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Bloomfield Hospital

Focused Inspection
Report 2025

Promoting Quality, Safety and Human Rights in Mental Health

BLOOMFIELD HOSPITAL

Stocking Lane, Rathfarnham, Dublin 16, D16C6T4

Date of Publication:
31 August 2026

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2025 Approved Centre Inspection Report (Mental Health Act 2001)

Approved Centre Type:
Continuing Mental Health Care / Long Stay
Psychiatry of Later Life
Mental Health Rehabilitation
Neuropsychiatry

Conditions Attached:
None

Most Recent Registration Date:
16 May 2025

Registered Proprietor:
Bloomfield Care Centre CLG

Registered Proprietor Nominee:
Mr. Joe Kelly, Chief Executive Officer

Inspection Team:
Damien Lanigan, Lead Inspector
Professor James V Lucey
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Inspection Dates:
16 –18 December 2025
22 December 2025
07 January 2026

Most Recent Annual Inspection date:
11 – 14 March 2025

The Inspector of Mental Health Services:
Professor James V Lucey MCRN000646

Inspection Type:
Unannounced Focused Inspection

Contents

1.0 Background

1.1 Background

Unsolicited information related to safeguarding concerns, in addition to concerns on the quality and safety of patient care in the approved centre were brought to the attention of the Mental Health Commission.

A communication from the Chief Executive Officer (CEO) of Bloomfield directed to the Mental Health Commission was sent on the 16 December 2025 describing a cluster of events as “Trust in Care” policy breaches at Bloomfield Hospital which had been reported in July of 2025 to the senior management of the approved centre.

1.2 Reason for focused inspection

The reason for this was to inspect the approved centre’s compliance with statutory regulations. The aim was to ensure the safety of the residents by examining the quality of care and treatment received by the residents at the approved centre.

2.0 Overview of the Approved Centre

2.1 Description of the Approved Centre

Bloomfield Hospital was registered with the Mental Health Commission for 131 beds, and at the time of inspection had 113 beds in operation, it was a voluntary hospital located on Stocking Lane in Rathfarnham, south Dublin. The hospital was originally founded in 1812 by the Religious Society of Friends in Ireland (Quakers). It provided treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders. The approved centre provided residential and specialist mental health assessment, treatment, and support services to adults throughout Ireland. It also provided a national facility for the care of residents with Huntington's disease. Bloomfield Hospital was an independent non-profit organisation.

The approved centre was comprised of seven distinct units:

- Kilakee was a 21-bed unit that provided care for residents with Huntington's disease.
- Kylemore was a 15-bed unit that was the Specialist Rehabilitation Unit (SRU).
- Owendoher was a 26-bed unit that provided care for residents with enduring mental illness and challenging behaviour.
- Donnybrook was a 31-bed unit that provided care for psychiatry of later life.
- Laurel Hill was a 12-bed unit that provided care for residents with high dependency needs.
- Pearson was an 8-bed unit that provided care for residents with severe and enduring mental illness with higher levels of independence.
- Swanbrook an 18-bed unit was not in use at the time of inspection.

3.0 Methodology

The inspection was to carry out a review of the approved centre, in line with the function of the inspector as per section 51(2)(a) of the Mental Health Act 2001, to visit and inspect at any time any approved centre or other premises where mental health services are being provided.

The inspection team attended the approved centre on three occasions both on an announced and unannounced basis across the period of the 16 December 2025 to the 7 January 2026, both during the daytime and nighttime. The inspection consisted of interviews with staff and residents, documentation review and walkabouts of the wards within the approved centre.

The inspection team interviewed the Chief Executive Officer, Clinical Director, the Acting Director of Nursing, the Head of People and Culture, the Head of Quality, Risk, Compliance & Patient Administration, a Senior Social Worker and a Night Clinical Nurse Manager 2. The inspection team also interviewed staff members and residents informally during two visual inspections of the units.

Reviewed the approved centre's policies relating to:

- Regulation 26: Staffing
- Regulation 27: Maintenance of Records
- Regulation 29: Operating Policies and Procedures
- Regulation 32: Risk Management Procedures
- Wound Prevention & Management Policy
- Adult Safeguarding Policy and Procedures
- Incident Reporting and Management Policy
- HSE Trust in Care
- Human Resource Disciplinary Processes

Reviewed documentation included:

- Board meeting minutes
- Senior Management Team meeting minutes
- Clinical Governance Committee meeting minutes
- Local Incident Management meeting minutes
- A statement of facts, detailing complaints of alleged poor standards of care to residents made by a Health Care Assistant (HCA) in July 2025.
- Safeguarding concerns reports arising from the HCA statement of facts.
- Safeguarding screening meeting documentation.
- Safeguarding committee meeting minutes.
- The clinical files of 28 residents and their individual care plans.
- The approved centre's staffing rostering for each unit.

- Staff training records for the past 12 months for all staff subject to the Trust in Care investigation in 2025 including those who were dismissed, disciplined or resigned arising from the HCA statement.
- 2025 Mandatory staff training record for all staff in the approved centre.
- The approved centre annual training plan.
- Recruitment processes and documentation for staff identified by the HCA statement including references, qualifications and Garda vetting.
- Trust in care investigation documentation including screening and outcomes for staff identified by the HCA statement.
- Human Resources management of staff who were investigated by the approved centre as part of Trust in Care allegations including recruitment procedures, and disciplinary procedures.
- An external review commissioned by Bloomfield Approved Centre to investigate the complaints raised by the HCA which commenced on the 7 August 2025.
- Reviewed the approved centre's internal risk management processes.

4.0 Inspection Findings

EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d)

The approved centre was found to be non-compliant with the following regulations on inspection:

- Regulation 15: Individual Care Plan: Non-compliant: risk rated as high.
- Regulation 26: Staffing: Non-compliant: risk rated as critical.
- Regulation 27: Maintenance of Records: Non-compliant: risk rated as critical.
- Regulation 32: Risk Management Procedures: Non-compliant: risk rated as critical.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

Each resident had an individual care plan (ICP). Twenty-two residents' ICPs were inspected. The documents within the ICPs were identifiable and uninterrupted and were not amalgamated with progress notes. The ICPs were discussed, where practicable, and drawn up with the participation of the resident and their chosen representative as appropriate.

Seven ICPs inspected focused on wound care. The ICP of one resident was not recorded in one composite set of documentation as the multi-disciplinary review was not recorded in the ICP and was not updated by the multi-disciplinary team to reflect any changes to the goals, treatment, care, best practice, and required resources.

Fifteen ICPs were inspected with a specific focus on identifying evidence of the safeguarding of these residents. Seven of the 15 ICPs inspected did not address the resident's goals, mental health care and treatment needs based on a multi-disciplinary team (MDT) assessment of the person or document appropriate goals in relation to safeguarding concerns.

Following the ICP review by the MDT, 12 out of 15 ICPs inspected were not updated contemporaneously in accordance with best practice to reflect any changes to the goals, treatment, care, and required resources as per the assessed needs of the resident to reflect safeguarding concerns.

The remaining ICPs inspected identified the resources required to provide the care and treatment in the cases where appropriate goals were identified. The ICPs were reviewed by the multi-disciplinary team (MDT) in consultation with the resident, at least every six months.

The approved centre was non-compliant with this regulation for the following reasons:

a) **The individual care plan of one resident inspected was not recorded in one composite set of documentation.**
b) **One of the individual care plans inspected was not updated by the multi-disciplinary team to reflect any changes to the goals, treatment, care, best practice and required resources.**
c) **Seven out of 15 individual care plans inspected did not document appropriate goals in relation to a safeguarding concern.**
d) **Twelve of the 15 individual care plans inspected were not updated contemporaneously to reflect a safeguarding concern.**

Regulation 26: Staffing

NON-COMPLIANT
Risk Rating CRITICAL

INSPECTION FINDINGS

The approved centre had a written policy and procedures in place relating to staffing. The policy was last reviewed in February 2025, and it included the recruitment, selection and Garda vetting requirements for staff in the approved centre.

An appropriately qualified staff member was on duty and in charge at all times, and this was documented.

The skill mix of healthcare staff was inadequate to meet the assessed needs of residents.

In relation to wound management and addressing the wound care needs residents in Bloomfield: prior to July 2025, a General Health Nurse was in post who had completed tissue viability training, and undertook the Tissue Viability Nurse (TVN) role within the approved centre. After they left their position, no adequate cover was provided by Bloomfield Hospital to meet the needs of residents. No internal nurse had completed formal training in wound management and tissue viability at time of inspection in December 2025. This was in breach of the approved centre's own policy on Wound Prevention and Management which stipulates that it was the responsibility of senior management in the approved centre to ensure that nursing staff are sufficiently equipped with the necessary skills and training for prevention and management of wounds.

The approved centre also relied on external TVNs to assess and grade wound care in the approved centre, and this took two formats. TVN input from medical teams in general hospitals where residents of Bloomfield had attended, however, this was limited only to a patient who had attended that service and was not available to all residents in Bloomfield, should it be needed. The approved centre informed the inspection team that they also had the option of an external private TVN. However, the approved centre did not provide a service level agreement at the time of inspection for this service and instead provided evidence of this external TVN having only attended the approved centre on one occasion in July 2025 where they reviewed six residents at that time.

The clinical skill deficit was inadequate for the provision of wound care and tissue viability to those residents who needed it during the period July 2025 to the time of the inspection in December 2025.

At the time of inspection, the approved centre's social work department had two senior social workers in post. There was no Principal Social Worker in the approved centre at the time of inspection who would ordinarily provide direct supervision for the social work service in the approved centre. This had led to a gap in the clinical supervision of the social work department and would be in breach of the approved centres own policy on staffing.

The mandatory staff training report documented that not all healthcare staff were trained in Basic Life Support, Fire Safety, the Management of Violence and Aggression, the Mental Health Act 2001 and Safeguarding. Not all mandated persons in the approved centre were trained in Children First. An annual training plan was evident for 2025 in the approved centre; however, the plan did not result in compliance with mandatory training for all staff. Of note the mandatory training report as supplied by the approved centre during this inspection for all staff represents a deterioration in compliance with mandatory training since the approved centre's annual inspection in March 2025.

Mental Health Commission Rules and Codes, and all other relevant Mental Health Commission documentation and guidance were available to staff throughout the approved centre.

Training Record												
Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (69)	60	87%	59	86%	53	76%	67	97%	67	97%	59	86%
Medical (4)	4	100%	2	50%	2	50%	4	100%	4	100%	3	75%
Occupational Therapist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	3	100%
Social Worker (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	2	100%
Peer Support Worker (1)	1	100%	1	100%	1	100%	1	100%	1	100%	0	0%
Physiotherapist (2)	2	100%	2	100%	2	100%	2	100%	2	100%	1	50%
Speech & Language Therapist (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
Dietitian (1)	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
HCA/MHSW/AC* (89)	77	87%	85	96%	66	77%	86	96%	86	96%	75	84%

*** HCA:** Health Care Assistant
MHCSW: Mental Health Care Support Worker
AC: Ancillary Carer

The approved centre was non-compliant with this regulation for the following reasons:

a) The registered proprietor did not ensure that the skill mix of staff were appropriate to the assessed needs of residents due to, inadequate tissue viability nurse access and inadequate supervision of the social work department, 26(2).

b) **The registered proprietor did not ensure that staff had access to education and training to enable them to provide care and treatment in accordance with best contemporary practice. Not all staff had completed training in basic life support, fire safety, in the management of violence and aggression and safeguarding. Not all mandated persons in the approved centre were trained in Children First, 26(4).**

c) **The registered proprietor did not ensure that all staff had completed training in the Mental Health Act (2001), 26(5).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

The approved centre had written policies and procedures relating to the:

- Creation of records.
- Access to records.
- Retention of records.
- Destruction of records.

The policy was last reviewed in October 2025. Throughout the approved centre, records were appropriately secured from loss, destruction, tampering or unauthorised access.

Residents' records were not developed or maintained in a manner so as to ensure completeness and accuracy. During the inspection it was found that not all resident records were physically stored together. Interim safeguarding plans arising from incidents of reported safeguarding events for residents were not kept in residents' clinical files. They were instead maintained as part of safeguarding investigation documentation by the approved centre separate to the clinical file. This practice resulted in individual residents' records not being complete and not accurately reflecting events happening for those residents.

The clinical files of residents were not kept up to date, and not all resident records were reflective of the residents' current status and the care and treatment being provided in the resident records inspected. One of the individual care plans inspected was not updated by the multi-disciplinary team to reflect any changes to the goals, treatment, care, best practice and required resources in relation to wound care. Twelve of 15 individual care plans inspected were not updated contemporaneously to reflect identified safeguarding concerns.

Records of senior management meetings provided during the inspection were not maintained in good order and in a manner so as to ensure completeness and accuracy and were missing essential components of record keeping.

Minutes from the Safeguarding Committee meetings, did not contain records of those staff who were present in all meetings, and it was not clear if decisions and interventions were implemented, and outcomes recorded and if some cases were closed. Records of safeguarding cases were not attributed to the individual residents correctly as there was only one identifier noted, the residents name on those records. Safeguarding concerns discussed at the safeguarding committee related to individual residents and therefore constitute a healthcare record for those individual residents. In Clinical Governance Committee meeting minutes provided, records of the staff who were present were not maintained in the majority of the records supplied and they also did not record accurate dates upon which these meetings took place.

These were in breach of the approved centre policy on the maintenance of records which states "that the content of the healthcare record must provide an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes." It also states that one of the legal standards of the healthcare record was that "Triple identifier is on each side of each page where resident's information is documented and has the correct unique resident medical record number, full name and date of birth."

The approved centre was non-compliant with this regulation for the following reasons:

a) **The registered proprietor did not ensure that resident records were maintained in a manner so as to ensure completeness and accuracy, as resident records were not up to date, did not have all resident records stored together and were not reflective of the resident's current status and the care and treatment being provided, 27(1).**
b) **Records of senior management meetings were not maintained in line with approved centres policy on maintenance of records, 27(1).**

Regulation 32: Risk Management Procedures

NON-COMPLIANT
Risk Rating CRITICAL

INSPECTION FINDINGS

The approved centre had written policies and procedures in relation to risk management. The policy was last reviewed in February 2025 and outlined:

- The process for the identification, assessment, treatment, reporting and monitoring of risks throughout the approved centre.
- The person with overall responsibility for risk management.
- The process for rating identified risks.
- The methods for controlling risks associated with resident absence without leave, suicide and self-harm, assault and accidental injury to residents or staff.
- The process for maintaining and reviewing the risk register and the record keeping requirements for risk management.
- The process for managing incidents involving residents of the approved centre.
- The process for responding to specific emergencies.
- The process for protecting children and vulnerable adults in the care of the approved centre.

Responsibilities were allocated at management level throughout the approved centre to ensure the effective implementation of the risk management policy. The person with responsibility for risk was identified and known by all staff.

Multi-disciplinary teams (MDTs) were involved in the development, implementation and review of the individual risk management processes. Residents and their representatives were involved in individual risk management processes. Corporate risks, were identified, assessed, treated, reported, monitored and documented in the risk register as appropriate.

Clinical incidents were reviewed by the multi-disciplinary teams at the regular MDT meetings. The person with responsibility for risk management reviewed incidents for any trends or patterns occurring in the services. The approved centre provided a six-monthly summary report of all incidents that had happened in the approved centre between January 2025 to June 2025 to the Mental Health Commission. Information provided was anonymised at resident level.

The registered proprietor did not however, ensure that the approved centre maintained a record of all incidents occurring in the approved centre, in line with the approved centres risk management and incident management policies. During the inspection it was found that in July of 2025, a number of safeguarding incidents whereby staff allegedly caused harm to residents were reported to senior management in the approved centre. The reporter, who was working in the approved centre made an initial report of their concerns on the night of 14 July 2025 to the nurse manager on duty, followed by 12 statements of facts detailing witnessed incidents of poor standards of care provided to residents in the

approved centre. These were noted and reported to senior nurse management and the hospital management. The senior management accepted the 12 incidents reported to the approved centre as credible, and further that there was a strong likelihood of the incidents having happened.

These incidents were not recorded by the approved centre on their incident recording system at the time when they were reported. There were delays noted by senior management in the processing and recording of these incidents and in control measures being implemented during Local Incident Management Team (LIMT) meetings that were convened to address the reported incidents and in the Senior Management Team (SMT) meetings minutes. A decision was made to manage the reported incidents by moving them into two other internal processes: Safeguarding and Trust in Care. In doing so these incidents were manged outside of the normal incident management framework and had not been returned to the incident management framework at the time of the focused inspection.

Trust in Care screening and management processes were undertaken for all the incidents identified by the statements of facts. Eleven of the 12 identified incidents were designated as trust in care events with one not deemed to be a trust in care issue. Trust in Care processes were completed using the approved centres disciplinary policy and procedures. Staff identified by the reporter underwent disciplinary processes which resulted in staff being dismissed, staff resigning, staff receiving final written warnings, staff receiving letters of concern, and some staff being cleared of any Trust in Care breaches. A decision was also taken by senior management at the centre to commission an independent Trust in Care investigation by an external auditor which commenced in August of 2025, and its findings presented and accepted by the Board of Directors in Bloomfield.

It was found on inspection that risk management procedures did not actively reduce identified risks to the lowest practicable level of risk. Incident forms were not completed at the time of the reporting in July, and then the expected incident management as per the approved centre's Incident Reporting & Management Policy was not applied.

Reviews and risk assessments and risk rating of the incidents were not completed, and in not evaluating the risk of each individual incident, this in turn did not assist the management of those risks and the possible subsequent need for reporting to external stakeholders. The approved centre did not identify a risk rating for all incidents, therefore risks could not be treated effectively and reduced to the lowest practical level of risk.

1. Incidents were not recorded and risk-rated in a standardised format.

The approved centre's policy states that "it is the responsibility of the staff member identifying the incident to report the incident by completion of an Incident Reporting Form on the incident reporting system. If the staff member is unable to complete an Incident Reporting Form, the manager on duty should complete the form on their behalf". Incident report forms were not completed for 11 of the 12 Health Care Assistant (HCA) reported incidents, one incident form was created for one of the reported incidents on 16 July. The approved centre's own policy on Incident Reporting & Management Policy was not complied with.

2. Clinical risks were not identified, assessed, treated, reported, and monitored.

The inspection found when reviewing incident reporting within the approved centre that there was evidence that the approved centre was not following their own policy to correctly identify clinical risk.

- Care plans of residents affected did not have their safeguarding needs identified in their clinical files in all cases.
- Lack of a timely incident reporting culture.
- Lack of reporting on the incident reporting system of identified incidents, which were moved outside normal incident management system into Trust in Care or safeguarding processes.
- Delays in reporting of incidents.
- Incident summary for 2025 provided by the approved centre for the period July to December 2025 showed that 125 incidents remained open for staff sign off, risk rating and uploading to the internal incident management system or the National Incident Management System (NIMS) and three were outstanding as of 23 December 2025.
- Delays to incident forms progression did not allow for trends to be monitored and treated by the approved centre in a timely manner in breach of approved centre's policy on incident reporting, which requires that all staff, "report all adverse events & near misses to their Line Manager / Manager on Duty via an Occurrence Reporting form on the internal incident management system, including those situations where no harm occurred and the person was unaffected or unaware of a problem, in a timely manner before the end of a shift".

3. The requirements for the protection of vulnerable adults within the approved centre was not appropriate and implemented as required.

Safeguarding processes were undertaken by the senior staff in the approved centre which included gathering 12 statements of facts, completing reports of safeguarding concerns and conducting safeguarding preliminary screening meetings for each reported incident. Actions arising from the safeguarding preliminary screening were implemented in relation to the staff and the management and supervision of staff involved in those incidents.

According to the approved centre's Safeguarding policy, "where reasonable grounds for concern exist following preliminary screening, safeguarding plans shall be written and developed to address safety issues for the resident. The safeguarding plan should include:

- Positive actions to safeguard the resident(s) at risk from further abuse/neglect and to promote recovery.
- Positive actions to prevent identified perpetrators(s) from abusing or neglecting in the future.
- Include consideration of what triggers or circumstances would indicate increasing levels of risk of abuse or neglect for resident(s) and how this should be dealt with.
- Support measures for residents who have experienced abuse or who are at risk of abuse should be carefully considered.
- Address the therapeutic and support needs arising from the experience and the protective

interventions aimed at preventing further abuse of the resident."

The policy goes on to say that:

- "The needs of the resident shall be paramount, and the Safeguarding Plan shall be developed with the resident(s), so far as reasonably practicable, in accordance to the resident(s) wishes.
- The Safeguarding Officer shall agree the interventions with the resident, where appropriate. Staff shall monitor the resident's wellbeing at all times.
- The Safeguarding Plan shall be implemented within three weeks of the Preliminary Screening being completed.
- The Safeguarding Plan shall be further developed in line with ongoing assessments, i.e., when the appropriate assessments/investigations have been carried out to establish levels of risk and whether abuse or neglect occurred.
- A Safeguarding Plan Review shall be scheduled at agreed intervals, within 6 months of the Safeguarding Plan commencing and, at minimum, at 6 monthly intervals thereafter or on case closure."

However, not one safeguarding plan with resident focused measures was found to be documented by the inspection team in the clinical files of the residents affected. The approved centre declared that they were not created for any case despite reasonable grounds for concern existing in the majority of the incidents identified.

The approved centre was non-compliant with this regulation for the following reasons:

a) The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre, in that all incidents were not recorded in a timely manner so as to facilitate follow up and incorporation, where required, into the risk management systems as per the policy, 32(1).

b) The registered proprietor did not ensure that the approved centre's risk management policy was implemented in practice in respect of the identification, recording and investigation of incidents or adverse events involving residents, 32(1).

c) The registered proprietor did not ensure that the approved centre maintained a record of all incidents occurring in the approved centre, in line with the approved centre's risk management and incident management policies, 32(3).

d) The registered proprietor did not ensure that the approved centre's risk management policy was implemented throughout the approved centre in relation to arrangements for the protection of vulnerable adults from abuse, 32(1)(f).

Appendix 1: Regulations

REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Regulation 15: Individual Care Plan

The registered proprietor shall ensure that each resident has an individual care plan.
[Definition of an individual care plan:"... a documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation".]

Regulation 26: Staffing

(1) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the recruitment, selection and vetting of staff.
(2) The registered proprietor shall ensure that the numbers of staff and skill mix of staff are appropriate to the assessed needs of residents, the size and layout of the approved centre.
(3) The registered proprietor shall ensure that there is an appropriately qualified staff member on duty and in charge of the approved centre at all times and a record thereof maintained in the approved centre.
(4) The registered proprietor shall ensure that staff have access to education and training to enable them to provide care and treatment in accordance with best contemporary practice.
(5) The registered proprietor shall ensure that all staff members are made aware of the provisions of the Act and all regulations and rules made thereunder, commensurate with their role.
(6) The registered proprietor shall ensure that a copy of the Act and any regulations and rules made thereunder are to be made available to all staff in the approved centre.

Regulation 27: Maintenance of Records

(1) The registered proprietor shall ensure that records and reports shall be maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. All records shall be kept up-to-date and in good order in a safe and secure place.
(2) The registered proprietor shall ensure that the approved centre has written policies and procedures relating to the creation of, access to, retention of and destruction of records.
(3) The registered proprietor shall ensure that all documentation of inspections relating to food safety, health and safety and fire inspections is maintained in the approved centre.
(4) This Regulation is without prejudice to the provisions of the Data Protection Acts 1988 and 2003 and the Freedom of Information Acts 1997 and 2003.

Note: Actual assessment of food safety, health and safety and fire risk records is outside the scope of this Regulation, which refers only to maintenance of records pertaining to these areas.

Regulation 32: Risk Management Procedures

(1) The registered proprietor shall ensure that an approved centre has a comprehensive written risk management policy in place and that it is implemented throughout the approved centre.
(2) The registered proprietor shall ensure that risk management policy covers, but is not limited to, the following:
(a) The identification and assessment of risks throughout the approved centre;
(b) The precautions in place to control the risks identified;
(c) The precautions in place to control the following specified risks:
(i) resident absent without leave,
(ii) suicide and self harm,
(iii) assault,
(iv) accidental injury to residents or staff;
(d) Arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents;
(e) Arrangements for responding to emergencies;
(f) Arrangements for the protection of children and vulnerable adults from abuse.
(3) The registered proprietor shall ensure that an approved centre shall maintain a record of all incidents and notify the Mental Health Commission of incidents occurring in the approved centre with due regard to any relevant codes of practice issued by the Mental Health Commission from time to time which have been notified to the approved centre.

Appendix 2: Background to the inspection process

The principal functions of the Mental Health Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres.

The Commission strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. The process for determination of the compliance level of approved centres against the statutory regulations, rules, Mental Health Act 2001 and codes of practice shall be transparent and standardised.

Section 51(1)(a) of the Mental Health Act 2001 (the 2001 Act) states that the principal function of the Inspector shall be to "visit and inspect every approved centre at least once a year in which the commencement of this section falls and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate".

Section 52 of the 2001 Act states that, when making an inspection under section 51, the Inspector shall

a) See every resident (within the meaning of Part 5) whom he or she has been requested to examine by the resident himself or herself or by any other person.
b) See every patient the propriety of whose detention he or she has reason to doubt.
c) Ascertain whether or not due regard is being had, in the carrying on of an approved centre or other premises where mental health services are being provided, to this Act and the provisions made thereunder.
d) Ascertain whether any regulations made under section 66, any rules made under section 59 and 60 and the provision of Part 4 are being complied with.

On a focused inspection, the Inspector does not assess all regulations, rules, code of practice, and Part 4 of the 2001 Act. The focus of the inspection will be on specific legislative requirements, or parts of legislative requirements where it is determined that there may be a risk to the safety, health and well-being of residents and/or staff members.

Following the focused inspection of an approved centre, the Inspector prepares a report on the findings of the inspection. A draft of the inspection report, including provisional compliance ratings and risk ratings, is provided to the registered proprietor of the approved centre. Areas of inspection are deemed to be either compliant or non-compliant and where non-compliant, risk is rated as low, moderate, high or critical.

In circumstances where the registered proprietor fails to comply with the requirements of the 2001 Act, Mental Health Act 2001 (Approved Centres) Regulations 2006 and Rules made under the 2001 Act, the Commission has the authority to initiate escalating enforcement actions up to, and including, removal of an approved centre from the register and the prosecution of the registered proprietor.

Appendix 3: Regulatory Actions and Special Measures taken

Enforcement Action	Date Applied	Reasons	Outcome
Special Measures Taken	17 December 2025	The Mental Health Commission made a referral to An Gardaí Síochána to report safeguarding concerns and requested acknowledgment of this report.	Acknowledgment received from An Garda Síochána.
Special Measures Taken	17 December 2025	The MHC issued correspondence to the Regional Executive Officer in the Dublin and Midlands Region to seek information and assurances on the immediate actions taken by the HSE on foot of the information received by the MHC on 16 December. Regular engagement took place with the HSE to ensure that each patient was clinically reviewed by the relevant HSE clinician. The MHC required written confirmation on the outcome of these clinical reviews.	The HSE has provided ongoing assurances to the MHC about the outcome of clinical reviews and the safety and quality of care on foot of HSE visits to the approved centre.
Special Measures Taken	17 December 2025	The MHC wrote to the registered proprietor seeking immediate assurances on the safety of residents. This required the proprietor to cease all admissions to the approved centre.	There have been no new admissions to the approved centre since December 2025 by agreement of the registered proprietor. Cessation to admissions remains in place.
Immediate Action Notice 10000393	23 December 2025	Issued during the focused inspection due to immediate concerns around the management of pressure care and lack of access to a Tissue Viability Nurse in the approved centre. There were inconsistencies identified around the grading and reporting of pressure areas. The registered proprietor was directed to submit weekly compliance updates to the regulator (see special measures below)	Immediate risk areas were addressed. The registered proprietor provided evidence of acceptable levels of improvement and immediate actions taken to ensure quality and safety of care.
Special Measures Taken	23 December 2025	The centre was required to submit weekly performance and safety data to the regulator specifically related to skin integrity, staffing numbers, safeguarding, medication errors, adverse incidents and risk management and any trust in care investigations.	Weekly reports continue to provide transparent data about the safe operation of the approved centre. The MHC continues to require these reports (August 2026). Where indicated, the MHC engage with the registered proprietor to seek additional information and assurances relating to the content of these reports.
Immediate Action Notice 10000394	13 January 2026	This was issued following the focused inspection in December 2025/ January 2026 due to concerns about • Regulation 32: Risk Management Procedures (Critical) • Regulation 26: Staffing (Critical) • Regulation 27: Maintenance of Records (Critical) • Regulation 15: Individual Care Plan (High).	Immediate risk areas were addressed. The registered proprietor provided evidence of acceptable levels of improvement and immediate actions taken to ensure quality and safety of care.