Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cloonlyon Service
Name of provider:	Health Service Executive
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	30 April 2026
Centre ID:	OSV-0008089
Fieldwork ID:	MON-0045049

About the designated centre

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

Cloonlyon Service provides a full-time residential service to four adults with a diagnosis of intellectual disability. The service comprises one accessible property based in a rural location within driving distance of a busy town. Support is provided by a team of nursing and healthcare assistants and includes waking night support.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 30 April 2026	10:00hrs to 16:30hrs	Catherine Glynn	Lead

What residents told us and what inspectors observed

The residents who received residential care in Cloonlyon service had a good quality of life. They had choices in their daily lives, were supported with personal development, and were involved in activities that they enjoyed. The person in charge and staff team were focused on ensuring that a person-centred service was delivered to the residents.

This inspection was completed to monitor and review the arrangements that the provider had in place in order to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulation (2013). It was an unannounced inspection completed in line with the regulatory process required. Overall, this inspection found that the service was person-centred and suitable to meet the needs of residents.This inspection found that improvements were completed following the previous inspection in April 2024, but some minor actions were noted on the day of this inspection.

The centre was located on the outskirts of a rural town. It was a short drive from larger regional towns that provided services, such as shops,cafes and other amenities. Each resident had their bedroom and access to suitable bathroom facilities. There was also suitable communal space throughout the centre, including a kitchen, dining area, laundry facilities, sitting rooms and staff office. There was also suitable garden space to the front and rear of the centre.

Following the initial meeting with management a walkaround of the centre was completed and the inspector noted that it was warm, clean and well maintained in general. The house was also suitably decorated throughout and personalised to reflect the residents' preferences and choice in their home.As part of this inspection, the inspector met with two residents at different times during the inspection, there was one vacancy and another resident was in hospital on the day of the inspection.

The person in charge and staff team prioritised the wellbeing, autonomy and quality of life for the residents. It was clear from observation in the centre, conversations with staff and observations in the centre during the inspection, that residents were supported in line with their assessed needs.

Residents were supported with a variety of individualised options for activities. This included home-based activities due to aging profile, while another resident was awaiting completion of a day service assessment. Activities provided included table top, arts and crafts and outings in their local community.

On review of documentation and discussion with the person in charge, the inspector found that the residents were availing of appropriate activities and were not limited in choice or accessing their local community. The management team shared that

residents, family and the staff team that all residents were content with the service in place.

Overall, the inspector found that while some minor improvements were required, residents received a high standard of care and support, which was promoted through effective governance and management and the service was very person centred, meeting the assessed needs of all residents living in Cloonlyon service.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how this impacted the quality and safety of the services delivered to the residents living in this centre.

Capacity and capability

The inspector found that the governance and management arrangements in the centre had improved since the inspection in April 2024 with some minor actions identified on the day of this inspection in areas such as risk, personal planning and governance and management. These are discussed in detail under each regulation in the report.

The governance and management arrangements in the centre had recently reconfigured. A newly appointed person in charge had recently commenced and the inspector noted they were getting familiar and established in their role. In addition, they met the requirements as specified in the regulations for the role. The person in charge was supported by an established and experienced management team and spoke of the support and supervision provided to them in their role. The inspector noted that the provider had addressed all actions identified from the previous inspection with some minor areas for improvement identified during this inspection. The provider had not recognised some of the deficits found during this inspection, but were aware of the gap in risk management.

The staffing arrangements in place were reviewed as part of this inspection. A planned and actual roster was available and it showed an accurate account of staff present at the time of the inspection. The provider ensured that the number and consistency of care and support was provided to the residents in Cloonlyon service.

Overall, the inspector found that the governance and management arrangements had significantly improved in this centre, however some minor actions were identified requiring review on the day of this inspection.

Regulation 15: Staffing

The provider had ensured that the staffing arrangements in place in the centre met assessed needs of the residents both day and night were in place.

A planned and actual staffing roster was maintained as required by the regulations. The inspector reviewed rosters for two months prior to the inspection and found that the planned numbers and skill mix was maintained and that there was a consistent staff team who were known to the residents.

The inspector met with two staff members, and the person in charge on the day of the inspection. They were found to be knowledgeable about the support needs of residents, and they could readily answer questions relating to the safeguarding of residents. Staff were knowledgeable about how to respond to residents who may have behaviours of concern, so as to ensure the safety of all residents living in the centre.

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

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the governance and management strategies and processes in place in relation to the safeguarding of residents, and the response to any complaints or concerns were managed effectively. However, some improvements were required to ensure the systems were robust and monitored effectively.

From a review of documentation, the inspector noted the following areas for improvement. This included:

- On the day of the inspection, there was no annual review completed since the previous annual review completed in January 2025.
- The inspector noted that the provider had completed actions identified in the previous inspection but had failed to complete an action identified on the unannounced audit completed in December 2025. The provider had highlighted the need to assess the need for a generator in the centre as it was relocated in May 2025. The provider had stated on their controls in a risk assessment, that in the event of power loss, a generator was in place in the service. On the most recent six-monthly unannounced audit, it also identified that the lack of a generator required review by 31/01/2026. No update or response was provided on the date specified. This remained outstanding on the day of the inspection.
- The inspector also found in a residents epilepsy protocol that signatures from all of the relevant stakeholders was not completed since January 2025 and

this resident was not reviewed by their neurology team since 2014, or to verify if the practice in place was still required.

There were clear lines of accountability in the centre. Staff knew who to contact should any issues arise. Information was shared at regular team meetings. The inspector reviewed minutes of meetings completed from December 2025 to February 2026. Meeting records showed discussions on specific issues relating to residents' care, such as a review of staffing supports and roster arrangements in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the statement of purpose and found that it included the prescribed information and adequately described the service provided in the centre, for example floor plans, and current staffing provided. On the day of the inspection minor amendments were required and these were completed during the inspection by the person in charge. The statement of purpose was also available in an accessible format in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The management of complaints was effective in this centre, and ensured that complaints raised by residents and or their representative were dealt with in an appropriate and timely manner.

The provider had a current complaints policy and procedure in place that was up to date in the centre. The person in charge maintained a log of all complaints and ensured that a record of the outcome of each complaint was recorded. The record showed the types of complaints submitted and the actions completed against each complaint. At the time of the inspection, there were no active or ongoing complaints in place. In addition, if a resident was not satisfied with the outcome of the complaint the provider had ensured there was an appeals process and other support persons that could be contacted if needed.

Judgment: Compliant

Quality and safety

The inspector found that the service provided in Cloonlyon residential service was person-centred and residents were supported to enjoy activities in line with their assessed needs. Some minor areas for improvement were required in risk and medication as identified on the day of the inspection.

The person in charge and staff team were very focused on ensuring that resident's general welfare, development, community involvement and leisure activities were prioritised on a daily basis. The centre had a dedicated transport which could be used for outings, home visits and other activities residents may choose. This included attending community social events, shopping or visiting local recreational places.

The provider had ensured that the resident's health, personal and social care needs were assessed. Care and support plans were developed as required. The inspector noted on the day of the inspection that the provider had completed actions as identified from the previous inspection but the it was noted that the easy read format of the personal plan did not included all of the information as listed on the index, the service users goals were not included on the easy read format of this document. In adddition, on review of a residents' epilepsy protocol dated January 2025, there were no signatures aside from the residents general practitioner (GP). This included the neurologist and clinical nurse specialist. Furthermore, the resident had not been reviewed by their neurology team since 2014.

On the day of the inspection, the inspector found that overall good systems were in place for the assessment, management and ongoing review of risk, but improvements were required. For example, on responding to emergencies, the provider had specified that in the event of power loss in the centre that a generator was on site, however the inspector noted that no generator was on site on the day of the inspection and was absent since May 2025. The inspector noted that on the minutes of the unannounced audit completed in December 2025, that this required review by the end of January 2026 and this remained outstanding at the time of inspection.

In summary, residents at this centre were provided with a good quality service. Further improvement was required in residents easy read versions of personal plans and that risk management required review to ensure controls listed were relevant and in place as specified in the centre.

Regulation 10: Communication

The provider had ensured that residents were supported to communicate their needs and wishes effectively.

Staff were observed speaking comfortably with residents during the inspection. This gave information to staff on how to present information to the resident so that they fully understood it. It also informed staff on the particular strategies used by the resident to express their needs, wishes and preferences. Inspectors noted that the provider had developed picture-based communication supports for residents to assist their understanding of complex issues.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had ensured that systems were in place to ensure that residents' personal belongings were safe and secure in the centre.

The provider had a current and detailed policy in place to guide staff in their role supporting the residents with their personal possessions. This included an appropriate financial management system and effective oversight through regular audits and monitoring by the staff and management in the centre. Residents were also provided with ample space and storage for their personal possessions.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had suitable systems in place for effective risk management, however the inspector found that improvement was required on a risk assessment for the loss of power.

The inspector noted that the provider had a system in place for the identification, assessment and management of risks in the centre, including a system for responding to critical incidents in the centre. A minor improvement was required in one assessment. The provider had a risk assessment for the loss of power in the centre. The inspector noted that a control specified was the availability of a generator in the centre, the inspector noted and was informed that there was no generator on site since mid-summer 2025. This was also highlighted in the last unannounced audit completed in December 2025. On this audit, it referred to the lack of a generator in the centre, and this required review by 31/01/2026. The inspector noted that there was no clarity on this action by the date specified by the provider on the day of the inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had effective arrangements in place for fire safety in the centre.

These included; fire containment measures, emergency lights, fire-fighting equipment and appropriate fire panel. In addition, a series of daily, weekly and monthly checks of the fire systems were in place, completed and maintained by the person in charge and staff team. In addition, audits were also completed by the staff team to monitor the fire safety measures in place in the centre.

Residents had a personal emergency evacuation plan (PEEP), which clearly outlined the supports required included pictures to communicate what was happening. Regular fire drills were carried out under different scenarios and to ensure all staff participated as scheduled.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had ensured that structures and procedures were in place to ensure the safe management of medications in this centre to ensure residents were supported as required.

The provider had ensured that suitable storage of all medication required for residents in this centre was in place. All residents had been assessed for their ability to self-medicate, but all residents were assessed as requiring full support with medication in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector found that the provider had addressed actions identified from the previous inspection but some minor improvements were found on the day of this inspection. The inspector reviewed a sample of records for two residents and found that gaps were noted in a personal plan. This included:

- The provider had addressed an action from the previous inspection by completing an easy-read document in the person-centred plan, but the provider failed to ensure that information about the service users' goals was included in the document as listed on the index of the easy read document.

- The inspector reviewed a seizure protocol for a resident and found that signatures required since January 2025 remained outstanding on the day of the inspection. This included the neurologist and clinical nurse specialist. In addition, while the resident had no recorded seizure activity since 2014, there was no review by a neurologist since 2014.

Overall, the staff team had ensured that each resident had an assessment with regard to the health, personal and social care needs of each resident had been completed. Care and support plans were developed and in place to guide staff in their practice and on the supports required by each resident in this centre. Some minor actions wer required as discussed previously.

Annual review meetings had occurred to review each resident's supports and well being in the centre. This was attended by their staff and representatives. At this meeting personal goals were identified for the year ahead and these were kept under review to ensure they were completed.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured that residents were protected from abuse.

Staff had received training in safeguarding. They were knowledgeable on the steps that should be taken if a safeguarding incident occurred. Safeguarding was included as a standing item on all monthly staff meetings. A designated officer was clearly displayed in the centre and staff were familiar with the process required in line with local policy, for effective safeguarding in the centre.

Residents had intimate care plans in place. This showed the support each resident required, was detailed, comprehensive and gave staff clear guidance on how to support residents.

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 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cloonlyon Service OSV-0008089

Inspection ID: MON-0045049

Date of inspection: 30/04/2026

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 Annual review for Cloonlyon service in now being completed in consultation with residents and family and will be completed by 15/06/2026. Resident surveys have been distributed for their contribution 21.05.2026. Risk assessment reviewed and updated, see below. One residents' epilepsy protocol has now been reviewed and consultation with Neurology has taken place. This protocol has now been updated and signed by the residents GP.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The risk assessment relating to loss of power has been updated to reflect current supports available at the centre. The risk of not having a generator has also been escalated to senior management and this is now under review for financial support. Awaiting update from GM and Head of Service, email sent 28.05.2026	

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:
All resident goals for 2026 have now been updated in the easy read version of the individual resident's PCPs documents. This was omitted for the Mayo Community living service document template and has now been rectified as a shared learning across the service.

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	15/06/2026
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	30/09/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an	Substantially Compliant	Yellow	31/05/2026

	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.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/05/2026