents such as restricted access to medications and chemicals. The centre ensured that restrictions were reviewed to ensure where possible restrictions could be reduced. Some reductions in restriction were in place such as window restrictions had been reduced. Where an additional restriction was required this was found to be reviewed by the committee and put in place. For example, a resident now required the use of an additional safety measure while using the centres transport, this had been approved by the committee and a protocol in place had also been updated to reflect this. The centre also had a risk assessment in place which identified the updated control measures in place.

Judgment: Compliant

Regulation 8: Protection

The provider had taken measures to safeguard residents from being harmed or suffering abuse. All staff had received specific training in the protection of vulnerable people to ensure that they had the knowledge and the skills to treat each resident with respect and dignity and were able to recognise the signs of abuse and or neglect and the actions required to protect residents from harm.

Staff spoken with were aware of the various types of abuse, the signs of abuse that might alert them to any issues and their role in responding to any concerns. Staff were confident that any concerns raised would be listened to, taken seriously and acted upon.

The designated officer was displayed in the centre and the staff and management spoken with on this inspection were aware that they could raise any concerns with the local management team.

On the day of the inspection there was one open safeguarding plan in place. This interim safeguarding plan included strategies to protect the resident from harm. The plan had a date identified for June 2025 for review. The review status/update had not been documented that the plan had been reviewed as outlined. This required review.

Judgment: Substantially compliant

Regulation 9: Residents' rights

In this designated centre there was an emphasis on ensuring that residents were supported to make their own choices and that their right to live safely was recognised. The team leader discussed with the inspector that meal planners are completed with the residents weekly, however if a resident requested a change of meal this is accommodated. The inspector observed a resident being provided with a choice of activity and the staff supported the resident with this.

Each resident had easy-to-read information in place in their bedrooms. The inspector reviewed one of these and contained information on safeguarding, complaints and about their home, who they live with and the supports in place for the resident.

Each resident had consented to the restrictive practices in place in the centre which was specific to their assessed needs. These documents contained pictures of each of the restrictions in place.

Residents were supported with weekly residents meetings and monthly keyworker meetings. These meetings discussed meal planners, activities, goals and upcoming events for residents. Along with complaints, safeguarding and advocacy.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mountainview OSV-0007982

Inspection ID: MON-0047419

Date of inspection: 30/07/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge will ensure that all staff complete their medication competency assessments within the timeframe identified in the annual review of the service, which set a completion date of June 2025. This target was not fully met, as assessments were ongoing at the time of the inspection and had not yet been completed by the full staff team. The Person in Charge will implement and maintain a competency schedule to ensure that all staff remain up to date with their medication competencies. Completed assessments will be recorded and monitored as part of the centre's regular governance and audit processes to ensure safe medication practices are maintained.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: To comply with Regulation 26, the Person in Charge will ensure that all control measures are identified and maintained in the relevant risk assessments. The previously identified risk assessment has been updated to include the safeguarding plan as a control measure.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: To comply with Regulation 5, the Person in Charge will ensure that all care and support plans are reviewed at a minimum annually, or sooner if required. On the day of the inspection, the resident had a scheduled GP appointment to review their bowel management plan. This appointment had been communicated to the inspector, and the plan was subsequently reviewed and updated immediately after the appointment to reflect any relevant changes. Additionally, the Person in Charge will ensure that goals achieved in the previous PCP year are reclassified as ongoing preferred activities rather than remaining as active annual goals.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Person in Charge will ensure that all safeguarding plans are reviewed in line with the timelines identified within the plan and that these reviews are clearly documented.	

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 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	30/10/2025
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the	Substantially Compliant	Yellow	30/08/2025

	resident's quality of life have been considered.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/08/2025
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/08/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers	Substantially Compliant	Yellow	30/08/2025

	abuse.			
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