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mental health commission

Bloomfield Hospital

Focused Inspection
Report 2026

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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2026 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 Roger Smyth

Inspection Team:
Kevin Miskelly, Lead Inspector
Barbara McGeough
Shayne Wilson

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

Inspection Date:
31 March 2026

Most Recent Annual Inspection date:
11 – 14 March 2025

Inspection Type:
Unannounced Focused Inspection

Contents

1.0 Background

1.1 Background

It was brought to the attention of the Mental Health Commission, through unsolicited information, that there were concerns in relation to the care and treatment of residents in Bloomfield Hospital. An inspection ensued.

1.2 Reason for focused inspection

The focused inspection was carried out to inspect the approved centre's adherence to statutory regulations, with the aim of ensuring residents' safety through an examination of the quality of care and treatment provided at the centre.

2.0 Overview of the Approved Centre

2.1 Description of the Approved Centre

Bloomfield Hospital is registered for 131 beds, it is 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 provides treatment for residents with a range of severe and enduring mental health issues and neuropsychiatric disorders. The approved centre provides residential and specialist mental health assessment, treatment, and support services to adults throughout Ireland. It also provides a national facility for the care of residents with Huntington's disease. Bloomfield Hospital is an independent non-profit organisation.

The approved centre was comprised of seven distinct units:

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

3.0 Methodology

The aim of the focused 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.
The inspection team attended the approved centre on the 31st of March 2026 on an unannounced basis. The inspection team had an initial meeting with the Registered Proprietor/Interim Chief Executive Officer, Interim Clinical Director, and Acting Director of Nursing. The inspection team also observed residents throughout the course of the inspection.

The inspection team reviewed the approved centre's policies relating to:

- Regulation 05: Food and Nutrition
- Regulation 15: Individual Care Plan
- Regulation 18: Transfer of Residents
- Regulation 19: General Health
- Regulation 23: Medication
- Regulation 26: Staffing
- Regulation 27: Maintenance of Records
- Regulation 32: Risk Management Procedures
- Incident Reporting and Management Policy

Reviewed documentation included:

- Local Incident Management meeting minutes
- The approved centre's incident management system
- Resident's clinical files and their individual care plans
- The approved centre mandatory training record for 2026
- 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 compliant with the following regulations on inspection:

- Regulation 5: Food and Nutrition
- Regulation 18: Transfer of Residents
- Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

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

- Regulation 15: Individual Care Plan – non-compliant and risk rated as high.
- Regulation 19: General Health – non-compliant and risk rated as moderate.
- Regulation 26: Staffing – non-compliant and risk rated as high.
- Regulation 27: Maintenance of Records – non-compliant and risk rated as high.
- Regulation 32: Risk Management Procedures – non-compliant and risk rated as critical.

Regulation 15: Individual Care Plan

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The individual care plan (ICP) was identifiable and uninterrupted. The ICP was not amalgamated with progress notes and was developed by the MDT following a comprehensive assessment.

Within the ICP inspected there was no evidence that the individual's ICP was discussed, agreed, or drawn up with the participation of the resident or their representative, there was no documented reason why this did not occur.

The ICP did not clearly define resident's needs in relation to a balanced diet and swallow as there was no reference to the needs identified within a clinical assessment by the Speech and Language Therapist (SLT).

Within the ICP it was identified, as a need, that food choice was a significant participating factor to resident engaging in behaviours of concern, however, there were no clear goals documented within the ICP in respect of this need.

The resident's file contained clinical guidelines; however, this was not recorded as an intervention within the resident's ICP. This was also a breach of Bloomfield Hospital Provision of Therapeutic and Modified Consistency Diets policy, which sets out that clinical guidelines shall be documented and transferred into the residents' individual care plan.

The ICP did not identify the resources required to provide the care and treatment identified, as the SLT was not identified as a required resource within the ICP.

The ICP was not updated contemporaneously, in accordance with best practice, to reflect changes to the resident's goals, treatment, care, and required resources based on assessed needs. This was despite a significant change to the SLT approach and the subsequent reinstatement of the original approach a number of weeks later, neither of which were reflected in the ICP.

However, there was some good practice identified on the units, each resident had an individual folder continuing significant and relevant information on how best to support that individual with their care needs. These folders were found to be comprehensive and contained, pertinent, clear information to staff on how to support the resident.

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

a) **The individual care plan did not identify appropriate goals in relation to the resident's therapeutic diet.**
b) **The individual care plan did not identify the care and treatment required to meet the goals, as Speech and Language Therapy guidelines were not recorded in the individual care plan. This was also in breach of the approved centre's Provision of Therapeutic and Modified Consistency Diets policy.**
c) **The individual care plan did not identify the resource required to provide the care and treatment.**
d) **The individual care plan was not updated contemporaneously to reflect changes to care and treatment in respect of Speech and Language Therapy guidelines and special observation arrangements.**
e) **The individual care plan was not reviewed by the Multi-Disciplinary Team as one review was not attended by medical staff.**
f) **The individual care plan was not developed or reviewed in consultation with the resident, and no reason was documented.**

Regulation 19: General Health

NON-COMPLIANT

Risk Rating MODERATE

INSPECTION FINDINGS

The approved centre had an emergency trolley, and staff had access at all times to an Automated External Defibrillator (AED) which was located on the units.

Residents received appropriate general health care interventions in line with individual care plans.

Of the clinical file inspected, there was no evidence of a six-monthly general health assessment being completed for the resident despite the resident being supported in the centre over six months.

The resident was assessed in relation to glucose regulation, blood lipids, electro-cardiogram heart function, and prolactin levels, and there were adequate arrangements in place for residents to access general health services and for their referral to other health services as required, including national screening programs.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure the resident's general health needs were assessed regularly as indicated by their individual care plan, and any event not less than every six months, as there was no general health assessment completed, 19(1)(b).

Regulation 26: Staffing

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

The numbers and skill mix of staff were sufficient to meet residents' needs. However, there was a vacancy in Speech and Language Therapy, as this position had recently become available. An appropriately qualified staff member was on duty and in charge at all times.

The approved centre had access to three Occupational Therapists, two Social Workers, two staff Psychologists, one locum full-time psychologist and two Physiotherapists.

Not all staff were trained in Basic life support, as nursing staff training was at 81% trained, Health Care Assistant (HCA) training was at 90% trained, Social Worker staff training was at 50%, psychology staff was at 50% as was physiotherapy staff.

Not all staff were trained in the Management of Violence and Aggression, as only 83% of nursing staff and 82% of Health Care Assistant (HCA) were trained, at the time of this focused inspection.

Not all staff were trained in Fire safety, as nursing staff training was at 69%, Health Care Assistant training was at 77%, social work staff was at 50% and psychology staff was at 0%.

Staff Training Record

Profession	Basic Life Support		Fire Safety		Management of Violence and Aggression		Mental Health Act 2001		Children First (mandated persons)		Safeguarding	
Nursing (67)	54	81%	46	69%	56	83%	67	100%	62	93%	64	96%
Medical (3)	3	100%	1	33%	2	67%	3	100%	3	100%	2	67%
Occupational Therapist (3)	3	100%	3	100%	3	100%	3	100%	3	100%	2	67%
Social Worker (2)	1	50%	1	50%	2	100%	2	100%	2	100%	2	100%
Psychologist (2)	1	50%	0	0	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)	1	50%	2	100%	2	100%	2	100%	2	100%	2	100%
Dietitian (1)*	1	100%	1	100%	1	100%	1	100%	1	100%	1	100%
HCA/MHSW/AC (81)**	73	90%	62	77%	66	82%	81	100%	78	96%	78	96%
Other (HR, Finance, Maintenance, Risk, Compliance, Patient Administration)	N/A	N/A	16	84%	16	89%	19	100%	17	89%	17	89%

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

a) **The registered proprietor did not ensure that all healthcare staff were trained in Basic Life Support, as only 81% of nurses, 90% of Health Care Assistants, 50% of social work 50%, psychology staff and 50% of physiotherapy staff, were trained in Basic Life Support, 26(4).**
b) **The registered proprietor did not ensure that all healthcare staff are trained in the Management of Violence and Aggression, as only 83% of nurses, and 82% of Health Care Assistants, had completed this training, 26(4).**
c) **The registered proprietor did not ensure that all healthcare staff were trained in the Fire Safety, as only 69% of nurses, 77% of Health Care Assistants, 50% social work staff and 0% psychology staff had completed this training, 26(4).**

Regulation 27: Maintenance of Records

NON-COMPLIANT

Risk Rating HIGH

INSPECTION FINDINGS

All resident records were physically stored together, where possible.

Records were maintained in good order with no loose pages.

Not all residents' records were reflective of residents' current status and the care and treatment being provided, and the resident's records were not developed and maintained in a logical sequence as changes to special observation arrangements were not recorded at the time of the decision and implementation.

The approved centre was non-compliant with this regulation because the registered proprietor did not ensure that records were maintained in a manner so as to ensure completeness and accuracy, as not all resident records were reflective of the resident's current status and the care and treatment being provided, 27(1).

Regulation 32: Risk Management Procedures

NON-COMPLIANT

Risk Rating CRITICAL

INSPECTION FINDINGS

Responsibilities for risk management procedures were allocated at management level and throughout the approved centre to ensure their effective implementation.

Clinical risks were identified, assessed, treated, reported, and monitored and these risks were documented in the risk register as appropriate.

Individual risk assessments were completed at admission and when a transfer of a resident was required.

Multi-disciplinary teams were not involved in the development, implementation, and review of all individual's risk management processes. Specifically, a clinical decision was made and implemented at a Local Incident Management Team (LIMT) Meeting. At this meeting it was decided to make changes to an intervention prescribed by a clinician; this decision was made by non-clinical members of management. This change to the prescribed intervention was later attributed to causing harm to the resident.

Incidents were recorded and risk-rated in a standardised format and all clinical incidents were reviewed by the multi-disciplinary team at their regular meeting, where a record was maintained of this review and recommended actions documented.

The approved centre was non-compliant with this regulation because the registered proprietor had not ensured that multi-disciplinary teams were involved in the development, implementation, and review of all individual risk management processes, as a clinical decision was made and implemented by non-clinical staff, 32(1).

Appendix 1: REGULATIONS

REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52(d)

Regulation 5: Food and Nutrition

(1) The registered proprietor shall ensure that residents have access to a safe supply of fresh drinking water.
(2) The registered proprietor shall ensure that residents are provided with food and drink in quantities adequate for their needs, which is properly prepared, wholesome and nutritious, involves an element of choice and takes account of any special dietary requirements and is consistent with each resident's individual care plan.

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 18: Transfer of Residents

(1) When a resident is transferred from an approved centre for treatment to another approved centre, hospital or other place, the registered proprietor of the approved centre from which the resident is being transferred shall ensure that all relevant information about the resident is provided to the receiving approved centre, hospital or other place.
(2) The registered proprietor shall ensure that the approved centre has a written policy and procedures on the transfer of residents.

Regulation 19: General Health

(1) The registered proprietor shall ensure that:
(a) adequate arrangements are in place for access by residents to general health services and for their referral to other health services as required;
(b) each resident's general health needs are assessed regularly as indicated by his or her individual care plan and in any event not less than every six months, and;
(c) each resident has access to national screening programmes where available and applicable to the resident.
(2) The registered proprietor shall ensure that the approved centre has written operational policies and procedures for responding to medical emergencies.

Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines

(1) The registered proprietor shall ensure that an approved centre has appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents.
(2) This Regulation is without prejudice to the Irish Medicines Board Act 1995 (as amended), the Misuse of Drugs Acts 1977, 1984 and 1993, the Misuse of Drugs Regulations 1998 (S.I. No. 338 of 1998) and 1993 (S.I. No. 338 of 1993 and S.I. No. 342 of 1993) and S.I. No. 540 of 2003, Medicinal Products (Prescription and control of Supply) Regulations 2003 (as amended).

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
Immediate Action Notice *10000401*	10 April 2026	This was issued following a focused inspection on 31 March 2026. There were five non-compliances as follows: • Regulation 32: Risk Management Procedures (Critical) • Regulation 26: Staffing (High) • Regulation 27: Maintenance of Records (High) • Regulation 15: Individual Care Plans (High) • Regulation 19: General Health (High)	Immediate risk areas have been addressed for the most part. The MHC continues to engage with the registered proprietor nominee on some outstanding actions.
Regulatory Compliance Meeting 10000402	16 April 2026	The registered proprietor was required to provide further assurances to the MHC about ongoing safety, governance and compliance arrangements. The MHC met with the registered proprietor nominee and representatives of the Board of Bloomfield.	On the 8 March 2026, the MHC were notified of a change in both the Clinical Director and the Chief Executive Officer. The registered proprietor provided evidence of improved governance arrangements. The registered proprietor informed the MHC that the approved centre continued to be supported by the HSE. The registered proprietor outlined arrangements whereby senior HSE management were present in the approved centre on a regular basis. On 14 May 2026, the HSE informed the MHC that they were providing the approved centre with further assistance under the Service Level Agreement between the HSE and the registered proprietor.

Attachment of 4 Conditions to the registration of the approved centre	27 May 2026	In accordance with the procedures set out in the Mental Health Act 2001 and following a notice of proposal and notice of decision process, the MHC successfully attached 4 conditions to the registration of Bloomfield. These conditions came into effect on 27 May 2026. **Condition 1:** The registered proprietor shall not admit new residents until such time as the issues in Conditions 2, 3 and 4 are addressed and the approved centre meets the relevant regulatory requirements under the 2001 Act to the satisfaction of the MHC. **Condition 2:** The registered proprietor shall develop and implement a comprehensive staffing plan to address the staffing deficits identified in the focused inspections of December 2025 and 31 March 2026. The staffing plan shall: a) be based on an evidence-based staffing needs assessment and b) shall be in accordance with the service level agreement(s) (SLA) agreed between the approved centre and the Health Service Executive as the principal funder of the service. The staffing plan shall establish the minimum staff ratios to be maintained and shall set out the skill mix of staff, including the grades of staff, that must be in place to meet residents' assessed needs. The staffing plan shall set out how staff training deficits will be addressed. **Condition 3:** The registered proprietor shall employ the services of an appropriately independent person or organisation to carry out an assessment of the adequacy of the arrangements in place to manage and oversee skin integrity. The outcome of this assessment and any associated quality improvement plan shall be provided to the MHC within 3 months of the date that this notice takes effect. **Condition 4:** The registered proprietor shall employ the services of an appropriately qualified independent person or organisation to carry out an assessment of the adequacy of safeguarding arrangements in the approved centre and further to provide independent assurance regarding the implementation of the recommendations of the external report of Tom Beegan of 10 November 2025. The scope of this assessment shall include the adequacy of the systems in place to identify, escalate, manage and report safeguarding risks and concerns in the interests of the care and welfare of residents. The outcome of the independent assessment, the assurance report and any associated quality improvement plan shall be provided to the MHC within 3 months of the date that this notice takes effect.	The registered proprietor has accepted these conditions which have been attached to the registration of the centre which sets out terms of operation. The registered proprietor is required to provide the MHC with regular reports on the implementation of these conditions. These conditions will remain in place until such time as all of the required areas have been actioned to the satisfaction of the MHC to ensure ongoing safety of all residents in Bloomfield.