17. Transfer of patients from St Ita’s Hospital 227
18. Transfer of patients from Beaumont Hospital 265
19. Transfer of patients from the Mater Hospital 279
20. ‘Home Truths’ – the Prime Time programme 287
21. Developments following ‘Home Truths’ 292
22. Closure of Leas Cross Nursing Home 309
23. Further responses to issues raised by Leas Cross 328
24. Conclusions 338

APPENDIX
CHAPTER 1

INTRODUCTION

The Commissions of Investigation Act 2004 allows for a commission to be created to “investigate any matter considered by the Government to be of significant public concern.” In this instance, the public concern related to serious deficiencies in the treatment of residents at Leas Cross, a private nursing home near Swords, County Dublin, and to an apparent failure on the part of the State to detect and remedy those deficiencies. Allegations in this regard had received widespread publicity, arising in the main from a television documentary broadcast by R.T.E. on the 30th May 2005.

With this final report, the Commission aims to increase public understanding of

(a) what in fact happened at Leas Cross Nursing Home,

(b) the reasons why it happened, and

(c) the reasons why it was allowed to happen.

To that end, the Commission has sought to place as much information as possible in the report concerning the role and response of relevant parties to the establishment, ownership, operation, management, staffing and supervision of Leas Cross Nursing Home over the seven-year period of its existence, from 1998 to 2005.

The Commission is conscious that the broad scope of this report, and the volume of information contained in it, may have the unwanted effect of diluting the emotional power of those individual stories of suffering which have emerged from Leas Cross. This was not the Commission’s intention. My team and I have met a number of families who were clearly scarred by their experience of Leas Cross Nursing Home. They have our deepest sympathy, and it is my hope that this report can, in some small way, assist them in coming to terms with the pain that they have endured.

I am the Sole Member of this Commission. However, the completion of the Commission’s work would not have been possible without the invaluable assistance of others.

In the first place, I sincerely thank my core team, Martina Finlay Solicitor, Eanna Hickey B.L., Helen Boyle B.L. and William Abrahamson B.L., who assisted me with all the work of the Commission with great diligence, professionalism and, indeed, good humour. They worked tirelessly to ensure that the final report was as complete and accurate as possible.

I acknowledge the excellent work of Michelle Carey B.L. and Leo Mulrooney B.L., who were engaged in research work for the Commission.
I also thank Diana Stafford, Ali Musgrave and Joanna Rust for their contributions as personal assistants to the Commission, with responsibility for clerical and secretarial duties.

The Commission is an entirely independent body and has operated as such throughout. However, it has been greatly assisted by the Department of Health (in particular liaison officers Dave Walsh and Michael Murchin) in certain practical matters relating to the setting up and running of the Commission, such as the provision of office space, furniture, IT equipment, and so forth.

The Commission is grateful to all persons who co-operated willingly and voluntarily with its requests for information and documentation. In particular, I would like to mention the Leas Cross Deaths Relatives’ Action Group, and all the families of former Leas Cross residents who came forward with their stories – sometimes in difficult or stressful circumstances.

This final report of the Commission of Investigation (Leas Cross Nursing Home) is submitted to the Minister for Health and Children pursuant to the provisions of section 32 of the Commissions of Investigation Act 2004.

Dated the day of June, 2009.

Diarmuid P. O’Donovan, S.C.
Sole Member.
CHAPTER 2

ESTABLISHMENT OF THE COMMISSION

Background

On 30 May 2005, RTE television broadcast a programme in the series, *Prime Time Investigates*. The programme was concerned with the treatment of residents at Leas Cross, a nursing home near the village of Swords, County Dublin. It included information and film footage obtained by an undercover reporter who worked at the nursing home for a number of weeks.

The broadcast of the *Prime Time* programme provoked a strong public reaction. Issues arising from the programme were debated in the Dáil on 31 May and 1 June 2005.

In June 2005, the Health Service Executive, Northern Area (HSE NA) established a committee to investigate and report on the complaints highlighted in the *Prime Time* programme. The HSE NA also commissioned Professor Desmond O’Neill, a consultant geriatrician, to carry out a review of the deaths of residents at Leas Cross Nursing Home between 2002 and 2005. Professor O’Neill’s review was limited by the terms of reference as set down by the HSE to the inspection and analysis of relevant written documentation.

Professor O’Neill’s report was presented to the H.S.E in April 2006. Between April 2006 and November 2006, the H.S.E has advised that it was engaged in the process of inviting those parties identified in Professor O’Neill’s draft report to respond. The H.S.E has advised that in accordance with the requirements of fair procedure and with the agreements of the said respondents to Professor O’Neill’s report, the written responses of certain parties who are identifiable from Professor O’Neill’s report were redacted to protect the identity of the respondents and to protect any third parties identified in their responses. Professor O’Neill’s report, together with the redacted responses was published on 10th November 2006.

On 24 April 2007, the Government announced its decision to set up a commission of investigation into the management, ownership and operation of Leas Cross Nursing Home.

Establishment of the Commission

The Commission of Investigation (Leas Cross Nursing Home) was established on 6 June 2007 by Order of the Government made under section 3 of the Commissions of Investigation Act 2004.
Notice of the Order of Government was published in *Iris Oifigiúil* on 26 June 2007, together with the terms of reference of the commission.

The Government appointed Mr Diarmuid P. O’Donovan, Senior Counsel, as sole member of the Commission.

The Commission was provided with offices in Bow Street, Dublin 7. The work of the Commission commenced on 10 September 2007.

**Staff and legal counsel**

Section 8 of the Commissions of Investigation Act 2004 empowers the Sole Member of a Commission (with the approval of the specified Minister and the Minister for Finance) to appoint

“...persons with relevant qualifications and experience (including barristers and solicitors) to advise or assist the commission in relation to any matter within its terms of reference.”

Under this provision, Ms Helen Boyle B.L., Mr Éanna Hickey B.L. and Ms Martina Finlay, Solicitor were appointed to assist the Commission in its work.

When the Commission was established, it was envisaged that three support staff would be seconded from the Department of Health and Children to provide administrative assistance to the Commission. However, the Department encountered difficulties in finding suitable persons to fill these positions. Following discussions between the Commission and the Department, it was agreed that, instead of the three support staff, the Commission would take on another Junior Counsel, and one person with appropriate administrative / secretarial skills.

On 17 October 2007, following formal approval by the Minister for Health and Children and the Minister for Finance, the Commission appointed Mr William Abrahamson B.L. under s.8 of the Commissions of Investigation Act 2004. The Commission also engaged the services of a full-time secretary.

**Interim reports**

Under the terms of reference the Commission was required “…to provide to the Minister for Health and Children an interim report on the matters examined by the Commission within 6 months and a final report within 12 months of commencement of the work of the Commission.”. The Commission’s first interim report was sent to the Minister for Health & Children in March 2008.

Further interim reports were submitted by the Commission in August 2008, December 2008, March 2009 and May 2009. These reports were submitted pursuant to sections 33(3) and 6(6) of the Commission of Investigation Act 2004. They contained requests to extend the timeframe for completion of the Commission’s investigation and
submission of its final report. The circumstances which gave rise to each request are set out in the relevant interim reports.

Budget

Under the Order of Government establishing the Commission, published in *Iris Oifigiúil* on 26 June 2007, the estimated legal fees, salaries and other administrative costs for the Commission in its initial 12-month period were set at €2 million.
CHAPTER 3

TERMS OF REFERENCE

The Commission is required by its terms of reference to examine the following matters:

“...the role and responses of such relevant parties as the Commission may determine... in relation to

a) the establishment, ownership, operation, management, staffing and/or supervision of Leas Cross Nursing Home (hereinafter ‘the nursing home’);

b) complaints made by or in respect of residents or former residents of the nursing home; and

c) the transfer of residents from medical and residential care facilities to the nursing home.”

The Commission interprets this as meaning that it must first identify relevant parties and their respective roles in relation to the matters specified in the terms of reference. Having done this, the Commission must then examine the responses of those parties to matters raised in the terms of reference, and measure those responses against the appropriate legal standards and relevant best practice.

The matters to be investigated under the terms of reference can be categorised as follows:

Establishment of Leas Cross

This includes:

- the planning, construction and expansion of Leas Cross; including the financial aspects of such construction, and
- all applications for registration or re-registration of Leas Cross as an approved nursing home.

Ownership, operation and management of Leas Cross

This includes:

- the ownership and management structure of the nursing home;
the respective responsibilities of the proprietors and the persons in charge of
the nursing home;

financial aspects of the operation of the nursing home, and

the role of general practitioners at Leas Cross.

**Staffing of Leas Cross**

This includes:

- the assessment of staffing requirements;
- recruitment of staff;
- numbers and qualifications of staff;
- staff training and development; and
- supervision and discipline.

**Supervision of Leas Cross**

This includes:

- internal monitoring of care standards at Leas Cross (by the person in charge
  and / or the proprietors), and
- external monitoring by health board nursing home inspectors, environmental
  health officers and other relevant supervisory bodies.

**Complaints made by or in respect of Leas Cross residents**

This includes:

- the number and nature of complaints made;
- the person or persons to whom complaints were made, and
- the response to such complaints by the nursing home and / or the relevant
  health authorities.

**Transfer of residents from medical / residential care facilities to Leas Cross**

This includes:

- the circumstances in which patients were transferred from general hospitals,
  mental hospitals and other related facilities to Leas Cross;
- the practices and procedures involved in such transfers;
- whether any complaints were made in relation to such transfers, and
- the nature and extent of any follow-up care provided by the facilities from which patients were transferred.
CHAPTER 4

THE COMMISSION’S METHODOLOGY

The conduct of the Commission’s investigation was governed by Part 3 of the Commissions of Investigation Act 2004. In accordance with section 15 of that Act, the Commission prepared rules and procedures, setting out the manner in which the investigation would operate.

Governing principles

The Commission’s rules and procedures set out the following governing principles for its investigation:

Independence

Section 9 of the Commissions of Investigation Act 2004 requires the commission to be independent in the performance of its functions.

Fairness

The commission has during the currency of its existence a continuing duty of fairness to all persons involved in the investigation.

Rights

The commission has, during the currency of its existence, a continuing duty to have regard to, and take due account of the constitutional and legal rights of all persons involved in the investigation.

Urgency

The commission is required by its terms of reference to carry out its investigation and report to the Minister for Health and Children within a period of twelve months. This limited period of time requires the commission to carry out its functions with urgency.

Co-operation

The commission asserts that during the currency of its existence there is a continuing duty on all persons concerned with its investigation to promptly and urgently co-operate with the commission.

Application
All persons involved with the commission, including all witness and their legal representatives are deemed to agree to adhere to these Rules and Procedures.

**Discretion**

Subject to the requirements of the Commissions of Investigation Act 2004 and these Rules and Procedures the conduct of and the procedure to be followed in this investigation are under the control and discretion of the commission.

**Voluntary co-operation and issue of directions**

In keeping with the provisions of section 10 of the Commissions of Investigation Act 2004 and in the interests of engaging openly with all those individuals and agencies affected by this investigation, the Commission sought from the outset to establish voluntary co-operation from all parties.

In general, this approach yielded positive results. However, in a small number of cases, the Commission found it necessary to issue directions pursuant to section 16 of the 2004 Act requiring relevant persons to furnish documentation or respond to written questions, where those persons had refused to cooperate voluntarily or had failed to respond within reasonable period.

The Commission issued 22 such directions during the course of its investigations. In each case the witness in question complied with the Commission’s direction.

**Public consultation**

The Commission engaged in public consultation in order to obtain evidence relevant to its investigation. Advertisements were placed in national and local newspapers on the 26th October and the 9th November 2007 seeking assistance and information from any interested parties who wished to contact the Commission.

With a view to enhancing public access to the Commission, a dedicated website was set up at www.lchni.ie. The site contained information about the establishment of the Commission, its purpose and how to contact its offices. The Commission’s rules and procedures, and other documents relating to the establishment of the Commission, were available to be viewed or downloaded from the website.

**Privacy**

Section 11 of the Commissions of Investigation Act 2004 required the Commission to carry out its investigation in private, unless the Commission was satisfied that it was desirable in the interests of both the investigation and fair procedures to hear all or part of the evidence of a witness in public.

The Commission conducted its entire investigation in private.
Fair procedures

In carrying out its investigation, the Commission was conscious of the need to comply with the highest standards of fairness and constitutional justice, as required by the Commissions of Investigation Act 2004 and as set out in In Re Haughey [1971] I.R. 217 and developed in subsequent case law.

Identification of relevant persons

A number of people referred to in this report are not identified by name. The Commission is satisfied that it has discretion under the Commissions of Investigation Act 2004 to include or omit the names of relevant persons. The decision to omit people’s names was not taken lightly by the Commission. The government having determined, under the 2004 Act, that the matters under investigation are of significant public concern, the Commission believes that there is a public interest in identifying those involved.

However, the Commission also considers that the public interest must be balanced against the rights of the individuals concerned to be treated fairly and to the protection of their good names. Both of those rights are guaranteed by the Constitution. While the Commission’s investigation has been carried out in compliance with the 2004 Act, which governs its activities, the Commission is concerned that there may be instances in which the safeguards provided by that Act are insufficient to meet the requirements of constitutional justice.

The Commission received requests for anonymity from a number of people involved in its investigation. In deciding on those requests, the Commission was required to balance the competing public and private interests outlined above. In addition, the Commission had regard to the following factors.

First, events at Leas Cross Nursing Home caused a sensation when they were first publicised by the Prime Time documentary in 2005. Rightly or wrongly, certain shocking incidents and practices shown in that documentary have become synonymous with the nursing home in the public mind. Accordingly, the Commission recognises that there is a real risk that the mention of an individual’s name in connection with Leas Cross – however innocent his or her involvement – may give rise to a negative perception of that individual, which may taint his or her personal and professional reputation.

Secondly, in relation to some specific matters under investigation the Commission, through no fault of its own, has found it difficult to determine conclusively which person or persons bore ultimate responsibility for those matters at the relevant times. The Commission considers that, in such cases, it would be unfair to name individuals, in circumstances where the extent of their duties and responsibilities cannot be established or is in dispute.
In light of the foregoing, the Commission has decided to omit the names of some of those people who requested anonymity. The persons who have been identified in this report are those who occupied positions of responsibility in Leas Cross Nursing Home, in the Health Board / H.S.E. or elsewhere. This is not to say that such individuals necessarily bear personal responsibility for events at Leas Cross, but that, by virtue of their positions, the Commission considers that it is both reasonable and justifiable in the public interest to identify them by name. In addition, the families of some former residents of the nursing home have consented to their names and those of their deceased relatives being included.

Those persons whose names have been omitted are identified in this report either by their titles within the organisations in which they operated, or by an anonymous designation, such as ‘Person A’.

**Evidence received by the Commission**

**Sources of evidence**

The Commission obtained evidence from a number of sources, including the following:

1. The former proprietors of Leas Cross Nursing Home
2. The Health Service Executive
3. The families of former residents of Leas Cross
4. Former matrons, nurses and care staff from Leas Cross
5. Hospitals from which patients were transferred to Leas Cross

557 residents passed through Leas Cross from the date it opened in 1998 until its closure in 2005. The Commission wrote to the family of every former resident for whom an address was available. However, evidence was received from the families of just 75 former residents. While the Commission made every effort to contact as many families as possible, it is inevitable that some have changed address since the nursing home closed, while others, understandably, may not have wanted to become involved in the investigation.

Similar difficulties were encountered tracing former staff members, many of whom came from overseas and may no longer reside in Ireland. Again, the Commission write to every former staff member possible, but received evidence from only 26. The Commission also made contact with each of the five former matrons of the nursing home.

In relation to the health services, the Commission received a considerable amount of evidence from the H.S.E., including relevant information formerly held by the Eastern Health Board, the Northern Area Health Board and the Eastern Regional Health Authority. The Commission also received evidence from over 30 current and former employees of the health services who had involvement with Leas Cross Nursing Home.
**Written submissions**

The Commission adopted a general policy of seeking evidence in written form and of avoiding formal oral hearings wherever possible. The purpose of this policy was to ensure that evidence was gathered in the most timely and cost efficient manner.

Any person from whom evidence was sought was invited to make a written submission to the Commission and, in some cases, was subsequently asked to respond in writing to further questions.

The Commission held informal meetings with the families of 74 former residents of Leas Cross. Following each meeting, the Commission prepared a draft written statement containing the information received from the family in question. The draft statement was then sent to the family to be approved and signed.

The Commission held similar meetings and drafted statements for 26 former staff members from the nursing home.

**Oral hearings**

Having obtained and examined the bulk of the documentation, information and written submissions requested by it, the Commission found it necessary to invite a small number of relevant parties to attend before it for the purpose of providing evidence on oath. This was done in order to receive evidence from persons whom the Commission considered to be most significant to its investigations or where written submissions gave rise to conflicts of evidence which the Commission considered were best resolved by way of oral evidence.

In accordance with section 12 of the Commissions of Investigation Act 2004 and with the requirements of fair procedures, the Commission wrote to such persons outlining the specific issues to be addressed, and enclosing copies of any relevant documentation which might assist them in giving evidence on those issues. A reasonable period of some weeks was allowed for the relevant parties to prepare themselves to give such evidence. Witnesses at those hearings gave evidence under oath and, in most cases, were accompanied by legal advisors.

**Original documentary evidence**

The principal sources of original documentary evidence were the former proprietors of the nursing home and the H.S.E.

Five affidavits of discovery were sworn on behalf of the H.S.E., containing approximately 36,000 documents.
The former proprietors of Leas Cross provided the Commission with all of the original documents from the nursing home, including nursing notes and medical records for former residents and staff files.

In addition, some original documentation was obtained from the families of former residents and, where necessary, medical records relating to former residents were obtained from hospitals.

**Film footage**

One of the reasons for the Commission’s establishment was the broadcast of a *Prime Time* documentary regarding Leas Cross Nursing Home. At the Commission’s request, R.T.E. furnished the Commission with the entirety of the footage captured by its undercover reporter at the nursing home, in unedited form. This amounted to some 60 hours of material in total, which was viewed by the Commission.

**Site visit**

The sole member and members of Commission’s staff visited the former premises of Leas Cross Nursing Home in Swords and toured the complex, part of which is currently in use as a nursing home and part of which is scheduled for demolition.
CHAPTER 5

RELEVANT ORGANISATIONS

The operation of Leas Cross Nursing Home coincided with a number of structural changes in the health services in Ireland. This chapter briefly summarises the history and development of the organisations governing and supervising the establishment and operation of nursing homes during the relevant period.

Department of Health and Children

The Ministers and Secretaries Act, 1924 established a number of Departments of State, including the Department of Local Government and Public Health. The name of the department was changed in 1947 to the Department of Health, and in 1997 to the Department of Health and Children.

In June 2003, the Government published plans for a major reform of the Health Service which included the following statements regarding the structure and role of the Department of Health and Children:

“Within the new structure there will be a clear separation of the executive and non-executive functions of the Department. The Department will have a dual role in the new structure which includes focusing on strategic and policy issues (by reducing its involvement in day-to-day matters) and having ultimate responsibility for holding the service delivery system to account for its performance. This will remove any confusion within the broader system about the role of the Department and create room to analyse and evaluate the performance of the service delivery system. The reforms require a fundamental reorganisation to reflect those roles.”

According to its website, the Department currently defines its role as follows:

“To support the Minister and the Government by:
• advising on the strategic development of the health system including policy and legislation;
• supporting their parliamentary, statutory and international functions;
• evaluating the performance of the health and social services; and
• working with other sectors to enhance people’s health and well-being.”

Section 4 of the Health Act, 1970 empowered the Minister for Health to create a number of boards for the purpose of administering the health services in the State. In July 1970 the Minister exercised this power to create eight such boards.\(^1\)

The first significant changes with regard to the functioning of the health boards came in the Health (Amendment) (No.3) Act, 1996. Section 3 of that Act limited the role of a health board to the performance of certain functions known as “reserved functions”. These functions, as set out in schedule 1 of the Act, concerned such matters as:

- the acquisition of land;
- the removal of officers and servants of the board;
- arrangements with local authorities for a health board to exercise certain powers, functions or duties;
- discontinuing provision for a hospital, home, clinic, health centre or similar

Under section 4 of the 1996 Act, all other existing functions of a health board were assigned to the chief executive officer. Further, section 12 allowed the Minister to transfer any reserved functions to the chief executive officer or another specified person, if the Minister was satisfied, following an investigation, that a health board was not performing such functions in an effective manner or that it had failed to comply with a direction given by the Minister.

The Health (Amendment) (No.3) Act, 1996 made other changes also. Section 6 required health boards to adopt and submit to the Minister a “service plan”, containing information to be specified by the Minister. Sections 7 and 8 provided that a health board must ensure its net expenditure and level of indebtedness in any given year did not exceed the amounts determined by the Minister for that year. Under section 15, health boards were obliged to submit an annual report in relation to the performance of their functions during the preceding year.

Section 2(1) of the Act set out a number of matters to which a health board must have regard in the performance of its functions:

“A health board, in performing the functions conferred on it by or under this Act or any other enactment, shall have regard to—

\((a)\) the resources, wherever originating, that are available to the board for the purpose of such performance and the need to secure the most beneficial, effective and efficient use of such resources,

\((b)\) the need for co-operation with voluntary bodies providing services, similar or ancillary to services which the health board may provide, to people residing in the functional area of the health board.

\(^1\) The Eastern, Midland, Mid-Western, North-Eastern, North-Western, South-Eastern, Southern and Western Boards respectively. See S.I. No. 170/1970.
(c) the need for co-operation with, and the co-ordination of its activities with those of, other health boards, local authorities and public authorities, the performance of whose functions affect or may affect the health of the population of the functional area of the health board, and

(d) policies and objectives of the Government or any Minister of the Government in so far as they may affect or relate to the functions of the health board.”

The health boards continued to function until the 1st January 2005, when they were dissolved by the Health Act 2004. The functions of the health boards were transferred under s. 59 of the 2004 Act to the new Health Service Executive (H.S.E.). Under s.60, anyone employed by the health boards at the time of their dissolution became an employee of the H.S.E.

**Eastern Regional Health Authority (1999-2004)**

The Health (Eastern Regional Health Authority) Act, 1999 marks the next significant alteration to the structure of the health service in the State. The legislation was intended to address the particular problems faced in the Eastern Health Board area, including the comparatively large population of the region and increasing pressure on acute hospitals in the region.

The 1999 Act dissolved the Eastern Health Board and created in its place the Eastern Regional Health Authority (E.R.H.A.). Under section 20(1), every member of the Eastern Health Board staff was transferred to the new Authority.

The functional area of the E.R.H.A. was comprised of the county borough of Dublin, and the administrative counties South Dublin, Fingal, Dún Laoghaire-Rathdown, Kildare and Wicklow.

The Act also created three new health boards to serve the areas under the control of the E.R.H.A. They were designated the Northern, East Coast and South Western Area Health Boards respectively. Leas Cross Nursing Home was located within the boundaries of the Northern Area Health Board.

Section 10(2)(a) of the Act provided:

“(a) … the Authority shall, having regard to the resources available to it, make and carry out an arrangement with each Area Health Board for the provision within the Area Health Board’s functional area of services which, immediately before the establishment day, were provided by the Eastern Health Board.”

Under section 17(6) of the Act the chief executive officer of the E.R.H.A., known as the Regional Chief Executive, was to delegate in writing to the chief executive of
each Area Health Board, “such of his or her functions ... which, immediately before the establishment day, were performed by the chief executive officer of the Eastern Health Board”.

The functions of an Area Health Board were set out in section 15 (2):

“An Area Health Board shall, with respect to its functional area—
(a) provide, or arrange for the provision of, such services as may be specified in any arrangements entered into with the Authority in accordance with section 10 (2),
(b) plan and co-ordinate the provision of services, in co-operation with persons providing services in the area and with such other persons as it may see fit, and
(c) advise the Authority on the provision of services generally.”

Regarding the oversight of such services, section 15(4) provided that:

“Where an Area Health Board makes an arrangement with a person for the provision of services, it shall put in place systems, procedures and practices to enable it to monitor and evaluate the services so provided.”

The E.R.H.A. and the area health boards continued to function until the 1st January 2005, when they were dissolved by the Health Act 2004. Their functions were transferred under the 2004 Act to the new Health Service Executive. All staff employed at the date of dissolution were also transferred to the H.S.E.

**Health Boards Executive (2002-2004)**

The Health (Eastern Regional Health Authority) Act 1999 also established a new agency known as the Health Boards Executive, which was comprised of the chief executive officers of the existing health boards and of the new area health boards. Section 21(4) provided:

“The Executive shall perform, on behalf of the health boards –

(a) such executive functions of the health boards as may be specified, from time to time, by the members of the Executive, and
(b) such other executive functions in relation to improving the efficiency and effectiveness of the health and personal social services as the Minister may, from time to time, direct.”

The Health Boards Executive was established by order of the Minister for Health and Children on the 14th February 2002. It was dissolved on the 1st January 2005 under the Health Act 2004. Its functions and staff were transferred under the 2004 Act to the new Health Service Executive.
Health Service Executive

Plans for reform


The Brennan Commission made a total of 136 recommendations, including:

- the establishment of an executive to manage the Irish health service as a unitary national service;
- a range of reforms to governance and financial management, control and reporting systems to support the Executive in the management of the system; and
- substantial rationalisation of existing health agencies.

Following the report of the Brennan Commission, in June 2003 the government launched its Health Service Reform Programme, which included the following commitments:

- A major rationalisation of existing health service agencies to reduce fragmentation. This includes the abolition of the existing health board / authority structures.
- The reorganisation of the Department of Health and Children, to ensure improved policy and development and oversight.
- The establishment of a Health Service Executive which will be the first ever body charged with managing the health service as a single national entity.

The Health Service Executive

The proposed Health Service Executive (H.S.E.) was introduced by the Health Act 2004. The establishment day for the Act was set by ministerial order as the 1st January 2005.

The object and functions of the H.S.E. are set out in section 7 of the Act. Subsection (1) provides:

“The object of the Executive is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.”

Subsection (5) provides:

“In performing its functions, the Executive shall have regard to-
(a) services provided by voluntary and other bodies that are similar or ancillary to the services the Executive is authorised to provide,

(b) the need to co-operate with, and co-ordinate its activities with those of other public authorities if the performance of their functions affects or could affect the health of the public,

(c) the policies and objectives of the Government or any Minister of the Government to the extent that those policies and objectives may affect or relate to the functions of the Executive,

(d) the resources, wherever originating, that are available to it for the purpose of performing its functions, and

(e) the need to secure the most beneficial, effective and efficient use of those resources.”

Under the Health Act 2004, the H.S.E. is run by an 11-member board (appointed by the Minister) and a chief executive officer, appointed by the board.

The H.S.E. replaced the previous administrative bodies in the health service – the health boards, area health boards, the Eastern Regional Health Authority and the Health Boards Executive. Under s. 63 of the 2004 Act, the H.S.E. took over every “contract, agreement or arrangement” entered into by any these bodies. Under s. 68 of the Act, references in previous acts or regulations to the chief executives of these bodies are now to be taken as referring to the chief executive officer of the H.S.E.

Although those bodies were dissolved by the Health Act 2004, s. 67 of the Act specifies that the geographical boundaries of their functional areas be retained by the H.S.E.

**Leas Cross Nursing Home**

Leas Cross Nursing Home was governed by the Health (Nursing Homes) Act 1990 and the Nursing Homes (Care and Welfare) Regulations 1993. Responsibility for enforcing that legislation lay with the Eastern Health Board, the Northern Area Health Board and, finally, the H.S.E. The administrative structures within each of those bodies for the supervision of nursing homes are set out in detail the relevant chapters of this report.

Although the body responsible for the supervision of Leas Cross Nursing Home changed from time to time as the health services were reformed, it is clear from the relevant legislation that this supervisory role of the health services was unaffected in its day to day operation by those reforms, as the relevant functions remained constant throughout the various changes outlined above.

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2 See further Chapter 6.
3 See Chapters 7, 8 and 13.
CHAPTER 6

REGULATORY FRAMEWORK

The following is a brief overview of the relevant statutory framework and non-statutory guidelines which regulated and informed nursing home practice during the period in which Leas Cross Nursing Home was in operation.

More detailed discussion of the legal provisions relating to specific aspects of nursing home care will be found in the chapters dealing with those aspects.

The Health (Nursing Homes) Act, 1990


The Act contains provisions on the registration of nursing homes, the prohibition of unregistered nursing homes, payments by health boards towards costs of maintenance of dependent persons in nursing homes, the temporary management of nursing homes by health boards, and the regulation of standards in nursing homes.

Section 6(1) of the Act provides:

“The Minister shall, for the purpose of ensuring proper standards in relation to nursing homes, including adequate and suitable accommodation, food and care for dependent persons while being maintained in nursing homes, and the proper conduct of nursing homes, make such regulations as he thinks appropriate in relation to nursing homes.”

Subsection (2) of section 6 goes on to list, “without prejudice to the generality of subsection (1)”, a number of areas in which the regulations may prescribe requirements. These include:

- the care, welfare and wellbeing of residents;
- the numbers, qualifications and availability of nursing home staff;
- the design and maintenance of the home;
- the display in nursing homes of specified notices;
- record-keeping and the availability of records for inspection by health board officers;
- the inspection of nursing home premises by health boards;
- the provision of staff training by the health boards; and
- procedures for considering and investigating complaints made about a nursing home to a health board.
The Nursing Homes Regulations

In 1993 the Minister for Health and Children, in fulfilment of the duty imposed by s.6 of the Health (Nursing Homes) Act 1990, made three sets of regulations concerning nursing homes:

- the Nursing Homes (Care and Welfare) Regulations, 1993;
- the Nursing Homes (Subvention) Regulations, 1993, and
- the Nursing Homes (Fees) Regulations, 1993.

Nursing Homes (Care and Welfare) Regulations, 1993

These regulations (S.I. no.226 of 1993) came into effect on the 1st September 1993. Matters dealt with in the regulations include:

- care and wellbeing of residents;
- contract of care between a nursing home and each resident;
- staffing;
- accommodation and facilities;
- hygiene;
- record-keeping;
- inspections by designated officers;
- complaints;
- fire precautions; and
- storage, administration and disposal of drugs and medicines.

Regulation 35 states:

“These regulations shall be enforced and executed in the functional area of each health board by the chief executive officer or deputy chief executive of that health board.”

Further statutory instruments issued on the 14th December 1993 (S.I. no.379 of 1993) and the 19th May 1994 (S.I. no.147 of 1994), made minor amendments to these regulations.

Nursing Homes (Subvention) Regulations, 1993

These regulations (S.I. no.227 of 1993) came into effect on the 1st September 1993. The explanatory note which accompanied the regulations described their purpose as follows:

“These Regulations provide for the payment of subventions towards the cost of nursing home care to persons who have been assessed by a health board as requiring nursing home care and without the means to pay all or part of the cost. The Regulations set out the procedures which must be followed in
applying for a subvention, in assessing the dependency, means and circumstances of an applicant, for determining the rate and amount of subvention, for the payment of subvention to the nursing home of the applicant's choice, for review at six monthly intervals of the level of subvention and for appeals against a health board decision in relation to a subvention.”

Further amendments to these regulations are contained in the following statutory instruments:

- S.I. no.378 of 1993
- S.I. no.225 of 1996
- S.I. no.498 of 1998
- S.I. no.89 of 2001

**Nursing Homes (Fees) Regulations, 1993**

These regulations (S.I. no.223 of 1993) came into effect on the 1st September 1993. They set out the fees to be paid for (i) an application to register and nursing home, and (ii) an application for a declaration that the applicant is a fit person to carry on a nursing home (in accordance with section 4(4) of the Health (Nursing Homes) Act, 1990).

**Guide to the Nursing Home Legislation**

In April, 1995, the Department of Health produced a document entitled ‘Guide to the Nursing Home Legislation’. The purpose of the guide was expressed to be “to explain the provisions of the legislation and to offer guidance on interpreting the Act and Regulations”. The introduction to the guide contained the following statement:

“The Guide also includes recommended standards in relation to certain aspects of nursing home care which may be used in association with the Nursing Homes (Care and Welfare) Regulations to assess the standards of staffing, care or accommodation in a home. However, neither the interpretation of the legislation in this Guide nor the recommended standards for the inspection of nursing homes has legal effect.”

The Commission is satisfied that the Guide to the Nursing Home Legislation provided guidance only and was not legally binding on the proprietors or operators of nursing homes or on health board staff in assessing nursing homes. This means that health boards were not acting outside their powers in approving the registration of nursing homes that did not meet the criteria in the guide.

However, in the absence of detailed provision in legislation regarding the manner in which nursing homes were to be assessed by health boards, and in the interests of ensuring consistency in such assessment, it was desirable for nursing home inspectors to have regard to the terms of the guide and to seek to have nursing homes to comply
with those terms wherever possible. The Commission has been informed that copies of the guide are available to nursing homes.

**Code of Practice for Nursing Homes**

In July 1995 the Department of Health published a Code of Practice for Nursing Homes. The foreword to the Code states:

“Legislation by its nature, is concerned with minimum standards. Those involved with the care of dependent elderly have felt the need for a code of practice which would set out the best standards of care to which all nursing homes should operate. This Code of Practice for Nursing Homes was drafted by a group of experts with first hand experience of caring for the dependent elderly.

*This Code is intended to help nursing home proprietors and staff, officers of health boards and the general public to a better understanding of what constitutes high quality care in nursing homes.*”

Paragraph 1.6 of the Code states:

“This document has been agreed by a group of people representing proprietors of nursing homes, health boards, the National Council for the Elderly, carers and other people with experience in the care of the elderly. It represents a consensus of what constitutes good nursing home care at the present time. Nothing in this document should be construed as interpreting or qualifying any statutory provision or regulation.”

Although not legally binding, the Code of Practice has been of assistance to the Commission in determining what constitutes best practice regarding certain areas of nursing home operation.
CHAPTER 7

THE ESTABLISHMENT OF LEAS CROSS NURSING HOME

Development of Leas Cross Nursing Home

The idea of developing a nursing home at Leas Cross was that of businessman Mr John Aherne. In a submission to the Commission, Mr Aherne and his wife, Mrs Genevieve Aherne explained that the idea arose from the illness of Mr Aherne’s older brother, who required full time medical and nursing care. His family were unhappy with the standard of care provided in the public facility where he was originally resident and were unable to find a satisfactory alternative. Accordingly, Mr Aherne decided to consider developing a private nursing home.

Although their primary intention was to create a nursing home which could provide appropriate care for Mr Aherne’s brother, Mr and Mrs Aherne acknowledge in their submissions that they were prepared to engage in the project only “if it made sense from a business point of view”. Mr Aherne states that he believed that there was “a genuine need for a purpose built high-spec facility where those in need of nursing home care could be catered for”. In oral evidence, Mr Aherne informed the Commission that he intended the nursing home to be a profitable enterprise and that it was, in fact, profitable during its operation.

Mr Aherne informed the Commission in oral evidence that, in the early planning stages, he contacted the Eastern Health Board for advice regarding the requirements for developing a nursing home. He stated that he found them receptive to his plans.

Acquisition of Leas Cross property

The lands on which the first phase of Leas Cross nursing home was built were acquired in 1997 by Sovereign Projects Ltd. Sovereign Projects Ltd is a company owned by Mr Aherne and other members of his family. In a written submission to the Commission, Mr and Mrs Aherne have stated that the running of the nursing home was operated by Sovereign Projects Ltd trading as Leas Cross Nursing Home. They also stated:

“The sole activity of Sovereign Projects Ltd at the time relevant to this investigation was the operation of Leas Cross Nursing Home. All income/turnover of Sovereign Projects Limited at the time relevant to this investigation was derived from the operation of Leas Cross Nursing Home.”

Sovereign Projects Ltd is a private limited company which was incorporated on the 13th February 1997. Mr and Mrs Aherne have been directors of the company since it commenced trading. In April, 2005, three children of Mr and Mrs Aherne, namely John Junior, Raymond and Siobhan, were added as directors of the company. The company secretary is Mrs Genevieve Aherne. The only shareholders of the company
are, and have been since it commenced trading, John and Genevieve Aherne. The Commission has found no evidence of any other owners of, or investors in, Sovereign Projects Ltd or Leas Cross Nursing Home.

In written submissions to the Commission, Mr and Mrs Aherne have stated that they invested IR£449,005 (€570,118) in the initial development of the nursing home. They state that the source of these funds was savings that Mr Aherne had accumulated over his years in business and from the sale of a commercial property. The remainder of the funds necessary for purchase of the lands and development of the nursing home were borrowed from banks.

Planning permission for Leas Cross Nursing Home

At the time of purchase, the lands contained a derelict two storey building and an annexe, which had previously belonged to a catering company. Planning permission for the change of use of existing offices, kitchens and ancillary buildings to a residential retirement complex was sought from Fingal County Council. The County Planning Officer’s report of the 19th August, 1997 concluded that, in principle, the proposal was acceptable: “it represents a reasonable reuse of a group of buildings in good condition in a rural location”. Permission was granted by Fingal County Council on the 30th September, 1997, subject to ten conditions. One of those conditions required the home to comply with the Homes for Incapacitated Persons Regulations 1985. In fact, those regulations had been revoked on the 1st September, 1993, by the Nursing Homes (Care and Welfare) Regulations 1993. On the 24th March, 1998, Fingal County Council decided to grant further planning permission, subject to six conditions, for the retention and completion of the entrance hall and for a new conservatory, laundry and covered walkway and the relocation of the lift. That grant of permission was made on the 7th May, 1998. Compliance with both planning permissions was certified by an architect on the 28th April, 1998.

Setting up Leas Cross Nursing Home

Mr Aherne was assisted in the establishment of the nursing home by the first matron, Ms Maureen Johnson. Ms Johnson assisted Mr Aherne in setting up the facility. Mr Aherne informed the Commission that he found Ms Johnson through a local G.P., (Doctor A), who later became the first medical officer for residents of the home. In oral evidence, Mr Aherne described the division of labour between himself and Ms Johnson as follows:

“My responsibility was the structure of the building, the services to the building, the fit-out of the building. Maureen Johnson’s responsibility would be dealing with the health service, northern area at the time, and all the medical side of the business.”
However, Ms Johnson was not involved in the recruitment of staff and left the nursing home before the first residents were admitted. Initial staff recruitment was carried out by her replacement, Ms Veronica McNamara.  

Registration of nursing homes – general principles

Legislative framework

Section 3 of the Health (Nursing Homes) Act 1990 prohibits a person from carrying on a nursing home, “unless the home is registered and the person is the registered proprietor thereof”. Section 4(1) requires each health board to establish and maintain a register of nursing homes in its functional area. Section 4 goes on to address the manner in which a nursing home can be included on or removed from that register. The following subsections are relevant in that regard:

Subsection (3):

(a) A health board may, on application to it in that behalf by a person who proposes to carry on a nursing home in its functional area, register or refuse to register the home.

(b) Subject to the provisions of this section, the period of registration shall be 3 years from the date of registration.

(c) Where a health board registers a nursing home, it shall issue to the registered proprietor thereof a certificate of registration in the prescribed form.

Subsection (6):

A health board shall not –

(a) refuse to register a nursing home in relation to which an application for its registration has been duly made, or

(b) remove a nursing home from the register, unless –

(i) it is of opinion that -

(I) the premises to which the application or, as the case may be, the registration relates do not comply with the regulations, or

(II) the carrying on of the home will not be or is not in compliance with the regulations,

(ii) the applicant or the registered proprietor, as the case may be, or the person in charge or, as the case may be, proposed to be

4 See further Chapter 9, regarding the role of the matrons at Leas Cross. As the recruitment and responsibilities of staff, see Chapter 11.

5 The requirement to maintain a register of nursing homes was transferred to the Health Service Executive by section 59 of the Health Act 2004.
in charge of the home has been convicted of an offence under this Act or the Act of 1964 or of any other offence that is such as to render the person unfit to carry on or, as the case may be, to be in charge of the home, or

(iii) the applicant or the registered proprietor, as the case may be, has failed or refused to furnish the board with information requested by it pursuant to subsection (10) or has furnished the board with information that is false or misleading in a material particular, or

(iv) the registered proprietor has, not more than one year before the date from which the registration or removal from the register would take effect, contravened a condition under subsection (8).

Subsection (8):

(a) A health board may –

(i) at the time of registration or subsequently attach to the registration conditions in relation to the carrying on of the nursing home concerned and such other matters as it considers appropriate having regard to its functions under this Act,

(ii) attach different conditions to the registration of different nursing homes,

(iii) amend or revoke a condition of registration.

(b) Conditions imposed under this subsection or amendments and revocations under this subsection shall be stated in the certificate of registration concerned or notified in writing to the registered proprietor of the nursing home concerned.

And subsection (10):

(a) A health board may request an applicant for registration or, as the case may be, a registered proprietor or an applicant for a declaration under subsection (4) to furnish it with such information as it considers necessary for the purposes of its functions under this Act.

(b) A person who, whether in pursuance of a request or otherwise, furnishes information to a health board for the purposes of this Act that is false or misleading in a material particular shall be guilty of an offence unless he shows that, at the time the information was furnished to the board he was not aware that it was false or misleading in a material particular.

Administrative structures and procedure

In 1998, the inspection and registration of nursing homes was administered within the Eastern Health Board under a ‘programme’ called Acute Hospitals and Services for Older Persons (AHSOP). The Programme Manager for AHSOP was delegated the responsibility for registering nursing homes by the Chief Executive of the Health Board.
Within AHSOP was a Nursing Home Section administered by a Senior Executive Officer (SEO), who reported to the Co-ordinator of Services for the Elderly. All nursing home inspections, whether routine or for the purposes of registration, were administered by the SEO of the Nursing Home Section.

When an application was made for registration, the SEO would ask the local inspection team to visit the home and would also seek a report from the Technical Services Department. The health board inspectors would visit the home and make a recommendation to the SEO, who in turn made a recommendation to the Co-ordinator of Services for the Elderly and, ultimately, to the Programme Manager. The Programme Manager would formally approve the recommendation and sign the certificate of registration for the nursing home.

An applicant for registration of a nursing home was required to complete an application form, to be accompanied by a copy of the nursing home brochure, a copy of the certificate of planning permission for the home, a plan of the home, written confirmation from a chartered engineer that the requirements of the statutory fire authority had been met, details of the work experience of the person in charge for the preceding six years and full particulars of all staff employed.

On receipt of an application form by the Eastern Health Board (EHB), three inspections of the proposed home would be carried out:

(a) inspection by designated officers under the Nursing Homes (Care and Welfare) Regulations 1993,

(b) inspection by an environmental health officer and

(c) technical inspection.

The curriculum vitae of the proposed person in charge was furnished to the designated director of public health nursing (DPHN) for the area.

Inspection by designated officers:

A submission received by the Commission from a former inspector of Leas Cross explains the role of designated officers in the registration process as follows:

“**My role in recommending first registration or re-registration of a nursing home formed part of my duties as a designated officer [under the Nursing Homes (Care and Welfare) Regulations 1993]. Before making a recommendation to register or re-register, I had regard to the preparedness of the proprietor and the director of nursing and the care environment for dependent persons in the proposed nursing home facility...**

*A first registration inspection was always undertaken with the inspection of a vacant building with the director of nursing / PIC [person in charge] or/and its proprietor. As a designated officer, I would inspect the accommodation and facilities, the equipment in place for the incoming residents. I would also*
review the proprietor’s application for registration form to identify proposed staffing levels and rosters, and the director of nursing/person in charge’s curriculum vitae. I would also inspect the nursing home’s policies and guidelines in relation to nursing, social and safe care, reporting arrangements, medication arrangements, residents’ activity plans and medical practitioner arrangements. I would then complete the nursing home inspection form and recommend suitability or unsuitability for registration following my inspection...

Decisions to register or re-register were not made by me. Rather, I and my fellow designated officers made recommendations by means of an inspection report. This report, with recommendations, was always attached to the nursing home inspection form and returned to the Nursing Home Manager, St Mary’s Hospital.

Technical inspections:

Technical inspections were carried out by the Technical Services Department of the Health Board. The Commission has received a submission dated the 2nd October, 2008 from Technical Inspector A, who carried out technical inspections of Leas Cross Nursing Home. He explains his role as follows:

When a nursing home applies for registration or re-registration I am contacted by the Nursing Home Section to carry out a technical survey of the home. By this I mean that I am requested to survey the home and prepare a report of my findings. My findings are based on the Guide to Nursing Home Legislation issued by the Department of Health in April, 1995. On completion of my report this is then forwarded to the Nursing Home Section who I understand forward this to the inspection teams.

... I did not make any recommendations or decisions in relation to the registering or re-registering of nursing homes. My role is and was limited to carrying out technical surveys of nursing homes in relation to accommodation standards (i.e. size and layout of rooms, accessibility, environment and services and also checklist in relation to health and safety aspects of the building) and compliance with the Guide to Nursing Home Legislation issued by the Department of Health in April, 1995 and the relevant building regulations. ...

Registration of Leas Cross Nursing Home

Initial application for registration

Mr Aherne, as proprietor, submitted an application for the registration of Leas Cross Nursing Home to the Eastern Health Board on the 5th March, 1998.
The nominated person in charge was Maureen Johnson. Mr Aherne has informed the Commission that Ms Johnson completed the application form, which was signed by him. The application for registration stated that the home would be able to accommodate 40 persons “on completion”, but registration was sought only for 31 beds at that time.

Dependency levels of residents:

The application indicated that the proprietors of Leas Cross intended to provide care for persons of all levels of dependency from low to maximum and that there were no restrictions on the type of residents who could be cared for in the home.

The Commission asked Mr and Mrs Aherne to explain the basis for this statement on the application form and to specify what analyses were carried out prior to the application for registration to ascertain that the home could cater for residents of maximum dependency. The following response was received from the Ahernes’ solicitors on the 20th August, 2008:

“The basis for the inclusion of the reference [to dependency levels on the application form] was that following completion of the construction work on LCNH the property was assessed by staff of the Eastern Health Board and that body placed no restrictions on the type of patients that could be looked after in the home.

On the grounds that our clients had no medical / nursing qualifications, we are instructed that as a corollary thereof, they were not qualified in assessing levels of dependency of each of the patients at the LCNH. The level of dependency of patients was determined by the Director of Nursing at LCNH.”

The matter was again addressed by Mr Aherne in oral evidence. He informed the Commission that the matron was responsible for filling in the form: that he had no understanding at the time of different dependency levels and had no input into the decision to register the home for maximum dependency residents.

The Commission considers that it has not received an adequate response in relation to this issue. The original response received in writing from the Ahernes’ solicitors was at odds with the true sequence of events. The nursing home was assessed by Health Board inspectors only after the application form stating proposed dependency levels was submitted. Accordingly, it is misleading to suggest that the proposed dependency levels for the home were arrived at on the basis of a Health Board assessment.

The application form was signed by Mr Aherne, as proprietor of the home, and clearly indicated that the home could cater for maximum dependency residents. Mr Aherne has not provided the Commission with any basis for this assertion on the application form, which was repeated on subsequent applications for re-registration and for the expansion of the nursing home. Given that Mr Aherne was the proprietor of the nursing home and signed the application form in that capacity, the Commission does not consider it reasonable for him to disclaim all responsibility for the matters
contained in the form, particularly in respect of such a significant issue as resident dependency levels.

Be that as it may, the fact that the application form proposed certain dependency levels did not preclude the Health Board from granting registration on a more limited basis, e.g. for low dependency residents only. However, it does not appear from the information available to the Commission that consideration was ever given by the Health Board to limiting the dependency levels of residents in Leas Cross Nursing Home.

Staffing and medical services:

In relation to the provision of medical services, the application form for registration stated the following:

Each resident will have access to a G.P. of their choice and an on-call system will operate for emergencies. A registered nurse will be on duty at all times supported by additional staff to provide a high standard of care for the residents.

The application form did not require the applicant to specify the proposed level of staffing for the home. He was asked to indicate, by ticking a box, whether the medical provisions were in accordance with regulation 10.5 of the Nursing Homes (Care and Welfare) Regulations 1993. That regulation requires, inter alia, that a sufficient number of competent staff are on duty at all times having regard to the number of residents and the nature and extent of their dependency. The application indicated that the nursing home complied with this regulation.

In relation to the proposed arrangements for drugs, the application form stated the following:

All drugs and medicines will be kept in a safe area accessed only by a registered nurse, all drugs administered will be recorded and records kept in a safe place. Drugs not in use will be returned to the pharmacy and a record kept of same.

It was indicated that occupational therapy would be included in residents’ fees. All other services – G.P., chiropody, dental care, optician, physiotherapy and speech therapy – would have to be paid for separately. The application stated that each of these services would be provided by the home and provided by arrangement with the health board. It is unclear what this was intended to mean in practice.

Technical inspection of Leas Cross

The application to register Leas Cross was received by the Acute Hospitals and Services for the Elderly Programme within the Eastern Health Board. On the 23rd March, 1998, an officer of the Eastern Health Board (Senior Executive Officer A) sent a copy of the application form to the Co-ordinator of Services for the Elderly for
Community Care Area 8. He also asked the technical officer, Technical Inspector A, to conduct a technical inspection of the premises.

Technical Inspector A carried out a technical inspection of the premises on the 21st April, 1998. He found that nine double bedrooms and two single bedrooms were below the recommended size. The “recommended size” referred to in Technical Inspector A’s report was the size recommended in the Guide to the Nursing Home Legislation, produced by the Department of Health in 1995, namely at least 9.3m² for single rooms and a minimum of 7.4m² per bed in shared rooms. Technical Inspector A also found that the main day room and three bedrooms were located on the upper first floor and accessible via steps only. There was no provision for a staff rest room and the area for staff changing was very small. Additional storage space for linen was required and a certificate of compliance with fire safety was required.

Technical Inspector A also found that the sluice was included in the patient’s toilet area and that a separate sluice should be provided. He noted that fire fighting equipment and fire notices were not in place at the time of inspection and that a certificate of compliance with fire safety was required.

Inspection by designated officers

An inspection team made up of Nursing Home Inspector A and Nursing Home Inspector B visited Leas Cross on the 20th April, 1998. Their findings were set out in a letter of the 30th April, 1998 to Senior Executive Officer A. The following seventeen issues were raised in that letter:

1. Nursing staff details were not available for inspection. The inspectors were assured that they would be forwarded in due course.

2. A report relating to fire safety was not available for inspection. The inspectors were informed that this had been sent to the Nursing Home section in the Eastern Health Board on the 16th April, 1998. A fire drill register and procedures were not available for inspection. The inspectors were assured that these would be forwarded in due course.

3. The nursing home had five toilets for the proposed 31 residents, which represented “marginally less” than the number recommended in the 1995 Department of Health Guide to the Nursing Home Legislation, namely one toilet for every six residents, and the resident of bedroom G1 would be required to go the length of the building to use a bathroom or toilet.

4. The sluice room was located at the farthest possible point from the laundry and there was no sluice room on the first floor. The inspectors recommended that the sluice room should be moved and the existing sluice room be converted to a toilet.

5. The room designated for linen storage was too small.
6. Some of the double rooms had no screens. The inspectors were assured that screens would be provided but that some of them would have to be mobile.

7. The main sitting room was accessible only after climbing four steps, so that wheelchair-bound patients would be unable to reach it.

8. The stairs to the first floor had been fitted with a carpet guard which jutted upwards and presented a hazard.

9. No designated staff room existed, other than a small alcove for staff changing.

10. The proposed drug recording and safe-keeping arrangements appeared to be adequate, but the proposed drug-administration arrangements “may be inadequate”. The inspectors advised the matron of appropriate arrangements and agreed to review the procedures.

11. An insurance certificate for residents was unavailable. The inspectors were informed that it had been sent to the Eastern Health Board.

12. The inspectors were concerned by a reference in the proposed contract of care to summary termination of the contract by the nursing home. The Nursing Home (Care and Welfare) Regulations 1993 required a minimum of fourteen days’ notice of discharge. The inspectors undertook to examine the proposed contract of care in more detail and discuss it further with the matron.

13. There was no designated area for storage of equipment such as wheelchairs, commodes and hoists.

14. The bedrooms were attractively decorated and contained hospital beds. However, there were no bedside lockers or adjustable height trays for eating in bed. The inspectors noted that the rooms appeared small for occupancy.

15. A register of medical, nursing and ancillary equipment was unavailable as such equipment had not yet been acquired. The inspectors were assured that a register would be made available as soon as possible.

16. No chemical or physical restraint policy, or policy for other nursing procedures had yet been drawn up.

17. The patient alarm in bedroom G1 did not operate correctly. The inspectors were assured that it would be repaired.

The inspectors pointed out to Senior Executive Officer A that Technical Inspector A’s report “raises major issues on the suitability of the bedrooms for the proposed occupancy level”. They identified four structural changes required for the nursing home to comply fully with the Nursing Homes Regulations:
(a) A ramp should be provided to allow wheelchair access to the main day area located on the first floor.

(b) A staff room for rest and changing should be provided.

(c) A sluice room separate from the patients’ toilet area should be provided.

(d) Additional storage space for linen and equipment should be provided.

The inspectors concluded as follows:

“In summary our findings ... indicate areas in which it is essential that the Nursing Home comply with regulations prior to registration. With regard to [Technical Inspector A]’s report more than half the bedrooms are below the recommended size for the proposed occupancy and structural issues (a) to (d) should be rectified to comply with regulations and the Nursing Home should also comply with the Fire Regulations.

The application for registration of the Leas Nursing Home is incomplete as the necessary documentation has not been provided as required by section 2.2.4(9) and (g) of the Guide to Nursing Legislation 1995 page 6 and 7.

It is therefore not possible to make a recommendation about registration at this point.

The report given here of the inspections carried out by ourselves and [Technical Inspector A], including our recommendations should be brought to the attention of the proprietor Mr J. Aherne and the person in charge Ms. M. Johnson so that they can arrange for the necessary changes in order that the premises and the carrying on of the Nursing Home comply with the Nursing Home Regulations.”

On the 22nd April, 1998, Senior Executive Officer A had written to the proposed matron of the nursing home, Maureen Johnson, seeking a certificate of compliance with planning permission, a fire safety certificate and written confirmation from an engineer of compliance with all fire safety requirements. He also sought documentary evidence that the home was insured against any injury that might be suffered by residents.

Senior Executive Officer A wrote to Mr John Aherne on the 8th May, 1998, enclosing the inspectors’ report and proposing a meeting. That meeting took place on the 15th May, 1998 at Leas Cross and was attended by Mr Aherne, Senior Executive Officer A, Nursing Home Inspector A, Nursing Home Inspector C and a new matron, Ms Veronica McNamara. The Commission has been provided with a handwritten note of the meeting, taken by Nursing Home Inspector A. Each of the seventeen issues raised in the inspectors’ report was discussed and it was noted that certain items (e.g. contracts of care, restraint policies) would be discussed subsequently by Nursing Home Inspector C and Ms McNamara. This is also reflected in typewritten minutes of the meeting, furnished to the Commission by Mr and Mrs Aherne. Technical Inspector A was also present at the nursing home on that date. He has informed the
Commission that, although he met the people referred to above, he did not take part in the meeting and was not “involved in any way” in the decision to register the home.

In relation to the structural issues previously identified by Technical Inspector A, Nursing Home Inspector A’s note of the meeting records the following decisions:

(a) a platform lift would be provided for access to the day room on the first floor;
(b) the staff room was “sorted”;
(c) the sluice would be moved to the laundry area;
(d) more storage was in place.

In relation to the size of the bedrooms, the notes of the meeting record that, although nine double bedrooms were 1.5m² under the recommended size, they had good light and good décor, the wardrobes were compact and the rooms were of regular shape. The notes go on to state “Recommended size – Guidelines not legislation”. The notes record the conclusion of the meeting that if all problem areas were addressed and the fire certificate furnished, registration would follow.

Although he was not involved in this particular decision, in a statement to the Commission Technical Inspector A has explained the circumstances in which he might, in general, be prepared to approve a room that does not meet the recommended size set out in the guidelines:

“Generally, where rooms are regular in shape and there is only one door leading into and out of the room and there are no obstructions preventing the suitable placing of a bed or other furniture then I may approve a room that may be up to 10% under the recommended size in the guidelines.”

The Commission notes that the 1995 guide does not expressly provide for a deviation of 10% from the recommended room sizes. Accordingly, it appears that this was a matter of practice and was not based on legislation or departmental guidelines. Although the Commission considers it desirable for nursing home inspectors to have had regard to the guide in the interests of ensuring consistency, the guide was not binding on the proprietors or operators of nursing homes or on health board staff in assessing nursing homes. This means that health boards were not acting outside their powers in approving the registration of nursing homes that did not strictly meet the criteria in the guide.

Nursing Home Inspector A’s notes go on to record a discussion of the Health Board staff, which took place after the meeting with Mr Aherne and Ms McNamara:

“Discussion EHB staff after meeting. If all problems corrected and fire cert => suitable for reg for 31 places. Double rooms – allowed as adequate even though below recommended size.”

Nursing Home Inspector A addressed the issue regarding room size in a submission to the Commission dated the 5th July, 2008. She pointed out that the building had been converted from a previous use and that the Nursing Homes (Care and Welfare) Regulations 1993 do not specify the sizes of bedrooms, but require “adequate
accommodation and space”. (See regulation 11.2(a) quoted above.) She concluded as follows:

“In conclusion, although the size of the rooms was below that recommended, we believed that they complied with the requirements set out in the Nursing Home Act 1990 and the Nursing Homes (Care and Welfare) Regulations 1993. Considering these facts, there was a consensus view that refusal of registration under the Nursing Homes (Care and Welfare) Regulations 1993 could not be justified on the grounds of room size alone. I think [Senior Executive Officer A] may have checked this with ... [the] solicitor for the E.H.B.”

Senior Executive Officer A has informed the Commission that he has no recollection of speaking to the solicitors for the E.H.B.

Nursing Home Inspector C visited the nursing home again on the 19th May, 1998, with Nursing Inspector B. Their report to Senior Executive Officer A dated the 20th May, 1998 stated that all of the items raised in the inspectors’ letter of the 30th April, 1998 had been addressed. Subject to Senior Executive Officer A’s satisfaction with the fire officer’s report, the Nursing Home Inspectors recommended registration of the nursing home for 31 residents, to be accommodated in nine single bedrooms and eleven double bedrooms.

On the 24th June, 1998, the Eastern Health Board decided to register Leas Cross Nursing Home for 31 beds for a period of three years from the 1st June, 1998. The recommendation was signed by Senior Executive Officer A and on behalf of Administration Eastern Health Board and approved by the Programme Manager (Acute Hospitals and Services for the Elderly). No conditions were attached to the registration.

In a report commissioned by the Chief Officer, HSE Eastern Region prior to the closure of Leas Cross to review the inspections carried out at the nursing home for the purpose of registration Mr Martin Hynes commented that the inspection report of the 20th May, 1998 referred primarily to “nursing related matters” and “does not deal with the infrastructural deficits which were referred to in the report of the 30th April”. Mr Hynes took issue with the statement in the later inspection report that all items in the earlier report had been addressed. He commented, “This clearly did not and could not have happened. The room sizes had not changed.” In relation to the registration of the nursing home, Mr Hynes stated, “In simple terms it should not have been registered in the manner in which it was or indeed registered at all.”

The Commission wishes to highlight two aspects of Mr Hynes’s findings. First, Mr Hynes stated that he was not provided with minutes of the meeting of the 15th May, 1998. Accordingly, he did not see the reasoning of the inspectors for permitting Leas Cross to depart from the recommended sizes for bedrooms. Secondly, Mr Hynes does not refer to the provisions of the 1993 Regulations regarding accommodation or to the text of the guidelines themselves and does not advert to the fact that the guidelines were not binding on nursing homes or health boards.
The Commission accepts the reasoning behind the decision to accept a number of rooms that were below the recommended size and, in all the circumstances, makes no criticism of the decision of the Health Board to grant registration to L.C.N.H. in 1998.

**Initial admission of residents**

The patients register for Leas Cross shows that six residents were admitted between the 2nd and 24th June, 1998. This was before the decision to register the nursing home was made, but after the inspectors had recommended registration of the nursing home “dependent on [Senior Executive Officer A] being satisfied with the Fire Officer’s report”.

Documents disclosed to the Commission by the H.S.E. include a letter from Mr Aherne to a fire prevention officer in Dublin Fire Brigade dated the 2nd June, 1998 which states:

“I can confirm that subsequent to our meeting of the above date I have consulted with [Senior Executive Officer A] Eastern Health Board, Nursing Home Section and conveyed details of our conversation to him, this referred to your agreement to permit in principle the partial use of the above premises so as to provide residential accommodation for patients urgently in need of care in the interim, subject to the issue of a full fire certificate from your good self.

[Senior Executive Officer A]’s agreement is subject to your consent on this matter and I would be therefore obliged if you could verify same to him at your earliest possible convenience.”

The copy of the letter furnished to the Commission by the H.S.E. bears a handwritten note dated the 2nd June, 1998, which the Commission has been told was written by Senior Executive Officer A’s secretary:

“... I phoned John Aherne and told him that he couldn’t admit patients as he’d be in breach of regulations – he seemed ok about it.”

The first residents were admitted on the same day that this letter and note were written.

Registration of the home, granted on the 24th June, 1998, was backdated to the 1st June, 1998.

The Commission wrote to Dublin Fire Brigade on the 29th July, 2008, seeking information about this matter. The response, received on the 25th August, 2008, stated that an inspection of the Leas Cross premises in April, 1998 revealed that it had been changed to nursing home use and that a fire safety certificate was required. An application was lodged on the 21st May, 1998 and a certificate was granted on the 17th June, 1998. Dublin Fire Brigade acted as agent for Fingal County Council in this matter and the certificate was granted by the County Council, which has furnished copies of the certificate to the Commission. No information was available from Dublin Fire Brigade regarding the letter from Mr Aherne of the 2nd June, 1998.
The Commission asked Mr Aherne to explain the circumstances in which residents were admitted prior to the decision to register the nursing home. His response, received from his solicitor on the 29th September, 2008, states that he does not recall the decision by the nursing home regarding the initial admission of patients. He proffers the suggestion that the fire officer and Senior Executive Officer A may have agreed to the use of the first 31 beds, pending the issue of a fire certificate for the remaining seven beds in an annex.

The Commission does not regard Mr Aherne’s suggestion as a credible explanation for the facts set out above. The annex had yet to be inspected by the Health Board for registration purposes. The fire safety issue in June 1998 clearly related to that part of the building which the Health Board was already prepared to register, subject to the grant of a fire safety certificate.

The Commission also asked Senior Executive Officer A, for his recollection of these events. In his response dated the 30th September, 2008, he states that he “did not agree that any residents could be admitted prior to the granting of a fire safety certificate”. He refers to the handwritten note made by his secretary, which indicates that Mr Aherne was informed that he could not admit residents prior to registration. Senior Executive Officer A states that he does not recall being aware that residents were admitted prior to registration. He explains the date of the registration certificate as follows:

“The practice at the time was to date the certificate from the first day of the month in which the decision to register was made. I am not aware of how this practice came about or on whose instructions the practice was commenced, but all certificates signed by me were dated the 1st of the month. Under no circumstances was the certificate of the 1st June, 1998 back-dated to accommodate the admission of any resident prior to the registration of the nursing home.”

In summary, it is clear from the documentation referred to above that six residents were admitted to Leas Cross Nursing Home before a formal decision to register the home had been made and, significantly, before a fire safety certificate had been granted. The Commission is also led to conclude that Senior Executive Officer A’s office had informed Mr Aherne that this would not be acceptable, but that residents were admitted nonetheless.

**Further registration application**

On the 15th September, 1998, Mr Aherne wrote to Senior Executive Officer A stating that the new wing of the nursing home was ready for occupation. Before this letter was sent the matron, Veronica McNamara, had tendered her resignation and was serving a two-week notice period.
Inspection by designated officers:

The new wing was inspected for the purpose of registration on the 24th September, 1998 by Nursing Home Inspector A and Nursing Home Inspector D. Handwritten notes taken by the inspectors and the inspection report were furnished. In addition, the matron’s notes were included in documents furnished to the Commission by Mr and Mrs Aherne. The inspection report, which was sent to Senior Executive Officer A on the 30th September lists the following six findings:

1. Bedrooms: One of the new double rooms appeared to be “on the small side”. The alarm system in the bedrooms was not fully installed and some work was in progress in an en suite bathroom. One of the bedrooms had a door leading to the courtyard and might not, therefore, be suitable for some types of residents.

2. Corridor: No carpets or handrails had been fitted in the corridor, which was narrower than those in the main building.

3. Bathrooms and toilets: No handrails had been installed beside the toilet and the main bathroom was incomplete.

4. Oratory and day space: It was unclear how much additional day space would be provided for residents in the extension or whether the proposed oratory was intended to double as day space.

5. Nursing care: The inspectors were informed by the matron that she had tendered her resignation and was unaware of the proposed staffing levels for the extension.

6. Staff room: The proposed staff room was full of stored items at the time of the inspection.

The inspectors also noted a number of concerns in relation to rooms in the existing part of the nursing home. In the dining room, which provided access to the extension, they observed a mop and bucket beside a storage unit for meal trays. A mini-kitchenette had been created in a corner of the dining room, were various appliances were connected via an extension lead with dangling plugs and leads. They were informed that this area was used after 6.30 p.m. when the main kitchen was locked, and that a bathroom sink was used for water and washing-up. The inspectors found that this situation constituted a safety hazard for residents and was unhygienic. They recommended that it be corrected urgently.

Installation of platform lift

During a previous routine statutory inspection on the 31st July, 1998, Nursing Home Inspector A and Nursing Home Inspector C had visited the operational part of the home and the annex which was then under construction. The inspectors’ handwritten inspection template for that visit states:
“Items which were to be completed to bring all aspects of the nursing home up to standard have been completed.”

However, during the inspection for registration on the 24th September, Nursing Home Inspector A and Nursing Home Inspector D observed that a platform lift had not yet been installed for access to the main day room, and that it was stored in a manner which might impede access to a nearby fire exit. The need to provide wheelchair access to the main day room (either by means of a ramp or a lift) had been flagged during the technical inspection for the initial registration in April 1998, and that registration had gone ahead on the understanding that a platform lift was being installed. It appears that three months after registration was granted, this had still not been done. The Commission does not understand why, in these circumstances, the inspectors had concluded on 31st July that all items required to bring the nursing home up to standard had been completed, when in fact the installation of the platform lift was still outstanding.

In any event, following their visit on the 24th September 1998 the inspectors concluded that the new wing was not yet ready for use and that they were, therefore, unable to make a recommendation to register it. They stated that the question of staffing would be reviewed once a new matron had been appointed. In addition to the resignation of the matron, the inspectors’ handwritten notes of the inspection record that the receptionist/administrator had resigned and that the chef had been fired.

Technical inspection

A technical inspection of the new wing at Leas Cross was carried out by Technical Inspector A on the 6th October, 1998. His report repeated his original assessment of the original part of the nursing home and also found that two double bedrooms in the extension were below the recommended size. However, he concluded that the extension to the home was “considered adequate”. Technical Inspector A has explained this in his submission to the Commission, dated the 2nd October, 2008, on the basis that the shape and layout of the rooms made them acceptable, notwithstanding that they were marginally smaller than the recommended size. The basis on which Technical Inspector A was prepared to approve rooms up to 10% smaller than the recommended size is set out above.

Technical Inspector A’s report was forwarded to Nursing Home Inspector A, who wrote to Senior Executive Officer A on the 2nd November, 1998 in the following terms:

“[Nursing Home Inspector C] and I both find [Technical Inspector A]’s technical report on Leas Cross difficult to understand as he appears to have changed his mind about the existing building which has been approved and I’m not sure of his conclusions about the staff room. Maybe when the extension is complete we can get together before giving final approval.”

Nursing Home Inspector A wrote to Technical Inspector A on the 11th November, 1998, referring to a telephone conversation with him and enclosing a copy of her inspection report of the 30th September. She pointed out the changes that had been
made since the initial inspection of the main building and reminded Technical Inspector A that bedrooms under the recommended size had nevertheless been approved owing to their regular shape. She also asked him whether the additional day space in the extension was sufficient for the proposed number of residents. In his submission to the Commission, Technical Inspector A has stated that he does not recall receiving this fax. However, he points out that the day space provided was above the size recommended in the Department of Health’s Guide to the Nursing Home Legislation.

It appears that some confusion arose from the fact that Technical Inspector A did not prepare a separate report following his inspection of the extension, but rather added his comments on the extension to the text of his original report on the nursing home. This may explain Nursing Home Inspector A’s impression that Technical Inspector A had “changed his mind” on the original building. Technical Inspector A has informed the Commission that he had not changed his mind, but that his report merely reflected his original opinion on the size of bedrooms, before the decision to approve registration. Technical Inspector A has made it clear to the Commission that he was not involved in any final decision, but merely reported his technical findings. In relation to the annex, he noted that two double bedrooms in the new wing were “below recommended size”, but did not state that they were unsuitable for two beds. Rather he considered the new wing to be “adequate”.

Further inspections

Nursing Home Inspector A and Nursing Home Inspector C again inspected the extension on the 20th November, 1998. By that time a new matron, Mary Chance, had taken over, although she was not formally appointed person in charge until December. The inspectors’ report to Senior Executive Officer A, dated the 23rd November, 1998, noted that two bedrooms were below the recommended size, but advocated their acceptance for two beds owing to their symmetry. They recommended “conditional approval” of the additional seven beds in the extension for a period of two months, to allow for a number of matters to be addressed, including the installation of handrails in all shower units. The inspectors’ report also addressed the issue of staffing in the extension. In doing so, the inspectors took into account the fact that “a totally unconscious patient with maximum dependency levels” was being transferred from another nursing home.

The Commission has been furnished with two copies of this inspection report. The copy furnished by Mr Aherne, which was forwarded to him by Senior Executive Officer A by fax in December, 1998, omits the reference to conditional approval of the seven beds, but is otherwise identical to the original report and bears the same signatures. The Commission has been unable to establish why two versions of this report exist.

The matron’s notes of the inspection reflect the issues in the inspection report, including staffing requirements. In addition, they record that the inspectors recommended that able bodied residents be placed in the extension, as the toilets were small and did not allow space for the provision of assistance, and that curtains were required between the oratory passageway and the door to the extension.
A copy of the inspection report furnished to the Commission bears a handwritten note from Senior Executive Officer A dated the 10th December, 1998, stating, “Discussed with Mr Aherne who agreed to forward written confirmation that matters outlined in this report have been addressed.”

Mr Aherne wrote to Senior Executive Officer A on the 10th December, 1998 enclosing a copy of the matron’s notes of the inspection and stating that “all items on the attached sheet have been adhered to with the exception of the curtains...” Senior Executive Officer A replied on the 15th December enclosing a copy of the inspection report of the 23rd November. He sought confirmation that the points raised in the report had been addressed and also sought “confirmation that the staffing levels set out by [Nursing Home Inspector A] and [Nursing Home Inspector C] have been put in place”. By letter of the same date, Mr Aherne stated that all issues raised in the inspection report had been attended to and that “staffing levels have also been increased as requested”.

Nursing Home Inspector A and Nursing Home Inspector C again visited Leas Cross on the 8th January, 1999. The purpose of this visit was to follow up on the previous inspection and to decide whether to recommend making final the conditional registration of the extension. In their report to Senior Executive Officer A dated the 15th January, 1999, they noted that all structural changes recommended on the previous occasion had been carried out. They recommended that registration of the nursing home be increased from 31 to 38 places.

However, the inspectors also found that the staffing levels did not comply with those recommended by them. This was despite Mr Aherne’s statement in his letter of the 15th December, 1998. The inspectors noted that the recommended staffing levels had taken into account the expected arrival of a maximum dependency patient, requiring constant observation. However, it had transpired on her arrival that the patient did not in fact require the anticipated level of care. Accordingly, the inspectors revised the necessary level of staffing for the extension. They addressed the failure to comply with their original recommendations in the following terms:

“We discussed this failure to comply with recommendation regarding staffing level with the matron, Mrs Chance, at the time of our visit. Mr Aherne, the proprietor was not available at the time of our visit but came to a meeting in Coolock Health Centre that afternoon to discuss this problem. We advised Mr Aherne that we took a very serious view of the fact that he provided false information in seeking registration. He apologised for misleading the Health Board and said he had not consulted the matron but just assumed the staffing levels had been increased to the recommended level. We advised Mr Aherne that he or matron should notify the Health Board if there are staffing difficulties or other problems, as soon as possible as we may be able to assist and advise.”

On the 16th February, 1999, the registration of the nursing home was formally increased from 31 to 38 beds for the remainder or the three-year period beginning on the original registration of the home (1st June, 1998). No conditions were attached to the registration. Senior Executive Officer A sent the certificate of registration to Mr
Aherne on the 16th February, under cover of a letter pointing out the inaccuracy of the information provided by Mr Aherne regarding staffing and “trust[ing] that you will ensure the accuracy of all information submitted in future”.

The Commission notes that under section 4(6)(iii) of the Health (Nursing Homes) Act 1990, a health board may refuse to register a nursing home or may remove a nursing home from the register where “the applicant or the registered proprietor ... has furnished the board with information that is false or misleading in a material particular”. This is not a mandatory provision and it is clear from the Act that a health board has discretion as to whether to grant or refuse registration.

In her written submission dated the 25th July, 2008, in response to a question from the Commission as to why registration was recommended notwithstanding the failure to comply with staffing levels and the misleading statement of Mr Aherne in that regard, Nursing Home Inspector A stated:

“From the correspondence available to me I would consider that having confronted Mr Aherne and heard his apology and excuse we accepted this in good faith. In addition the staffing levels that had been recommended in November 1998 included a resident who in fact did not require that anticipated level of care. This would mean that the recommended staffing levels were not required. [Nursing Home Inspector C] was thus satisfied with staffing levels so we recommended registration of the new wing.”

The Commission asked Mr Aherne to explain the circumstances in which he provided false information to the Eastern Health Board regarding staffing. In a letter dated the 20th August, 2008, Mr Aherne’s solicitors responded as follows:

“Our clients instruct that at this remove in time Mr Aherne has no recollection of this interaction with [Senior Executive Officer A]. However, that is not to say that interaction did not occur. It was not Mr Aherne’s intention to mislead [Senior Executive Officer A] in any way as the former was fully cognizant of the fact that at any point in time the Eastern Health Board could call to LCNH and assess for itself any issues regarding the management / administration thereof. Our clients can only surmise that the Director of Nursing had informed Mr Aherne that additional staff were in place and that he replied to [Senior Executive Officer A] accordingly. Furthermore, if it was the case that staffing recommendations by the Eastern Health Board were not adhered to at that time that this was addressed within a reasonable period thereafter. Our clients instruct that the Eastern Health Board at no time revoked or even threatened to revoke the licence granted in respect of LCNH.”

The matron at the time, Mary Chance, has informed the Commission that she was not the source of the misleading information that Mr Aherne furnished to the Eastern Health Board regarding the recruitment of additional staff. She states that, in general, she kept Mr Aherne informed at all times on the number of staff employed and any requirement for additional staff. Ms Chance also states that one of the reasons she left
the nursing home was because she felt that there was a resistance on Mr Aherne’s part to the recruitment of staff.\textsuperscript{6}

\textsuperscript{6} See further Chapter 11.
CHAPTER 8

THE EXPANSION AND RE-REGISTRATION
OF LEAS CROSS NURSING HOME

Expansion of Leas Cross Nursing Home

Decision to expand Leas Cross Nursing Home

In 2000, Mr and Mrs Aherne purchased a tract of land in North County Dublin, adjoining the existing lands, in their own names. They also entered into an option agreement to purchase lands from the same vendors. This option was exercised later that year. The lands were purchased to facilitate the construction of a new building which would almost triple the capacity of Leas Cross nursing home.

In written submissions to the Commission, Mr and Mrs Aherne described their decision to expand the home in the following terms:

“The demand for private nursing homes grew greatly as a number of state run institutions scaled down their operations. With this in mind, Sovereign made the business decision to extend LCNH.

This idea was discussed with the Eastern Health Board and again based on [Mr Aherne’s] performance to date, he received positive and encouraging feedback.”

In oral evidence, Mr Aherne informed the Commission that the architectural division of the Health Board provided structural advice regarding the development of the new wing of the nursing home.

It appears that the person in charge at that time, Grainne Conway, may also have sought interest and support for the proposed extension. Documents disclosed to the Commission by Mr and Mrs Aherne include copies of letters to Ms Conway dated in 2000 and 2001 from various hospitals and health boards supporting the notion that Leas Cross might seek registration of additional beds. On the 4th March, 2000, a letter was sent from the Nursing Home Section in the Eastern Health Board to Ms Conway which stated:

“Following our telephone conversation, I am very pleased to hear that you are applying for additional beds at Leas Cross.
I would like to take this opportunity in wishing you every success and look forward to a continued good working relationship with yourselves and the Nursing Home.”

Letters of support were also received from St Michael’s House, the Mater Misericordiae Hospital, the Mater Private Hospital, Beaumont Hospital, St James’s Hospital and Retirement Home Information Service Ltd.
The Commission notes that the Eastern Health Board and latterly the Northern Area Health Board expressed support for the proposed expansion of Leas Cross Nursing Home before the extension had been built and before any application for registration of the new beds had been made. It does not appear that the individuals involved in expressing such support on behalf of the health boards were later involved in determining the application for registration. However, the Commission considers it undesirable for the registering authority to have expressed support in advance for a development which would necessarily be the subject of an application for registration. The actions of the health boards in this regard give rise to a perception that the authorities may have been predisposed to grant registration for the extension to Leas Cross Nursing Home.

Planning permission for new building

Planning permission for a single storey extension to the nursing home, providing an additional 44 bedrooms and ancillary accommodation, was granted by Fingal County Council on the 5th October, 2000. The grant of permission was subject to five conditions, none of which is directly relevant to the matters under investigation by the Commission. A fire safety certificate for the construction of the extension was obtained from Fingal County Council on the 3rd April, 2001.

Following alterations to the plans, a subsequent application was made for planning permission for revisions to the previously approved extension. Permission was granted on the 4th January, 2002. This grant was subject to thirteen conditions. Again, none of the conditions is directly relevant to the matters under investigation by the Commission. Compliance with planning permission was certified on completion of the works by a consulting engineer on the 21st November, 2002.

The Northern Area Health Board was formally notified of the extension to Leas Cross in 2002. On the 3rd January, 2002, the matron, Grainne Conway, sent plans for the extension to the Health Board. A handwritten note on the letter states that copies were furnished to Technical Officer A and to the relevant Area Medical Officer. The matron sent further copies of the plans, together with copies of the fire safety certificate and planning permission, to the Nursing Homes Section and to Nursing Home Inspector E on the 22nd February, 2002.

Re-registration of existing nursing home in 2001

Legislative framework

Registration of a nursing home under the Act of 1990 is for a period of three years. On the expiry of the registration period, it is open to the registered proprietor of a nursing home to make a further application for registration. This is provided for in section 4(11) of the Health (Nursing Homes) Act 1990:
“The registered proprietor of a nursing home who proposes to carry on the home immediately after the expiration of the period of registration of the home may apply under subsection (3) to the health board concerned not less than 2 months before such expiration for the registration of the home and, if the board does not notify him before such expiration that it proposes to refuse to register the home, it shall register the home and its date of registration shall be the day following the day of such expiration.”

Evidence before the Commission suggests that the application of this section frequently resulted in nursing homes being re-registered automatically, owing to staff shortages which prevented the inspection of homes before the expiration of the existing registration. This problem has been acknowledged by the Manager of the Nursing Home Section in the HSE, in her submission to the Commission. The Nursing Home Section Manager wrote to General Manager A in March, 2003 to highlight the issue, following which a group was set up to review the inspection process. This ultimately resulted in the introduction of a dedicated nursing home inspection team, in October, 2004.

Registration – changes in procedure

In or around 2000, following the establishment of the Northern Area Health Board, responsibility for the registration of nursing homes changed. Reports regarding registration were sent directly by nursing home inspectors to the General Manager of the relevant Community Care Area. The General Manager would formally approve the inspectors’ recommendation and issue a certificate of registration. Leas Cross Nursing Home was located in Community Care Area 8 (CCA8).

Following the change in procedure in 2000, the person making decisions on registration was different to the person to whom routine inspection reports were sent. This is confirmed by the General Manager, CCA8, in his submission to the Commission dated September, 2008:

“Formal recommendations from the [inspectors] were submitted to me in order to approve/refuse registrations only. Following my formal approval, registration certificates, signed by me, would be issued to nursing home proprietors for display on their premises. I was not given any other inspection reports other than reports recommending registration or re-registration.”

The General Manager, CCA8 explained how he dealt with recommendations received from inspectors:

Once the inspectors had made a recommendation that a nursing home be registered / re-registered, I relied on this recommendation. While I never received a recommendation to refuse registration / re-registration, if I had, I would have consulted my line manager, i.e. Asst. Chief Executive, for advice / direction on how to proceed.

The Commission asked the General Manager, CCA8 the following question in writing:
“Whether [the General Manager, CCA8] had regard to or considered any factors other than those set out in the standard inspection template prior to recommending or approving the registration of Leas Cross nursing home for 111 places. In particular, whether [he] had regard to the capacity of the matron and staff of the nursing home to provide adequate care for 111 residents.”

The General Manager, CCA8 responded in writing, stating, “No other factors were considered. It was standard procedure to rely solely on the recommendations of the inspectors.”

Re-registration of Leas Cross Nursing Home

The initial registration of Leas Cross was for a three-year period ending on the 31st May, 2001. On the 22nd May, 2001, Mr Aherne submitted a new application for registration. This application was made less than two months before the expiration of the existing registration, contrary to the provisions of section 4(11) of the Act, quoted above.

The application was for 38 residents at all levels of dependency. The person in charge was stated to be Ms Grainne Conway, who had replaced Ms Mary Chance as matron in August, 1999.

The details set out in the application form were largely similar to those contained in the original application for registration in 1998. In relation to medical services, the application stated that a local G.P. attended the nursing home daily. G.P. services were stated to be within the nursing home fee, whereas in 1998 the application form had stated that such services were in addition to the fee. The application also stated that the nursing home’s insurance cover did not include residents’ own effects, whereas such items were apparently covered in 1998.

By the time of the application for re-registration in 2001, the Eastern Health Board’s functions had been taken over by the Northern Area Health Board and some of the personnel had changed. In particular, there was a new Co-ordinator of Services for the Elderly.

The nursing home was inspected on the 18th June, 2001. The inspectors were Nursing Home Inspector C and Nursing Home Inspector F. The Commission has been furnished with a copy of the handwritten inspection template completed by the inspectors but not a copy of the inspection report. In the ‘comments’ section of the template, the inspectors concluded as follows:

“All residents appeared well cared for. Registration of the Nursing Home in accordance with the Health (Nursing Homes) Act 1990 for a further period of three years is recommended.”

The Commission notes that Health Board inspectors had expressed concerns regarding the level of staffing at the home during inspections in January, June and
August, 1999 and concerns regarding the drugs recording system in February and July, 1999, such that they found it necessary to conduct a number of spot checks in addition to the routine inspection. It appears from the inspection reports from 2000 and 2002 that the inspectors were satisfied that those issues had been resolved by the end of 1999.

The nursing home was accordingly registered for a further three years from the 1st June, 2001 to the 31st May, 2004. No conditions were attached to the registration. A copy of the certificate of registration was sent to Nursing Home Inspector C for her records on the 4th July, 2001.

Registration of expanded nursing home

The planned new building at Leas Cross was completed in 2002. Unlike the original building, it was designed from the outset as a nursing home, with a capacity of 73 beds. This gave the newly extended nursing home a total of 111 beds.

Application for registration

On the 29th October, 2002, Mr Aherne applied to have the nursing home re-registered for 111 beds. Other than the number of rooms, the details on the application form generally reflected those on forms submitted for previous registrations.

As in the case of the initial application for registration, the application form for the extension indicated that residents of all dependency levels could be accommodated in the nursing home. In oral evidence, Mr Aherne informed the Commission that the matron, Grainne Conway, filled in the form and that he did not discuss this issue with her. He also stated that the layout of the extension was such that it could accommodate different types of residents in different wings.

A copy of the application form was forwarded by the Nursing Homes Section of the Northern Area Health Board to Nursing Home Inspector E with a request that she arrange a visit to inspect the premises.

Inspections prior to registration

A technical inspection was carried out by Technical Inspector A on the 23rd October, 2002. He concluded that “the accommodation is suitable to accommodate 73 beds”. An environmental health inspection of the new wing was carried out on the 11th November, 2002. The Senior Environmental Health Officer concluded, in a report dated the 12th November, that the layout of the kitchen and food storage areas and the equipment for preparing and serving foodstuffs were satisfactory.

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7 See further Chapter 13.
8 See further Chapter 11.
Nursing Home Inspector E and Nursing Home Inspector G carried out an inspection of the home on the 20th November, 2002. In her submission to the Commission Nursing Home Inspector E states that the matron escorted the inspectors throughout the inspection and that Mr Aherne escorted them through the new extension of the nursing home.

Nursing Home Inspector E has informed the Commission that the inspection included the following:

“The accommodation facilities were inspected by us, the preparedness for the intake of residents was discussed with Ms Conway, i.e. staffing, medication management, day to day management, activities for residents and her extended management role in the new development. ... I discussed the staff roster with Ms Conway and advised Ms Conway to review this frequently as resident numbers increased. ...”

In the handwritten inspection template, filled out at the time of the inspection, the inspectors concluded as follows:

“The 73 bedded extension was found to be satisfactory with a few items listed on registration letter requiring attention. Staff ratios appear satisfactory. Matron advised to review frequently as resident numbers increase.”

**Decision to register for 111 beds**

The inspectors sent their report to the General Manager, CCA 8, on the 22nd November, 2002. They listed a number of issues requiring attention, including the need for grab rail fixtures in assisted bathrooms and works to be completed in two of the new bedrooms. The inspectors stated that the matron had assured them that these items would be attended to as soon as possible. They concluded by recommending that registration of the nursing home be changed to reflect the number of beds in the new extension. On the same date, the General Manager CCA8 approved the alteration and a new certificate of registration issued stating that Leas Cross was registered for the period from the 1st June, 2001 to the 31st May, 2004 for 111 residents.

The Commission asked the General Manager CCA8 (a) why he decided to register the home for 111 beds before outstanding matters had been addressed and (b) whether he took into account any factors other than those set out in the standard inspection template, such as the capacity of the home to provide adequate care for 111 residents. He replied as follows in September, 2008:

“(a) I approved the registration on foot of the recommendation contained in letter dated 22nd November 2002 from the inspectors, [Nursing Home Inspector E] and [Nursing Home Inspector G]. This letter outlined the items requiring attention which were minor technical / structural matters that would have been capable of rectification within a short period of time. The matron of Leas Cross had given an assurance that these items would be attended to.
The inspectors’ letter had also stated that the reports of the Environmental Health Officer, Fire Officer and Technical Services Officer indicated satisfaction with the premises.

(b) No other factors were considered. It was standard procedure to rely solely on the recommendations of the inspectors.”

The Commission is concerned to note that a decision of this significance was taken at a high level within the NAHB without regard to the history of the nursing home and based solely on the outcome of one standard inspection. Although Nursing Home Inspector E has informed the Commission that, as a matter of practice, she considered previous inspection reports at the time of an inspection, the person ultimately making the decision, was not, as a matter of practice, furnished with routine inspection reports for the nursing home.

The Commission is concerned that a fully informed decision on the expansion of the nursing home from 38 to 111 beds could be made only if the inspectors took into account factors other than those set out in the standard inspection template. The Commission asked Nursing Home Inspectors E and G, who had carried out the pre-registration inspection, whether they had regard to any factors other than those in the standard inspection template in recommending the registration of Leas Cross for 111 places. In particular, they were asked whether they had regard to the capacity of the matron and staff to provide adequate care for 111 residents.

In her statement to the Commission, Nursing Home Inspector E identified a number of matters not expressly set out in the standard inspection template, to which she always had regard during inspections. These included nursing records and client records, accident and incident reports and physical restraint records. In relation to residents’ dependency levels, Nursing Home Inspector E stated the following:

“The identification of dependencies of residents was always discussed with the Director of Nursing / person in charge and the staff rosters were also reviewed to ensure adequate staffing, particularly at high needs times during the day and night…”

Specifically in relation to Leas Cross, Nursing Home Inspector E responded to the Commission’s question as follows:

“In relation to the capacity of the matron and staff of Leas Cross, the capacity of the matron / PIC, Ms Conway had already been determined as suitable in earlier inspections. Since then, no difficulties had arisen in relation to Ms Conway’s fitness as Person in Charge in any previous inspection. As I was registering an empty facility as suitable for occupancy by 73 residents, I determined at that time that Ms Conway remained fit to be Person in Charge according to Article 10.3 of the Care and Welfare Regulations and that she had prepared to increase the staff number to service the area. Registered General Nurses are deemed competent to deliver clinical nursing care and have a duty of care through registration with An Bord Altranais.”
Nursing Home Inspector G, in her submission to the Commission explained that the inspection of the extension to Leas Cross coincided with a routine inspection of the existing premises. She stated the following in relation to the inspection of the extension:

“The pre-registration inspection was of a 73 bed extension that was not yet operational; there were no residents in place. The purpose of a pre-registration inspection was to ensure that the premises were in compliance with the legislation and that the staff had the capacity to be able to provide adequate care to the new residents. Staff rosters were reviewed to ensure that adequate numbers of competent staff either were or were intended to be on duty to care for the new residents. [Nursing Home Inspector E] also spoke to Grainne Conway, Director of the Nursing Home, about issues relating to the increase in residents and the areas of particular importance, i.e. staffing levels, nursing rosters, recruitment of extra nursing and care staff, daily management, drug storage and management. These were considered to be very important when considering whether to make a recommendation for re-registration for increased capacity or not.

I never had any reason to believe that Grainne Conway was not a competent person, she was always willing to cooperate during all inspections.”

Some observations on the expansion of Leas Cross Nursing Home

The Commission considers that the registration of 73 additional beds at Leas Cross was granted without adequate regard to the wellbeing of the residents who would occupy the new wing. There were three approaches open to the Northern Area Health Board, which might better have protected future residents:

- First, greater emphasis should have been placed prior to registration on considering the viability of a nursing home for 111 residents and the likely ability of the nursing home’s management to cope with the proposed increase.

- Secondly, the grant of registration should have been conditional, to ensure that numbers increased at a reasonable rate, dependency levels were manageable and staffing was adequate.

- Thirdly, developments at the nursing home should have been monitored more closely once registration had been granted.

Pre-registration assessment:

Assessment of the newly extended Leas Cross Nursing Home was part of the inspectors’ function during the pre-registration inspection. This has been acknowledged by Nursing Home Inspector G to the Commission, in a passage from her submission quoted above, where she stated that one of the purposes of the
inspection was to ensure that staff at the nursing home had the capacity to provide adequate care to the new residents.

Clearly, it would have been unreasonable to have expected Leas Cross Nursing Home to hire enough staff to run the 111-bed nursing home at full capacity, in advance of any residents actually being admitted to the new wing of the home. However, rather than merely approving an empty building in which residents would eventually be accommodated, the pre-registration inspection should have included consideration of the implications of registering such a large nursing home and a discussion of the likely staffing and other requirements. The Commission can find no evidence in the inspection report or the inspectors’ submissions that these factors were given any detailed consideration. The Commission is satisfied that the terms of the 1993 Regulations were sufficiently broad to permit the inspectors to consider these factors at a pre-registration inspection.

The nursing home inspectors have stated, in their submissions quoted above, that Ms Conway’s fitness to act as matron had been determined at earlier inspections and Nursing Home Inspector E states that she discussed issues such as staffing and management of the new wing with the matron. However, previous inspections were of a home for 38 residents, so the matron’s ability to manage a nursing home for 111 residents could not have been based on previous assessments of the nursing home.

The Commission’s concerns in this regard are echoed in a June, 2005 report of Mr Martin Hynes. Mr Hynes had been asked by the Chief Officer of the HSE Eastern Region to review the inspections carried out at Leas Cross for the purpose of registration. In his report, Mr Hynes commented that the increase in capacity from 38 to 111 beds “does not appear to have generated any debate on the wisdom of registering a home of this size”.

Professor O’Neill, in his 2006 report on Leas Cross, points out that the median number of beds in 2004 for nursing homes in the ERHA was 45. Also of interest in this regard is information obtained by the Commission concerning the nursing homes that tendered to the H.S.E. for intermediate and high dependency beds in January 2005: apart from Leas Cross, only one other nursing home had more than 100 beds, and it was a public nursing home. The next largest home had a capacity of 76.

It may be that a private nursing home for 111 residents is simply not a viable proposition in any circumstances. While the Commission makes no specific finding in that regard, it has found no record that this issue was considered by the inspectors or by Health Board management before registration was granted.

**Imposition of conditions:**

The second option open to the NAHB was the imposition of conditions. The application for registration of the new wing made by the proprietor expressly indicated that there was no limit on the type of residents that would be cared for in the nursing home and that care could be provided for patients at all levels of dependency, from low to maximum.
It was open to the Health Board to have granted registration of the extension subject to conditions, such as:

i) a limit on the level of dependency of residents to be accommodated there;

ii) a limit on the percentage of high or maximum dependency residents, relative to the overall population of the nursing home;

iii) a restriction on the rate at which resident numbers increased in between inspections;

iv) specific requirements regarding staff numbers and the ratios of nurses to care attendants.

The Commission considers that the imposition of one or more conditions along these lines would have been desirable, at least temporarily, to allow the NAHB to monitor the capacity of the home to deal with the significant increase in numbers. No conditions were imposed.

In a written response to the Commission, the solicitors for the H.S.E. commented as follows:

“Whilst the H.S.E. is not in a position to comment on evidence available to the former Health Board in relation to the imposition of conditions at the relevant time, the H.S.E. would like to comment that conditions can only be imposed in accordance with the provisions under s.4(13) of the Act and the proprietor can appeal such a decision to attach a condition to the District Court (s.5). The former Health Board would have required specific evidence at the pre-registration stage that the proprietor would not have been capable of managing the number and level of dependent residents intended for admission to the home. That evidence was not available at that time.”

The Commission accepts that the imposition of conditions would have to be based on breaches of the regulations or potential future breaches of the regulations. However, there is nothing in the evidence disclosed to the Commission to show that the option of imposing conditions was considered at all by those responsible for registering the nursing home.

The Commission is satisfied that the regulations do not require evidence of an actual breach of the regulations before conditions may be imposed. That would mean that conditions can never be imposed on the registration of a new nursing home until there exists some evidence of non-compliance with the nursing home regulations. In effect, this means that a nursing home must first be allowed to breach the regulations - thereby putting residents at risk - before conditions may be imposed. No such restriction is imposed by the legislation.

Clearly one function of the provision for conditions is to ensure that, on the first registration of a nursing home (or, as here, the new wing of a nursing home), precautions can be taken for the safety of residents before they are admitted. Any other interpretation of the legislation makes no sense and renders the provisions practically ineffective. It is true that the H.S.E. might have to stand over its decision
to impose conditions before the District Court, but the Commission can see no reason why, in an appropriate case, the evidence of experienced nursing home inspectors as to potential risks to residents should not suffice to justify the imposition of conditions.

Not only was the newly extended nursing home registered without any restrictions as to the dependency level of those who might be admitted to the home, but the Northern Area Health Board took the opportunity to purchase a number of contract beds from Leas Cross in August 2003, in order to transfer a group of elderly, high dependency patients from St Ita’s Hospital, many of whom had problems with dementia and Alzheimer’s disease and required significant amounts of nursing care.

The Health Board had indicated an interest in obtaining the use of beds in the expanded nursing home as early as the 24th January, 2001, when the Eastern Health Board wrote to the matron of Leas Cross, Grainne Conway in the following terms:

“I refer to our conversation of today’s date ... regarding the new development of nursing home beds which I understand is not due to come on stream until September 2001. We would be very interested in talking to you about contracting some of those beds. I will make direct contact with you nearer the time to make arrangements to meet.”

On the 23rd November, 2001, the Northern Area Health Board wrote again to Ms Conway stating that they had an “urgent need for contract beds” and asking to be kept informed of the availability of beds in the nursing home.

The Commission has established that the Health Board officials who wrote these letters had no direct involvement in either inspecting or registering nursing homes and has found no direct evidence that the NAHB’s urgent need for contract beds was taken into consideration in registering Leas Cross for an additional 73 beds. However, the coincidence of these facts potentially gives rise to an inference that the Health Board may not have given adequate consideration to the problems which could arise from such a dramatic increase in nursing home size.

**Nursing home inspections:**

Thirdly, it was open to the NAHB to have increased the frequency of inspections of the nursing home following its expansion, to ensure that the large number of proposed new residents were receiving adequate care.

The Commission notes a marked difference in the approach of the Health Board between the early years of operation of Leas Cross and the time of its expansion. When it opened in 1998, the nursing home originally accommodated a maximum of 31 residents, increasing to 38 in 1999. At that time, inspection reports reveal serious concerns regarding staffing levels, in response to which Health Board inspectors carried out a number of spot checks in addition to the biannual routine inspections. By 2000, as a result of the inspectors’ monitoring of the nursing home, acceptable staffing levels were achieved.
In contrast, following the expansion of Leas Cross in 2003 to cater for 111 residents, the level of Health Board supervision dropped, as there was only one routine inspection carried out in 2004. The Commission believes that the Health Board should have monitored developments at the nursing home more frequently, to ensure that staff numbers increased in tandem with the increase in residents and to ensure that there was an appropriate balance of nurses to care attendants. This did not occur.

In a response to the Commission on this issue, the solicitors for the H.S.E. stated:

“In 2003-2004 the former Northern Area Health Board carried out a recruitment drive in order to try to recruit Public Health Nurses which would necessarily have resulted in more inspectors being made available to inspect the Leas Cross Nursing Home at that time. In the former Northern Area Health Board and indeed nationally there was a crisis in relation to the recruitment of appropriately qualified nursing staff.”

Re-registration of Leas Cross Nursing Home in 2004

Registration – changes in procedure

The system for registration and re-registration of nursing homes changed again in 2004, when a dedicated nursing home inspection team was established. Under this regime, recommendations from the inspection team relating to registration were sent to the Manager of the Nursing Home Section, who would prepare a formal decision and a certificate of registration and send them to a General Manager who was responsible for certain administrative functions in relation to nursing homes and other care facilities, for signature. Elsewhere in this report, this individual is referred to as ‘General Manager A’.

The Nursing Home Section Manager and the General Manager A have both told the Commission that their role was administrative and that they relied exclusively on the inspectors’ recommendations regarding registration. The Nursing Home Section Manager states the following in her submission to the Commission:

“As Manager of the Nursing Home Section I had no involvement in the inspections of private nursing homes. In relation to the decision to register or re-register nursing homes generally and in particular Leas Cross Nursing Home my function was purely administrative. I prepared the certificate of registration and the decision order based on the recommendation in the inspection report. ... The certificate of registration and the decision was forwarded to the [General Manager A] which was duly signed and returned to me I then forwarded a letter to [the nursing home proprietor] enclosing a copy of the decision form together with the certificate of registration.”

The Nursing Home Section Manager also states that she did not have regard to previous inspection reports in processing the application for registration:
“At the time of re-registration of Leas Cross Nursing Home I only dealt with registration inspections every three years. Six-monthly inspection reports and reports dealing with complaints and files were held in the local community care areas.”

In response to subsequent questions from the Commission, the Nursing Home Section Manager confirmed that she made no assessment of nursing homes in recommending registration:

“The only qualitative assessment of an application for registration of a nursing home was made by the inspectors who would have considered previous routine inspections or complaints.”

General Manager A, has provided similar information to the Commission:

“My involvement in decisions to register or re-register nursing homes in general and Leas Cross in particular was an administrative function. The nursing home section at the Phoenix Park obtained a decision number from the decision file held at headquarters in Swords. Once this was obtained, a decision form was completed by the nursing home section and a certificate of registration was completed for the particular nursing home within Area 6, Area 7 and Area 8. On production of these documents to me I signed same. ... Any variance from a recommendation to register nursing homes of which I can recall no instances would have been escalated to my Line Manager [Michael Walsh].”

In this regard, Mr Walsh has pointed out that General Manager A also had a reporting relationship to the Assistant C.E.O. for Community Services in relation to private nursing homes.

In light of her evidence and that of the Nursing Home Section Manager, the Commission put the following written question in a letter to General Manager A:

“[General Manager A] has stated that she performed an administrative function in signing decision forms and certificates of registration once a recommendation had been made to register or re-register a nursing home. The Commission has also received a submission from [the] Manager of the Nursing Home Section, who was responsible for providing [General Manager A] with the draft decision and certificate of registration for her signature. [The Nursing Home Section Manager] has also indicated that her function in this regard was administrative only and that she relied on the inspectors’ recommendation regarding registration.

From this information, the Commission understands that the only qualitative assessment of an application for registration of a nursing home was made by the inspectors. Although the decision form contained a recommendation from the Manager of the Nursing Home Section and an approval from [General Manager A], it is the Commissions’ understanding that neither of these people, nor anyone in a senior managerial position within the HSE, made any judgement regarding the registration of nursing homes; they did not consider
previous routine inspections or previous complaints, but had regard only to the recommendations of the inspectors who had visited the home in question in response to the application for registration.

Perhaps [General Manager A] would confirm whether this understanding is correct and provide further details if she considers it appropriate.”

General Manager A replied as follows:

“The Commission’s understanding is correct with regard to the administrative function I performed in signing decision forms and certificates of registration once a recommendation had been made to register or re-register a nursing home. My signature function is outlined in the Nursing Home Section Procedure.”

General Manager A furnished the Commission with an undated document entitled ‘1st Draft Procedure for Nursing Home Registration’. It sets out the following steps to be carried out on receipt of completed inspection reports:

- Nursing Home Section draws up registration certificate
- Get a decision number from [General Manager A] and draw up decision form
- The Manager of the Nursing Home Section recommends the registration on the decision form
- Organise for the certificate and the decision to be signed by [General Manager A]
- The Manager of the Nursing Home Section sends the certificate and a copy of the decision form with a covering letter to the nursing home
- If there are conditions of registration they are included in the letter
- Update registration database

In response to further questions from the Commission, General Manager A has confirmed that she did not receive the relevant inspection reports before signing the decision and certificate of registration, “as the process checks were in place prior to presentation for my signature as outlined in the Nursing Home Section Procedure”.

Although the procedure for registration referred to above is described as a “1st draft”, General Manager A has informed the Commission that it was “the template by which all registrations and re-registrations of nursing homes were conducted”. General Manager A has pointed out that the reference on the certificate to registration having been “approved” by General Manager A is misleading, insofar as it suggests that she was required to make any decision regarding registration. She has highlighted to the Commission the fact that her role was “purely and exclusively functionary”. She states that her role did not involve the qualitative assessment of any nursing home: she had “neither the functional authority nor the skills set required to perform such a role”.

62
Similarly, the Nursing Home Section Manager has taken issue with the suggestion that she had any decision-making role in the process of registration of nursing homes. She has informed the Commission that she was “not qualified, trained nor entitled to make any decisions as to whether or not a nursing home should be registered ...” The Nursing Home Section Manager describes her role as “organising the paperwork for the registration of nursing homes” and asserts that it was not open to her to make a decision regarding registration. She states that the “recommendation” completed by her is merely an administrative form and that she did not, in fact, make any real recommendation.

Both General Manager A and the Nursing Home Section Manager emphasise that the job of recommending registration of a nursing home is that of the inspectors, who have the training and expertise to make a judgment in that regard.

A member of the inspection team (Nursing Home Inspector H) has given a contrary view in a written submission to the Commission dated the 6th May, 2009:

“With reference to registration, it was always my understanding that further consideration was given to whether the registrations should go ahead or not by those who sign off on the registration.”

It is not possible for the Commission to determine conclusively where ultimate responsibility lay for decisions regarding registration. It is clear from the foregoing conflict of evidence that there was a lack of understanding within the Health Board as to where that responsibility lay, which meant that nobody appears to have been accountable for such important decisions.

In relation to the imposition of conditions, the Nursing Home Section Manager has informed the Commission that “the proposal to attach conditions to a registration is based on the recommendation of the nursing home inspection report”. The General Manager A has told the Commission that the imposition of conditions was “based on the recommendations as specified in the decision form”. She states that “a recommendation on the inspection form to attach conditions would have been included in the decision form ...”

Nursing Home Inspector H has told the Commission that the imposition of conditions was a matter for senior management:

“...we list all issues of concern (identified during the course of an inspection) on the reports. Those reports were then sent by us to the Nursing Home Section, we did not recommend the imposition of conditions in the reports and I never did so. It is my understanding that the reports were sent from the Nursing Home Section to the C.E.O.’s office and senior executives where a decision was then made in relation to the imposition of conditions.”

The Commission is concerned that the Northern Area Health Board procedures for the registration of nursing homes did not ensure adequate consideration of relevant material at a senior level. General Manager A (or prior to 2004, the General Manager CCA8) signed certificates of registration without reference to reports of previous
inspections of the home. Further, General Manager A did not see the current inspection report on which the recommendation to register the home was based.

General Manager A seeks to explain this by reference to the procedure for nursing home registration referred to above. Although the document in question sets out in the barest detail the hierarchy for the decision-making process, the evidence indicates that General Manager A and the Nursing Home Section Manager carried out their duties in formal compliance with that process. However, in the Commission’s view, that does not excuse senior management in the Health Board from taking adequate steps to ensure that all relevant information is considered before a nursing home is registered or re-registered.

It is also evident that there was a serious misunderstanding regarding the manner in which conditions could be imposed. Nursing Home Inspector H has stated that she did not recommend conditions per se, but set out issues of concern in her inspection report for decision by “senior executives”. On the other hand, the Nursing Home Section Manager and General Manager A have said that it was not for them to impose conditions unless recommended to do so by the inspectors. Thus it appears that the consideration of the need for conditions may have been neglected. The Commission considers this to have been a serious failing in the system, which may have contributed to events at Leas Cross Nursing Home, as set out in subsequent chapters of this report.

**Application for re-registration**

On the 11th May, 2004, the Nursing Home Section of the Northern Area Health Board wrote to Grainne Conway to inform her that the nursing home would be due for re-registration on the 31st May. An application form for registration, signed by Mr Aherne on the 24th May, was duly submitted. The form was in similar terms to previous applications and stated that the home could accommodate 111 residents without limitation as to their levels of dependency.

**Inspections**

On the 25th May, 2004, the Nursing Home Section wrote to Nursing Home Inspector H. Nursing Home Inspector H and Nursing Home Inspector G inspected the premises on the 2nd June, 2004. The handwritten inspection template includes the following comments:

“One complaint still outstanding – awaiting consultant’s report. The outcome of this complaint may affect recommendation for registration. Recommendation: Registration subject to outcome of complaint. Small no. of repairs given to DON [Director of Nursing] for action.”

Nursing Home Inspector H has provided more detail regarding the inspection in her submission to the Commission dated the 25th September, 2008. In particular, she sets out her concerns regarding staffing and her intention to carry out an assessment of
resident dependency to ascertain the adequacy of the skill mix of staff. Nursing Home Inspector H has also explained the reference to an outstanding complaint:

“... I considered the complaint ... to be very serious and that it may have affected the re-registration of the nursing home depending on the outcome of the complaint.”

I was informed by the Nursing Home [Section] Manager ... at the time that it was not possible to defer re-registration as the complaint was not completed. Registration would therefore go ahead by default. I considered that I needed it documented. I am advised that s. 4(13) of the Health (Nursing Homes) Act 1990 states that a proposal to refuse to re-register a nursing home must be notified to a proprietor prior to the expiry of the current registration and if that is not done the a Health Board (HSE) must re-register the home. I am also advised that a Health Board (HSE) may only refuse to register a nursing home in limited circumstances contained in s. 4(6) of the Act, one of which is that the premises or the carrying on of the home is or will not be in compliance with the 1993 Regulations. I am advised that it was for this reason that re-registration could not be deferred pending the outcome of the investigation of the complaint.”

The Nursing Home Section Manager has informed the Commission that she does not recall the conversation with Nursing Home Inspector H referred to above. She points out that she was junior to the inspectors within the Health Board hierarchy and, accordingly, asserts that it is unlikely that Nursing Home Inspector H would make a decision based on a conversation with a junior administrative staff member.

Re-registration

On the 2nd February, 2005, the Nursing Home Section Manager drew up a decision form which was signed by General Manager A, who also signed the certificate of registration Leas Cross was accordingly re-registered for a three year period beginning on the 1st June, 2004.

The Commission asked the Nursing Home Section Manager what matters she took into consideration in deciding to recommend re-registration of the home. She responded in her submission to the Commission as follows:

“The Nursing Home Section requested the nursing home inspectorate to conduct the re-registration on the 25th May, 2004. The inspection was carried out on the 2nd June, 2004. The inspection report stated there was “one complaint outstanding awaiting consultant report. The outcome of this complaint may affect recommendation for registration.” The recommendation of the inspectorate was “registration subject to outcome of complaint”. No other matter was taken into consideration. Prior to the establishment of the dedicated nursing home inspectorate the two annual inspection reports were

9 See further Chapter 13.
10 See further Chapter 15.
The Commission also asked the Nursing Home Section Manager why there was a gap of eight months between the inspection of Leas Cross on the 2nd June, 2004 and her recommendation to grant registration on the 2nd February, 2005. She responded as follows:

*I cannot remember the details, but my recollection is the nursing home was registered. I have reviewed the inspection report of the 2nd June, 2004 and comments therein indicate that there was an outstanding complaint which may affect registration. I may have waited for the outcome of the complaint or it may have been an administrative omission. Although the registration certificate was not signed until the 2nd February, 2005 it was registered because of the provisions set down in section 4(11) of the Health (Nursing Homes) Act 1990.*

General Manager A has pointed out to the Commission that the nursing home was entitled to automatic re-registration under the relevant legislation:

*“Leas Cross Nursing Home had been re-registered automatically in accordance with the Health (Nursing Homes) Act 1990. There was a statutory requirement that a certificate of registration had to issue by the then Northern Area Health Board.”*

General Manager A was also asked why there was a gap of eight months before she signed the certificate of registration. She stated:

*I cannot recollect why there is a gap of eight months. Leas Cross was registered by default therefore it was a statutory requirement that a certificate of registration had to issue by the then Northern Area Health Board. I further say that I was not aware of any complaint outstanding at the time that affected the application for re-registration of the nursing home.”*

The Commission asked both the Nursing Home Section Manager and General Manager A whether, in light of the complaint, they considered imposing conditions on Leas Cross subsequent to the grant of re-registration. This is envisaged by section 4(8) of the Health (Nursing Homes) Act 1990, which provides that the Health Board may attach conditions to the registration of a nursing home “at the time of registration or subsequently” (emphasis added). The Nursing Home Section Manager replied as follows:

*I did not give consideration to the possibility of imposing conditions subsequent to the re-registration of the nursing home. The nursing home inspectorate would have made recommendations to impose conditions.*

General Manager A replied:

*“No recommendations were made to me to attach subsequent conditions to Leas Cross registration.”*
As noted above, Nursing Home Inspector H has explained that the inspectors did not, as a matter of course, recommend conditions. She understood that any concerns expressed by her in an inspection report would be considered by “the C.E.O.’s office and senior executives”, who would make a decision on the imposition of conditions. However, both General Manager A and the Nursing Home Section Manager strongly contend that they had no role in the imposition of conditions. Their administrative functions required them only to sign off on the inspectors’ recommendations in this regard.

The Commission is troubled by the sequence of events leading to the re-registration of Leas Cross in 2004. It is true that the 1990 Act requires the HSE to notify the proprietor of a nursing home before the expiry of registration if it proposes to refuse to register the home. However, the same section requires the proprietor to submit an application for re-registration at least two months before the registration expires. That was not done in this case.

Further, the Act empowers the HSE to impose conditions on the carrying on of nursing homes “at the time of registration or subsequently”. From the evidence submitted to the Commission, it appears that, once the registration of Leas Cross had expired, it was renewed automatically with no regard to the suitability of the home for re-registration, to previous inspection reports, to outstanding complaints or to the need to impose conditions. In particular, it is clear that the nursing home was re-registered notwithstanding the existence of a serious complaint of which the inspectors and Health Board management were aware. In a submission to the Commission dated the 1st May 2009, the H.S.E. accepted that there was an outstanding complaint in June 2004, when re-registration took place, but pointed out that by the time the registration certificate was actually signed in February 2005 (approximately seven months later) that complaint had been resolved.

Nonetheless, it is the opinion of the Commission that the practice of the Health Board in this regard seriously undermined the inspection process and potentially posed serious risks for the residents of nursing homes. Where there was a serious complaint outstanding, that complaint should have been determined prior to re-registration to ascertain whether the home should be re-registered at all or whether it would be appropriate to impose conditions.

In this case, the complaint in question was made in January 2004. The Health Board should have been aware that the registration was due for renewal in June 2004 and either ensured that the complaint was dealt with before that date or notified the proprietor in time that the complaint could result in the refusal of re-registration. At the very least, consideration should have been given to the imposition of appropriate conditions in light of the seriousness of the complaint. If time did not permit this to be done prior to re-registration, conditions could have been imposed afterwards. From the information disclosed to the Commission, it seems that this course was not considered by the Health Board.
CHAPTER 9

THE OPERATION AND MANAGEMENT
OF LEAS CROSS NURSING HOME

Responsibility for the operation and management of a nursing home is assigned, by the relevant legislation, to the proprietor and the person in charge. In the case of Leas Cross, the proprietor was Mr John Aherne and the role of person in charge was held by the matron. There were five matrons at Leas Cross from the first application for registration of the nursing home until June, 2005, when a person in charge was assigned by the H.S.E. Throughout this report, the person in charge of Leas Cross Nursing Home is referred to as the matron.

This chapter examines the respective roles of the proprietor and the matrons at Leas Cross Nursing Home and addresses the circumstances in which each matron was appointed and resigned. Information on the nursing and care staff, together with general practitioner services at Leas Cross, can be found elsewhere in this report.11

Legislative background

The Health (Nursing Homes) Act 1990 requires the H.S.E. to maintain a register of nursing homes. The Act defines the ‘registered proprietor’ as “the person whose name is entered in the register … as the person carrying on the home”.

‘Person in charge’ is defined by the Nursing Homes (Care and Welfare) Regulations 1993 as “the person in charge of the care and welfare of patients in a nursing home”.

The regulations include the following provisions regarding the person in charge:

“10.1 There shall be a person in charge of a nursing home.

10.2 … the post of person in charge shall be full-time and the person in charge shall be a nurse with a minimum of three years appropriate post registration experience within the previous six years.

10.3 …

10.4 The registered proprietor shall notify the health board in writing if the person in charge on the date of registration ceases to be the person in charge during the period of registration and shall notify the health board in writing of the name of the new person in charge within one month of appointment.”

11 See Chapter 11.
The Commission considers that it would be preferable for the relevant legislation to specify in more detail what constitutes “appropriate” experience and to identify qualifications required for a director of nursing, over and above the basic nursing qualification.

The duties of the proprietor and the person in charge

The 1993 Regulations provide a number of requirements for nursing homes, in areas such as welfare and well-being, staffing, accommodation and facilities and hygiene. These legislative requirements are set out at relevant parts on this report.

The Regulations clearly provide that responsibility for each of these matters will be shared by the proprietor and the person in charge. For example, regulation 5(b) provides:

“The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home a high standard of nursing care.”

A similar formula of words is used throughout the Regulations to refer to both the proprietor and the person in charge.

The management structure at Leas Cross Nursing Home

John Aherne has informed the Commission that responsibilities at Leas Cross were divided between him and the matron. He has stated that he was responsible for the structure, surroundings and services to the buildings at Leas Cross.

The evidence from Mr Aherne and a number of the matrons indicates that Mr Aherne had no prior experience of operating a nursing home. This is not required by the legislation, so long as a suitably qualified matron is in charge. Mr Aherne has informed the Commission that the day to day running and management of the nursing home was the responsibility of the matron.

Prior to 2004, the matron had full responsibility for the day to day management of the nursing home and there was no other formal management structure in operation. This does not appear to have caused concern to the Health Board’s nursing home inspectors until June 2004, by which time the nursing home had expanded and resident numbers had reached 96. At that point, the inspectors recommended the appointment of an assistant director of nursing. This role was created in November 2004.12

Denise Cogley, who was appointed assistant director of nursing in 2004 and subsequently became matron in March 2005, informed the Commission that she was

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12 See further Chapters 13 and 15.
concerned at the lack of a management structure in relation to nursing care at Leas Cross:

“Care staff numbers were generous but nursing staff numbers were minimal and nursing staff did not appear to have any real input into patient care. Much direct patient care went unsupervised. I did not deem this appropriate for the residents particularly those with complex needs, which at this time, amounted to approximately 70% of the resident population.”

In 2005, Ms Cogley introduced a structure of care teams led by staff nurses: a development that was welcomed by the nursing home inspectorate, during a two-day inspection of Leas Cross in April, 2005.

The inspectorate further discussed the management structure with the matron, at that inspection. They recommended the imposition of a senior nursing structure, with two clinical nurse managers grade 2 and one clinical nurse manager grade 3, “in order to optimise standards of care and based on the current dependencies of residents”. These appointments did not, in fact, occur before the nursing home closed in August, 2005.

In relation to the management of nursing homes, Prof. O’Neill commented as follows in his report on deaths at Leas Cross Nursing Home:

“A sufficient number of middle and senior grade nursing staff relative to the size of the nursing home will be needed to be added to the calculated tool to ensure an adequate care infrastructure.”

**Staff meetings**

Evidence received by the Commission from former matrons and staff members suggests that there was no formal system for staff meetings until 2005. Grainne Conway, who was matron at Leas Cross for almost six years, told the Commission that she held nursing meetings approximately every two months as she felt they were needed. The meetings were attended by the matron and any staff on duty at the time.

Ms Conway’s successor, Denise Cogley, has informed the Commission that she instituted weekly meetings with care attendants and monthly nursing meetings at the nursing home.

**The proprietor’s role at Leas Cross**

The Commission has been informed that John Aherne had an office in the Leas Cross complex and visited the nursing home at least once a day.

Evidence given to the Commission by Mr Aherne and some of the former matrons of Leas Cross gives rise to a certain conflict as to the extent of his involvement in running the nursing home, in particular in relation to staffing.
Mary Clayton Chance, who was matron from October 1998 to June 1999, stated the following:

“My recollection was that Mr Aherne appeared practically every day either in the morning or in the evening and that we often had discussions in relation to the running of the home.

In relation to recruitment, I could not recruit any staff unless I had the prior authority of Mr Aherne. I reported to him on occasions when I had concerns about any matters in relation to the home. Usually he was willing to listen, but I don’t believe that he always acted on my advice or on the basis of my opinion. …

I felt that there was some resistance from him in relation to implementation of some suggestions that I made about the running of the home and in particular in relation to the recruitment of extra staff. I felt that there was a resistance on his part on the expenditure of money on the recruitment of staff and a query for him in relation to whether or not such extra staff were in fact necessary for the proper running of the home. I myself expressed the view that extra staff were needed and that it was important to have staff at a proper trained level. … I felt that Mr Aherne was not happy with what he perceived to be unnecessary demands being placed on his care home.”

In oral evidence, Mr Aherne responded to that statement as follows:

“As proprietor I employed a matron to manage and run the nursing home. Any time the matron required the recruitment of additional staff, she informed me of same and when required I authorised same. I had never had an issue with listening to Ms Mary Chance. …”

Notes furnished to the Commission by the H.S.E. arising from inspections of Leas Cross include a reference to the concerns of another matron, Veronica MacNamara, who worked at the nursing home from June 1998 to October 1998. Those concerns included her dissatisfaction that certain staff had been engaged or dismissed and difficulties encountered obtaining equipment for the nursing home.

Again, Mr Aherne responded in evidence to the Commission to the effect that he was not responsible for engaging staff: that was a matter for the matron. He also stated that he never refused a request from any of the matrons for equipment.

It is difficult for the Commission to resolve these conflicts of evidence. As noted above, the Nursing Home Regulations assign joint responsibility for the care and welfare of residents to the proprietor and the person in charge. Accordingly, where issues arose – for example, where the inspectors criticised staffing levels – both Mr Aherne and the relevant matron share responsibility.

In addition to Mr Aherne’s involvement, Genevieve Aherne, who was also a director of Sovereign Projects Limited, the company which owned the nursing home, visited weekly to inspect the premises. She has informed the Commission that the purpose of this was as follows:
“I went around once a week with matron just to see if bed linen was clean, curtains were in order, hoovering was done, to see how the dining room was. If I saw anything I didn’t like, I noted it down and gave it to the matron or John. That was all my involvement in it.”

It is not clear when Mrs Aherne commenced this practice. Ms Chance, who was matron from October 1998 to June 1999, has informed the Commission that she did not take part in any inspection of the premises with Mrs Aherne.

Another member of the family, Raymond Aherne, was also involved in the operation of the nursing home. He commenced employment with Sovereign Projects Limited in March, 2004 in a financial administrative capacity. It appears from the evidence that Raymond Aherne had some dealings with the matrons at Leas Cross, particularly when John Aherne was unavailable. He was also involved in negotiations with the H.S.E. in 2005 in the lead up to the closure of the nursing home.

The matrons at Leas Cross Nursing Home

The matrons at Leas Cross Nursing Home were as follows:

5. Denise Cogley – March 2005 to June 2005
6. Mary Flanagan – June 2005 to August 2005 (Assigned by the H.S.E.)

Maureen Johnson

Ms Johnson was named as matron on the initial application for registration of Leas Cross Nursing Home. She was involved in the establishment of the nursing home. In evidence to the Commission, Mr Aherne has described the division of labour during that period as follows:

“My responsibility was the structure of the building, the services to the building, the fit-out of the building. Maureen Johnson’s responsibility would be dealing with the health service, northern area at the time, and all the medical side of the business.”

See further Chapter 7.
There were no residents in the nursing home while Ms Johnson was in charge. There is some conflict of evidence regarding the reason for Ms Johnson’s departure from Leas Cross. She resigned immediately after the nursing home opened.

**Veronica MacNamara**

Veronica MacNamara was appointed matron of Leas Cross in February 1998. She had not previously worked in a nursing home, her experience being in mainstream nursing.

Ms MacNamara’s job included the initial recruitment of staff for the nursing home. She has informed the Commission that this did not pose a difficulty, as a nearby nursing home had recently closed and she recruited former staff from that home.

Ms MacNamara’s tenure ended in October, 1998. She has informed the Commission that the reason for her departure was to look after her mother. However the Commission has been furnished with notes taken by a member of the nursing home inspectorate which suggest other reasons for Ms MacNamara’s resignation.

On the 15th September 1998, two Eastern Health Board inspectors visited Leas Cross and spoke to the matron. Handwritten notes taken by one of the inspectors record the fact that Ms MacNamara had tendered her resignation on the previous day giving two weeks notice. The note records a number of issues of concern to Ms MacNamara, and concludes that Ms MacNamara complained that she “was not given the scope and authority to be the person in charge”.

**Mary Clayton Chance**

Ms MacNamara was replaced by Mary Clayton Chance. Ms Clayton Chance commenced work at Leas Cross as a staff nurse in August 1998. She took over as acting matron on Ms MacNamara’s resignation on the 8th October 1998 and was formally appointed matron on the 19th December 1998.

The number of residents increased significantly from six to 31 during Ms Clayton Chance’s time as matron. She has informed the Commission that she found it difficult to recruit and retain staff to cater for the number of residents and that Mr Aherne was not always open to her requests for additional staff. She has cited this as one of the reasons for her resignation in June 1999:

“I left my employment at Leas Cross for a number of reasons. I felt that I was working an excessive number of hours and that the proper running of the home required my presence there for too many hours. I felt that I was under considerable pressure and had difficulty in recruiting staff and had difficulty keeping staff because of the location of the home. For instance, on occasions I actually drove staff members to the home and collected them from the home. ...
I had discussions with Mr Aherne on a number of occasions and as a result of comments that he made to me, I felt that there was and would continue to be resistance on his part to expenditure of money on the running of the nursing home. I was concerned that the proper care of the patients and the proper running of the nursing home would not be compromised and I did not want to be in charge of a nursing home where I had concerns about the proper conduct of the home. ...”

In response to these comments, Mr Aherne has informed the Commission that, in his recollection, Ms Clayton Chance resigned because she found the responsibilities of the position of matron too onerous.

**Grainne Conway**

Grainne Conway, who took over from Ms Clayton Chance in June, 1999, was the longest-serving matron of Leas Cross Nursing Home. Prior to her appointment, three matrons had been engaged by the nursing home within two years. Ms Conway managed Leas Cross for almost six years, including the period when the nursing home was expanded and the number of residents increased to over 90. Prior to Leas Cross, Ms Conway had worked for ten years as a nurse in a centre for people with mild to moderate learning disabilities. Her experience of care for the elderly was limited to agency work at nursing homes.

Staff recruitment was a particular challenge during Ms Conway’s tenure, given the number of residents and the shortage of nursing and care staff in Ireland at the time.¹⁴ She has informed the Commission that she would discuss recruitment with Mr Aherne, who always accepted her suggestions. There was a shortage of nurses until the nursing home managed to recruit from overseas. Although she has stated that she was happy with the level of staff while she was at Leas Cross, and followed the Health Board’s recommendations, there is evidence to suggest some difference of opinion between the matron and the nursing home inspectorate regarding staffing during this time.¹⁵

In evidence to the Commission, Ms. Conway has summarised her experience of Leas Cross as follows:

“I enjoyed my time there. I felt it was a very well run nursing home and I felt Mr Aherne was very involved in the nursing hope considering that he had other businesses as well. He was very kind to the patients. I found that most of the patients were very, very well cared for. That is why it just shocked me that so many, sudden complaints come through when the people are invited ... to complain.” ¹⁶

Ms Conway tendered her resignation in January 2005 and left in March 2005 to pursue a business opportunity unrelated to nursing.

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¹⁴ See further Chapter 11.
¹⁵ See Chapter 13.
¹⁶ As to complaints made during Ms Conway’s tenure, see Chapters 12 and 15.
Denise Cogley

Denise Cogley commenced employment in Leas Cross on the 8th November 2004 as assistant matron. She became the acting matron on Ms Conway’s departure on the 28th March 2005 and was formally approved by the H.S.E. in May 2005. On her appointment as matron, an acting assistant matron was appointed. Ms Cogley was the last matron of Leas Cross before the nursing home was taken over by the H.S.E. and ultimately closed.

Ms Cogley has informed the Commission that she applied for the position of matron in late February 2005 when it became clear that there were no applicants for the post, which meant that she would have had to take on the role in a caretaker capacity until the position was filled. She agreed with John Aherne to accept the position in an acting capacity for three months.

An issue arose regarding Ms Cogley’s qualification for the position. As noted above, the 1993 Regulations require the person in charge of a nursing home to have “a minimum of three years appropriate post registration experience within the previous six years”. Ms Cogley’s relevant experience was spread over the preceding nine years, rather than six years as specified in the Regulations. Notwithstanding this, the H.S.E. did approve her appointment as matron.

Ms Cogley told the Commission that she made the recruitment of additional staff a condition of taking on the role of matron. She states that she set about restructuring the delivery of care, delegating responsibility to nursing staff to oversee care delivered in allocated areas and to ensure that all issues were reported to her immediately. She also states that she implemented changes in the areas of supervision, meetings and training of staff.

The Commission has interviewed a number of nurses and care attendants from Leas Cross, most of whom stated that Ms Cogley attempted to improve the nursing home. In particular, the nurses note that she rostered an extra nurse on the night shift.

Ms Cogley’s tenure as matron ended on the 1st June, 2005, when the H.S.E. assigned a team to take over the nursing home. This was originally envisaged as a temporary measure. Ms Cogley offered her resignation, which was refused by the H.S.E. and took a period of leave while the new acting director of nursing, Mary Flanagan, was in charge. The nursing home closed on the 1st August, 2005.

**Some observations on the qualification requirements for persons in charge**

In his report on deaths at Leas Cross, Prof. O’Neill recommended that “directors of nursing at all long term facilities should have the Diploma in Gerontological Nursing or equivalent”.

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One of the nursing home inspectors who visited Leas Cross on a number of occasions, Nursing Home Inspector H, responded to this proposal in a written submission to the Commission. While she agreed that directors of nursing should have the Diploma in Gerontological Nursing, in her opinion the director of nursing of a nursing home should also have an appropriate qualification in health services management, in order to ensure that the person in charge has the requisite knowledge for both the clinical aspect of the role and its management function.

Prof. O’Neill has also criticised what he perceived as the failure of the H.S.E. to seek appropriate experience in persons in charge:

“There is no evidence that the nursing home inspection team or HSE had expectations of experience with specialist nursing of older people as a prerequisite of approving Directors of Nursing of residential care for older people”

This was rejected by Nursing Home Inspector H, in her reply to Prof. O’Neill’s report. She stated that it is for the proprietor of a nursing home to employ the person in charge and to inform the H.S.E. within one month of the appointment. If assistance is sought by a proprietor, the H.S.E. will offer job descriptions advice to ensure a suitable person is appointed. Nursing Home Inspector H stated that the H.S.E. is aware that proprietors may lack the expertise in deciding competencies, and she noted that a review of private nursing homes showed that many directors of nursing have different qualifications to those in the public sector.

Nursing Home Inspector H has suggested that legislation should require the input of the nursing home inspectorate prior to the appointment of a person in charge.

The Commission also considers that the role of the H.S.E. is not merely to receive notification of the appointment of a person in charge. In the case of Leas Cross, it appears that there was discussion within the Health Board about the qualifications of at least one of the matrons. 17 Although the legislation does not specify who should decide whether the experience of the person in charge is “appropriate”, the responsibility of enforcing the Nursing Home Regulations lies with the H.S.E. under Regulation 35 of the 1993 Regulations. Therefore, it would appear to be open to the H.S.E. to conclude that a person in charge does not have the appropriate experience.

**Financial aspects of the operation of Leas Cross Nursing Home**

Leas Cross Nursing Home was owned by Sovereign Projects Limited, of which John Aherne and other members of his family were the directors and shareholders. 18 The owners have informed the Commission that the sole activity of that company during the period under investigation was the operation of the nursing home.

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17 See above.
18 See further Chapter 7.
The company accounts identify operating profits/(losses) on ordinary activities before taxation as follows:

1999: (IR£277,602) – i.e. (€352,481)
2000: IR£46,785 – i.e. €59,404
2001: IR£96,794 – i.e. €122,903
2002: €126,466
2003: €239,488
2004: €433,678
2005: €619,836
2006: (€885,375)

According to the annual returns, the directors received no remuneration in 2003. Their remuneration prior to that time, if any, does not appear in the annual returns. Their remuneration for the years 2004 to 2006 are stated to be as follows:

2004: €34,429
2005: €38,092
2006: €39,215

The annual returns record the following interest free loans from John Aherne to the company:

2004: €8,872
2005: €7,352

The annual returns also indicate that rent was paid by the company to John Aherne in the sum of €600,000 plus V.A.T. for the short term lease of Leas Cross 2. The accounts state that this amount is comparable to the loan repayments on the property.

The accounts for the year ended the 31st January, 2007 include the following notes:

Post balance sheet events
The company ceased to trade in July, 2005 further to the withdrawal of the support of the Health Service Executive (HSE). The HSE commissioned an independent report from Professor O’Neill with regard to the deaths in Leas Cross which was released into the public domain in November, 2006. The directors refute allegations in the O’Neill report. The Commission of Investigation (Leas Cross Nursing Home) was then established by Order of the Government in June, 2007. The commission was established to examine the role and responses of various parties including the HSE on the events surrounding Leas Cross Nursing Home. The company is co-operating fully with the commission. The future impact of this commission on the company is unknown. In addition the company has re-commenced trading within a different trade since 1st February, 2007 and allowed its nursing home licence to lapse effective May 2007.

Going concern
The company ceased to trade as a nursing home in July, 2005. The company’s financial statements have been prepared on this basis which does not differ
from the going concern basis. The company is solvent. The company re-commenced trading with effect from the 1st February, 2007 within a different trade and it is envisaged that the company will continue into the foreseeable future.

Capital Allowances

Under a tax incentive scheme introduced in 1998 and subsequently extended, capital allowances are available in respect of capital expenditure incurred on the construction or refurbishing a nursing home (not including the price paid for purchasing the lands). The full investment may be written off over a seven-year period, at 15% per annum for the first six years and 10% in the seventh year. The scheme includes a ‘claw-back’ provision, whereby the allowances claimed are lost if the investor sells the nursing home within the first ten years of the initial investment.

The Revenue Commissioners have advised the Commission that Leas Cross Nursing Home received the following industrial buildings capital allowances under the incentive scheme:

1999: €102,294  
2000: €104,213.10  
2001: €104,213.10  
2002: €309,305.73  
2003: €318,790.60  
2004: €320,665.60  

As a result of the closure of Leas Cross, in 2005 there was a balancing charge of €560,497.91 and in 2006 there was a balancing charge of €698,984.21. Effectively the full amount of the capital allowances set out above were clawed back from Sovereign Projects Ltd and from Mr and Mrs Aherne over those two years.
CHAPTER 10

RESIDENTS OF LEAS CROSS NURSING HOME

A total of 557 residents stayed at Leas Cross Nursing Home between 1998 and 2005. They came from a variety of locations. Many came directly from acute hospitals such as Beaumont and the Mater. A number were transferred from St Ita’s Psychiatric Hospital. Others were clients of St Michael’s House, a charitable organisation which helps people with learning disabilities. Many other residents came to the nursing home directly from their own homes.

The reasons for moving to Leas Cross varied: some residents went there for periods of respite care, either from hospital or from home, while others were admitted as long-stay residents. In some cases, residents who initially went to the nursing home for respite care ultimately remained for longer periods.

Advertisement of Leas Cross Nursing Home

Documents furnished to the Commission include an undated advertisement for L.C.N.H. from 1998. The advertisement stated that the home had 39 beds. It quoted prices of £450 per week for a private room and £420 per week for a shared room. It stated that incontinence wear would be charged separately and that a supplement for “high dependency respite care” would apply. Under the heading “Category of Resident”, the advertisement stated the following:

Leas Cross provides a first class service for a wide range of needs. These include short and longer term care. Categories include geriatric, disabled and physically handicapped. Also accommodated are the visually impaired, bed bound patients, those recently having had a stroke and holiday or respite care. Respite care may occur an additional fee according to levels of dependency. An excellent environment is also provided for post-operative convalescence. Alzheimer’s patients may be accommodated, but only those in the early stages, and only for respite care. Mr & Mrs Aherne are currently in the process of designing a high dependency unit, which they hope to open this winter. Until that time, any residents with mental disorders will be assessed to ensure that their needs can be met in full.

Mr Aherne has informed the Commission that he did not draft the wording of this advertisement and that it was probably written by the matron, who may have discussed it with him at the time. The Commission notes that the statement regarding levels of dependency contained in this advertisement was at odds with the information provided by Mr Aherne in his application for registration of the nursing home. It is also at odds with the practice in the nursing home, which accepted patients at all levels of dependency, including Alzheimer’s patients.

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19 For more detail on the transfer of residents from medical and residential facilities, see Part IV.
20 As to which, see Chapter 7.
Lists of ‘approved’ nursing homes

A number of families of former residents have informed the Commission that Leas Cross Nursing Home was recommended to them. Such recommendations apparently came from a variety of sources, including acute hospitals and the Health Board.

The H.S.E. maintains a list of registered nursing homes on its website and similar lists were kept by the Health Boards of registered nursing homes in their respective areas. At the time that Leas Cross Nursing Home was in operation, such lists were furnished by the Health Board to successful applicants for health board subventions.\(^{21}\) There is no evidence of a H.S.E. / Health Board policy of recommending a specific home to successful subvention applicants. Applicants were notified of the rate of subvention to which they were entitled and advised to contact the nursing home of their choice from the list of registered homes.

Information received by the Commission indicates that hospitals such as Beaumont, the Mater or James Connolly Memorial Hospital did not have a policy of recommending specific nursing homes: patients were provided with the H.S.E. / Health Board list of registered nursing homes in the area. As far as the assignment of contract beds to certain hospitals was concerned, the selection of the nursing home was the responsibility of the H.S.E. / Health Board, not the hospital.

One family told the Commission that they felt let down by the Eastern Health Board in its failure to provide adequate advice on the selection of a nursing home. They were given the list of registered nursing homes, which included Leas Cross Nursing Home. They have expressed their view to the Commission that, if the Health Board had received complaints regarding Leas Cross prior to that time, it should have been omitted from the list. They also complain that they were disadvantaged by having to visit the nursing home without advice from the Health Board as to what to look for or what questions to ask.

The Commission considers that, ideally, advice or support should be available to families seeking accommodation for a dependent relative, so that they are not left to make an uninformed decision. However, the Commission acknowledges that the primary responsibility for ensuring that residents receive adequate and appropriate care lies with the nursing homes. Families should be able to rely on the fact that a nursing home has been registered by the H.S.E. and trust that the management and staff will assess their dependent relative and provide a bed only if the home in question is capable of caring for that person.

Two families told the Commission that Leas Cross Nursing Home was recommended to them by the Alzheimer Society of Ireland. The Society informed the Commission that it provides an information service to the public, including a list of nursing homes. The list is compiled on the basis of a questionnaire sent to nursing homes, asking about the ability of the homes to care for persons with Alzheimer’s Disease or dementia. The society has made it clear to the Commission that it does not

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\(^{21}\) As to which, see below.
recommend homes, but provides the names of homes which have stated that they can care for such patients. According to the Society, callers to its helpline are always advised that they should visit the nursing home themselves to form their own judgment as to whether it is appropriate for the resident in question.

**Assessment of residents prior to admission**

The Commission has been informed that, in some cases, staff from Leas Cross Nursing Home visited prospective residents prior to their admission, to assess their suitability for the nursing home. One of the matrons, Grainne Conway, has stated that she “visited hospitals on the invitation of social workers to assess possible patients ready for transfer”.

A nurse who worked at Leas Cross between 1999 and 2001 told the Commission that a system for the assessment of prospective residents was introduced while she was working there. She or the matron visited patients to assess their dependency. According to this nurse, patients requiring one-to-one nursing or having very complex needs were considered unsuitable for the nursing home.

**Categorisation of residents**

When L.C.N.H. opened in 1998, it had 31 beds. This was increased to 38 beds in 1999 and to 111 beds in 2002. The Commission has two sources of information on the profile of the residents: (i) the inspection reports completed biannually by members of the nursing home inspection team, and (ii) a dependency assessment carried out by the matron in April, 2005.

**Inspection reports**

The Health Board / H.S.E. carried out routine inspections of Leas Cross Nursing Home twice each year. The inspection template filled in by the inspectors on those occasions recorded the total number of residents and the numbers who were ambulatory, wheelchair bound and bedfast. The inspectors did not carry out any detailed examination of residents or assess dependency levels, so the information contained in the inspection templates provides a general picture only of the profile of residents during the life of the home. The inspection templates reveal the following:

<table>
<thead>
<tr>
<th>Date of inspection</th>
<th>Total residents</th>
<th>Ambulatory</th>
<th>Wheelchair</th>
<th>Bedfast</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/1998</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>16/02/1999</td>
<td>20</td>
<td>15</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>09/07/1999</td>
<td>31</td>
<td>24</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>15/02/2000</td>
<td>36</td>
<td>24</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>06/10/2000</td>
<td>35</td>
<td>27</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

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22 See further Chapter 13.
Dependency assessment in 2005

In April, 2005, the dependency of the residents was assessed using a tool provided by members of the inspection team. The purpose of this assessment was to identify the appropriate number and skill mix of staff for the home. Each resident was assessed under the following headings:

**Personal care -**
Bath self / with assistance / complete

**Feeding -**
Partial help required / complete help or nil by mouth

**Mobility -**
Up and about / bed rest and up with help / bed or chair with support

**Nursing attention -**
4 hourly or less / 2-4 hourly / hourly or constant

**Other -**
Involuntary drainage / major intervention

The results of this assessment allowed each resident to be classified within one of the following four categories of dependency:

**Category I**
A person who is deemed to be Category I may be regarded as largely of ‘self care’. This would indicate that the person is a ‘resident’ who may require advice from the appropriate community nurse.

**Category II**
A person who is deemed to be Category II may be regarded as requiring ‘average care’. This would indicate that the person may require nursing home care.

**Category III**
A person who is deemed to be Category IV may be regarded as needing ‘above average care’. This would indicate that the person would mostly require general nursing care in a nursing home.

**Category IV**
A person who is deemed to be Category IV may be regarded as needing ‘maximum nursing care’. This person requires total nursing supervision in a nursing home.

There were 93 residents in L.C.N.H. on the dates when the tool was applied. The assessment revealed the following numbers of residents in each category:

- Category I – 8 residents
- Category II – 31 residents
- Category III – 42 residents
- Category IV – 12 residents

Applying a system of weighting to these figures, it was concluded that, in terms of nursing time, the 93 residents were equivalent to 236.5 Category I residents.

Subventions and contract beds

The cost of a resident’s stay at Leas Cross Nursing Home was funded either by the resident and his or her family or by the Health Board / H.S.E. Three different forms of funding were available from the Health Board: subventions, enhanced subventions and contract beds. The H.S.E. has informed the Commission that 74 residents received subvention payments and 65 residents availed of contract beds in Leas Cross Nursing Home between 1998 and 2005. Leas Cross received a total of €7.27 million between 1999 and 2005 in respect of subventions and contract beds. These payments were made by the Eastern Health Board and the Northern, South Western and East Coast Area Health Boards.

Each form of funding is explained in more detail below, but they may be summarised as follows:

(a) Subvention payments are contributions by the Health Board towards the cost of maintaining a resident in a nursing home. They are governed by legislation and may be made up to a fixed limit. Subventions are granted on the basis of assessments of a resident’s means and dependency level.

(b) Enhanced subventions are payments which may be made by the Health Board in addition to basic subventions. They are not governed by legislation and have no individual fixed limits, but are limited overall by the resources available to the scheme. They are paid, at the discretion of the Health Board, where a dependent resident’s means are insufficient to meet the cost of nursing home care, even with a basic subvention payment.

(c) Unlike subventions and enhanced subventions, which are personal to individual residents, contract beds are beds in private nursing homes which are bought by the Health Board for a particular period to be used by public patients. Contract beds are not governed by legislation and
there are no set criteria for the assignment of contract beds to particular residents. Whereas a resident in receipt of a subvention receives a contribution towards the cost of his or her care, a resident occupying a contract bed has the full cost of his or her care paid for by the Health Board.

Subventions – the legislative framework

The Commission notes that the subvention scheme which was applicable to residents of Leas Cross has since been replaced by the Health (Nursing Homes) (Amendment) Act 2007. The provisions applicable to residents of Leas Cross Nursing Home were to be found in the Health (Nursing Homes) Act 1990 and the Nursing Homes (Subvention) Regulations 1993 (as amended).

The Act of 1990 made the following provision for subvention payments in section 7:

“(1)(a) Where, following an assessment by a health board of the dependency of a dependent person and of his means and circumstances, the health board is of opinion that the person is in need of maintenance in a nursing home and is unable to pay any or part of its costs, it may, if the person enters or is in a nursing home, and subject to compliance by the home with any requirements made by the board for the purpose of its functions under this section, pay to the home such amount in respect of such maintenance as it considers appropriate having regard to the degree of the dependency and to the means and circumstances of the person.

... (2) The Minister may by regulations prescribe the amounts that may be paid by health boards under this section and such amounts may be specified by reference to specified degrees of dependency, specified means or circumstances of dependent persons or such other matters as the Minister considers appropriate.”

The 1993 Regulations came into effect on the 1st September, 1993 and were amended on a number of occasions. The grounds on which a subvention could be granted were set out in regulation 6:

“A person in respect of whom a subvention is being sought shall not qualify for a subvention unless the responsible health board is of the opinion that the person to whom the application refers is:

(i) sufficiently dependent to require maintenance in a nursing home, and

(ii) unable to pay any or part of the cost of maintenance in a nursing home.”

Regulation 4 provided that an application for a subvention should be made by or on behalf of a person prior to his or her admission to a registered nursing home. On receipt of an application, the Regulations required the Health Board to assess both the dependency and the means of the person in question. The procedures for each of
these assessments were set out in the first and second schedules to the Regulations respectively.

The Regulations envisaged three levels of dependency in respect of which a subvention might be paid: medium, high and maximum. They were defined as follows:

(a) Medium dependency — describes a person whose independence is impaired to the extent that he or she requires nursing home care because the appropriate support and nursing care required by the person cannot be provided in the community. His or her mobility would be impaired to the extent that he or she would require supervision or a walking aid.

(b) High dependency — describes a person whose independence is impaired to the extent that he or she needs nursing home care but who is not bed bound. The person may have a combination of physical and mental disabilities, may be confused at times and be incontinent. He or she may require a walking aid and physical assistance to walk.

(c) Maximum dependency — describes a person whose independence is impaired to the extent that he or she requires constant nursing care. The person is likely to have very restricted mobility, require assistance with all aspects of physical care or be confused, disturbed and incontinent.

Prior to 2007, the maximum subvention payable depended on the resident’s level of dependency. In 1993, the Regulations set the maximum subvention payments as follows:

Medium dependency: IR£70 (€88.88) per week
High dependency: IR£95 (€120.63) per week
Maximum dependency: IR£120 (€152.37) per week

Those maximum figures were amended in 2001 as follows:

Medium dependency: IR£90 (€114.30) per week
High dependency: IR£120 (€152.40) per week
Maximum dependency: IR£150 (€190.50) per week

Although not applicable to residents of Leas Cross, the Commission notes that, since 2007, the maximum subvention payable is €300 per week, irrespective of the dependency level of the resident in question.

Regulation 16 provided that subventions were available only in respect of “any service which is considered to be essential to the maintenance of a person in a nursing home and common practice in nursing homes”. These services were defined as including the following:

“... bed and board, nursing care appropriate to the level of dependency of the person, incontinence wear and bedding, laundry service and aids and
appliances necessary to assist a dependent person with the activities of daily living.”

The Regulations provided that special services or equipment required by a person in receipt of a subvention would be the subject of a separate agreement between the Health Board and the nursing home. Regulation 16.3 expressly prohibited the proprietor or person in charge of a nursing home from discriminating in the provision of such services between a person in receipt of a subvention and a person not in receipt of a subvention.

Enhanced subventions and contract beds

In 1996, the Nursing Homes (Subvention) Regulations were amended by the insertion of the following paragraphs:

“22.3 A health board may, from 31 July, 1996 enter into an arrangement with a home registered under the Health (Nursing Homes) Act, 1990 to provide in-patient services .... Such an arrangement shall be considered to be in accordance with the provisions of these Regulations for as long as the home is registered under the Act ....

22.4 In making an arrangement with a home under article 22.3 a health board may, in respect of a person, pay a rate exceeding the maximum rate payable in respect of each of the three levels of dependency of persons assessed as requiring maintenance in a nursing .... In making such an arrangement a health board shall not pay less in respect of a person than the maximum rate payable in respect of each of the three levels of dependency of persons assessed as requiring maintenance in a nursing home ...”

It appears that these provisions have been used as the basis for Health Boards to provide enhanced subventions to residents and obtain contract beds in private nursing homes. There is no detailed legislative provision governing these types of arrangements.

Dependency assessment for subvention applications

In 2005, the assessment of dependency carried by the H.S.E. under the subvention application process classified 21 residents of L.C.N.H. as being of maximum dependency. As noted above, a separate assessment was carried out in April, 2005 by the matron for the purposes of determining the adequacy of staffing in the home. This yielded an entirely different result, showing that only four residents were of maximum dependency and eight of high dependency. This is despite the fact that the two assessment tools used were very similar in content.

The reason for the discrepancy in the results of the two assessments has been explained in the following terms by a member of the nursing home inspection team, Nursing Home Inspector H, during oral evidence to the Commission:
“... why some people ended up maximum in one and minimum in another was that there was a difficulty that if people ended up in a minimum or moderate dependency level they got no financial support at all. So people that filled out those subvention forms were facilitated towards, if you could give them maximum at all, you'd give it to them. So they’d get their finance. But it was only done for a financial reason …”

Nursing Home Inspector H has explained to the Commission that the dependency assessment form for subventions was inadequate for dementia patients: a patient might qualify as minimum dependency owing to his ability to walk, despite having very high needs owing to dementia. For this reason, it was sometimes necessary to categorise a patient as high or maximum dependency, in order to ensure that they would receive a subvention for adequate care, despite the fact that he or she fell within the minimum dependency criteria set out on the form.
CHAPTER 11

STAFFING OF LEAS CROSS NURSING HOME

Background to staffing issues

Staffing – the legislative framework

Guidance on staffing levels in nursing homes may be found in regulations 5 and 10 of the Nursing Homes (Care and Welfare) Regulations 1993, which provide, *inter alia*, as follows:

5. The registered proprietor and the person in charge shall ensure that there is provided for dependent persons maintained in a nursing home:—
   (a) suitable and sufficient care to maintain the person’s welfare and well-being, having regard to the nature and extent of the person's dependency;
   (b) a high standard of nursing care;
   (c) appropriate medical care by a medical practitioner of the person’s choice or acceptable to the person;
   ...

10.5. The registered proprietor and the person in charge of the nursing home shall ensure that:
   (a) a medical practitioner of the dependent person’s choice or acceptable to that person is available to ensure that he or she receives appropriate medical care;
   (b) a medical practitioner is available to attend the person in the nursing home and to be on call for emergencies;
   (c) a nurse is on duty at all times;
   (d) a sufficient number of competent staff are on duty at all times having regard to the number of person maintained therein and the nature and extent of their dependency.

The Regulations offer no further guidance as to how one should calculate what constitutes “a sufficient number of competent staff” in any given instance. The Commission considers that it would have been preferable for the Regulations to have specified minimum numbers of nursing and care staff required, or at least to have provided a method by which staffing numbers (in particular numbers of nursing staff) should be calculated.

In any event, the Commission is satisfied that the Regulations made clear the need to provide adequate staffing. The primary responsibility for ensuring that a nursing home has sufficient staff lies with the registered proprietor and the person in charge of the home. In the absence of more detailed legislative guidelines, the Health Board /
H.S.E., through the registration and inspection processes, has an important role to play in assessing whether the staffing levels at individual homes are in fact adequate.

The Commission is also satisfied that there was ample provision in the legislation to enable the Health Board or the H.S.E. to take action in circumstances where they identified a failure to meet the required levels of staffing. The appropriateness of such action would need to be assessed on a case-by-case basis, having regard to the paramount welfare of the residents, in light of relevant nursing, medical and legal advice.

In theory, it would be possible for a nursing home to calculate the minimum number of staff necessary for it to fulfil the duties imposed by the regulations, and to operate on that basis. In practice however, full compliance with the regulations will only be achieved by going beyond minimum staffing requirements. It is important to remember that the calculation of staffing needs is not an exact science: it must take into account the number of patients, their dependency levels and degrees of mobility, the physical layout of the nursing home, and the experience and qualifications of the staff available. In circumstances where a lack of staff (or of sufficiently qualified staff) could significantly affect residents’ health and quality of life, a nursing home is obliged, in the Commission’s view, to ensure that it exceeds the minimum staffing requirements, in case its estimate of the minimum turns out to be wrong.

Methods of assessing appropriate staffing

The Commission notes that a determination as to appropriate staffing involves not only a consideration of staff numbers, but also regard to the appropriate skill mix of staff, e.g. the ratio of nurses to care attendants. Nursing Home Inspector H, who was one of the nursing home inspectors involved with Leas Cross Nursing Home, informed the Commission that two methods of assessing appropriate staffing were used or contemplated for the nursing home. They were as follows:

(a) The historic measurement or ‘nurses per occupied bed’. This term is used to describe an informal method, whereby future staff levels are determined on the basis of existing practice.

(b) The acuity-quality model. This method, which was first applied to Irish nursing homes by the H.S.E. in 2005, takes into account the dependency of residents and the nursing workload. The model recognises that a highly dependent resident will require more nursing hours than a resident with low dependency. Accordingly, the appropriate number of nurses for a home will change as the dependency levels of residents changes and two homes with the same number of residents may require different numbers of nurses in light of the dependency of residents.

Nursing Home Inspector H furnished the Commission with a 2005 publication from the Department of Health and Children entitled ‘Report of the working group to examine the development of appropriate systems to determine nursing and midwifery staffing levels’. That report addresses the methods described above. It states that the
historic measurement “took no account of differences in workload or variations in practice and is now considered outdated and should not be the sole basis for determining staffing levels”. The report describes the acuity-quality method as “presently the most inclusive method in meeting patient’s needs” and notes that “It is the preferred option in many organisations.”

The Commission has no evidence to establish that any formal assessment tool was employed at Leas Cross Nursing Home in relation to staff levels prior to 2005. The longest-serving matron, Ms Grainne Conway, told the Commission in oral evidence that she would discuss the matter with her nursing staff and then decide herself as to what staff increases, if any, were required. She also said that if the Health Board / H.S.E. instructed her to increase staff numbers, she would do so.

In 2004, Nursing Home Inspector H provided the nursing home with a tool to calculate residents’ dependency levels, for the purpose of applying the acuity-quality model. Nursing Home Inspector H has informed the Commission that she developed this tool herself by simplifying an existing model, over the course of a number of months, to make it more “user-friendly”. She did this for the specific purpose of measuring the adequacy of staffing at Leas Cross Nursing Home, having become concerned that the ratio of nurses to care attendants may have been inadequate.

Although there is some conflict of evidence as to whether dependency levels were assessed by the matron in 2004, it is clear that they were assessed in April, 2005 but that the results were never applied to the question of staffing, owing to the closure of the nursing home.

Nursing Home Inspector H expressed the view to the Commission that a measurement of dependency should be routinely carried out in all nursing homes for the purposes of determining appropriate staff numbers and skill mix. The Commission supports this view. An accurate assessment of staffing requirements in a nursing home is not possible without knowing the dependency levels of residents.

**Recommended staffing levels**

In 2006, H.S.E. West issued recommendations in relation to staffing in private nursing homes. The Commission recognises that these recommendations were issued after the closure of Leas Cross Nursing Home. While Leas Cross cannot be criticised for failing to comply with standards that came into existence after it closed, these are indicative of the type of staffing levels that might have been appropriate in that nursing home.

The recommendations state that staffing numbers and skills should be agreed between the registered proprietor, the person-in-charge and the Health Board at the time of registration and subject to periodic review at statutory inspections. It is suggested that the number and skill mix of staff should be agreed on the basis of the following criteria:

- resident numbers;
- categories of resident (e.g. psychiatric, intellectual disability, dementia);
dependency levels of residents;
needs of individual residents, as set out in care plans;
size and layout of the nursing home;
peak periods of activity during the working day.

The recommendations go on to state that the minimum staff patient ratio should be as follows:

- 1 staff to 7 residents in the morning;
- 1 staff to 8 residents in the afternoon and evening;
- 1 staff to 15 residents at night;
- minimum of 2 staff on duty at all times;
- additional staff may be required at peak times.

The Commission notes that these recommendations do not specify the ratio of nurses to care attendants. As set out below, that became a significant issue at Leas Cross Nursing Home.

**Shortage of nurses in Ireland**

It appears to be accepted that there was a shortage of qualified nurses in Ireland from 1998, which meant that nurses had to be recruited from overseas. Nursing Homes Ireland has confirmed to the Commission that there was a shortage of suitably qualified nurses and care assistants during the period 1998 to 2005. The nursing home organisation lobbied the Department of Health consistently on this issue. The Irish Nursing Homes Organisation and the Federation of Irish Nursing recruited significant numbers of overseas staff during this period and in May 2000 the first of the overseas staff arrived in Ireland for orientation. The organisations recruited in excess of 200 overseas staff per year initially and this number does not include staff recruited by commercial agencies who also recruited significant numbers of overseas staff during that period.

The Head of the Nursing Home Inspectorate from 2004, addresses this issue in his response to the report of Professor O’Neill into deaths at Leas Cross Nursing Home:

“Upwards of 80% of all nursing/care/support staff employed in the private nursing home sector were recruited from overseas. The private sector continually state that they are competing with the public sector for a very scarce resource and are finding it increasingly difficult to retain staff. There is a very significant difference in the nursing supervision/management structure between the private and public service. There are very few nurses employed in the private sector with specialist gerontological nursing qualifications. It was acknowledged by the nursing home inspection team that certain issues based staff from other countries particular their culture and their ability to communicate with other persons.”
Registration of foreign qualified nurses

Registration of nurses from non-EU countries

All applicants for registration as a nurse with An Bord Altranais from non-EU countries must hold current registration and be in good standing with the regulatory authority in their country of origin and any other jurisdiction in which they have worked as a nurse. Applicants are assessed on an individualised basis and their educational qualifications and clinical practice experience are assessed by a staff member in the Education Department comparing the applicant’s qualifications and experience with the requirements and standards for nurse registration education programmes in Ireland applicable at the time. The requirements and standards for nurse registration education programmes were first published in July 1999 and subsequently revised in November 2000 and February 2005. Based on the assessment, registration was refused or the applicant was required to successfully complete a period of supervised clinical practice as a pre-requisite to registration.

In June 2003 the standards applied in relation to applicants for registration from non-EU countries were revised and an English language test requirement was introduced for the first time. Applicants who meet the required English language test standard are granted or refused registration or the applicant is required to successfully complete a period of supervised clinical practice This period of supervised clinical practice is called an ‘adaptation’ period. This adaptation period takes place in a hospital approved for such purposes by An Bord Altranais. It is a minimum of six weeks but can be up to twelve weeks if deemed necessary by the Director of Nursing. In addition, a formal competency-based assessment process was introduced in 2003. At the conclusion of the adaptation period, the applicant is recommended/not recommended for registration by the Director of Nursing.

In March 2003, based on review of the previous standard and in line with changing international practices, the required standard for the English language test was increased.

An Bord Altranais does not require a non-EU applicant for registration to provide police clearance or disease screening as a pre-requisite to registration. Nurses are required to take cognisance of the Guidance for Nurses and Midwives with Serious Contagious/Infectious Diseases (An Bord Altranais, June 2001).

Registration of nurses from EU countries

All applicants for registration from EU Member States are assessed in accordance with the provisions of the relevant EU Directive in operation at the time of application. This gives many applicants a legal right to direct registration.

An Bord Altranais has informed the Commission that, under E.U. law, it is not open to the Irish authorities to require the assessment of English language competence as a pre-requisite to registration for E.U. qualified nurses.
Staff numbers at Leas Cross Nursing Home

The person in charge of Leas Cross Nursing Home was the matron. Nurses reported directly to the matron and supervised care attendants. The nursing home also employed chefs, kitchen porters, cleaning staff, laundry staff, activity therapists, administrative staff and maintenance staff. This section of the Commission’s report is concerned with the numbers of nurses and care attendants at Leas Cross.23

Insofar as staff numbers are concerned, the Commission has identified three distinct periods in the life of Leas Cross Nursing Home:

- The first period runs from 1998, when the nursing home opened, until the end of 1999. It includes the expansion of Leas Cross from 31 to 38 beds. During that time, the Health Board inspectors frequently found that there was not enough staff on duty to provide care to the residents. A campaign of regular inspections and spot-checks eventually resulted in adequate staff numbers.

- The second period covered the years 2000 to 2002. The inspection reports for those years do not reveal significant staffing problems.

- The third period begins with the expansion of Leas Cross in 2003 to cater for up to 111 residents and continues until the closure of the nursing home in August, 2005. During that time, the number of residents increased dramatically from 38 to as many as 96. As the resident population increased the nursing home did engage additional staff, most of whom were care attendants rather than nurses. As a result, the focus of the nursing home inspectors moved from the number of staff to the skills mix: though there appeared to be enough staff members to care for the residents, the inspectors were concerned that the ratio of nurses to care attendants was inadequate having regard to the number and profile of the residents.

Total number of employed nursing and care staff

The reports of biannual inspections carried out by the Health Board / H.S.E. show the total numbers of nurses and care attendants employed by Leas Cross Nursing Home on the date of inspections. While those figures are of interest, it is important to note that they do not represent the numbers of staff on duty, but show how many staff were employed by the nursing home overall. The following chart sets out the numbers of nurses and care attendants employed by the nursing home on the dates of inspections, together with the numbers of residents on those dates:

<table>
<thead>
<tr>
<th>Date of inspection</th>
<th>Nurses</th>
<th>Care attendants</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>31/07/1998</td>
<td>12</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>16/02/1999</td>
<td>9</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>09/07/1999</td>
<td>7</td>
<td>21</td>
<td>31</td>
</tr>
<tr>
<td>15/02/2000</td>
<td>7</td>
<td>25</td>
<td>38</td>
</tr>
<tr>
<td>06/10/2000</td>
<td>7</td>
<td>17</td>
<td>35</td>
</tr>
</tbody>
</table>

23 As to the matrons at Leas Cross, see Chapter 9.
The Commission notes that the number of nurses employed by L.C.N.H. was the same in 1998, when there were six residents, as it was in 2005, when there were 96 residents. The number of nurses employed dropped as low as five in 2002 and then doubled in 2003, when the new wing of the nursing home became operational and the number of residents increased from 36 to 60. However, there was initially no increase in the number of nurses employed when the number of residents increased from 60 to 93 in 2003.

**Rostered nursing and care staff, 1998 to 2003**

Of greater significance than the number of nurses employed by the nursing home is the number rostered to work there each day. Information in this regard is available from rosters furnished to the Commission by the proprietors of Leas Cross Nursing Home as well as from inspection reports and statements made to the Commission by former staff.24

Shifts at the nursing home operated from 8 a.m. to 8 p.m. (‘day shift’) and 8 p.m. to 8 a.m. (‘night shift’). In addition to the nurses rostered for duty, the matron was generally on the premises between 9 a.m. and 5 p.m. Monday to Friday.

During the first routine inspection of the nursing home in July, 1998, there were two nurses and two care attendants on duty to cater for six residents. At night, one nurse and two care attendants were rostered for duty. In January, 1999, Health Board inspectors recommended the following minimum staffing levels:

- **Day duty:**
  - 1 nurse 8 a.m. to 8 p.m.
  - 1 nurse 8 a.m. to 1 p.m. whenever matron is not on duty (e.g. every Saturday and Sunday)
  - 3 care attendants 8 a.m. to 8 p.m.

- **Night duty:**
  - 1 nurse 8 p.m. to 8 a.m.
  - 3 care attendants 8 a.m. to 8 p.m.

An unannounced spot inspection was carried out on the 21st April, 1999 to ensure that the above staffing arrangements were being implemented. The inspectors were satisfied that this was so.

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24 Information on staffing contained in inspection reports has been summarised here. For more details regarding inspections, see Chapter 13.
In June, 1999, the inspectors again visited L.C.N.H. and found that there were frequently only two care attendants on duty from 6 p.m. to 8 p.m. The matron was informed that at least three care attendants were required at all times, in line with the recommended levels outlined above. The inspectors visited again in July, 1999, when there were 31 residents in occupation and the minimum staffing levels were being met. However, the following month, the inspectors received a telephone call from a nurse in the home to complain about staffing levels. The inspectors carried out a “spot check” and found that the extra nurse scheduled to work at weekends when the matron was away had been removed from the roster and that care attendant numbers had been reduced from three to two from 11 p.m. to 8 a.m. However, the number of care attendants rostered on the day shift had increased to four or five. The inspectors’ notes of the visit record that the matron agreed to address the issue of nurses.

In the same month, another nurse wrote to the proprietors to complain that staff were unable to deliver adequate care owning to the low number of nurses. In particular, she stated that short stay residents from St Michael’s House were placing great demand on the staff. It does not appear that any reply was received to this letter and the nurse in question resigned shortly afterwards.

A further unannounced spot inspection took place in October, 1999, at which the inspectors found staffing levels to be acceptable.

No significant issues in relation to staffing numbers are noticeable from a review of the inspection reports for the years 2000 to 2002. Staff numbers increased during that period, so that there were two nurses and seven care attendants rostered for the day shift by November, 2002, when there were 36 residents.

**Expansion of Leas Cross Nursing Home**

The extension to Leas Cross Nursing Home was granted approval by the Northern Area Health Board in November, 2002, so that the home could cater for a total of 111 residents. The number of residents increased dramatically from 36 in November, 2002 to 60 in July, 2003 and 93 in November, 2003. A routine inspection in July, 2003 showed that there were three nurses and seven care attendants rostered for the day shift and two nurses and five care attendants for the night shift.

By November, 2003, when there were 93 residents in the home, two nurses and sixteen care attendants were rostered on the day shift and two nurses and eight care attendants on the night shift. One of the Health Board inspectors, Nursing Home Inspector H, has informed the Commission that although she considered the staff-resident ratio to be appropriate at this time, she became concerned that there might have been an imbalance in the skill mix of staff, because the number of care attendants had increased in response to the increase in residents, but the number of nurses had not. In order to confirm this, Nursing Home Inspector H recommended the use of a dependency tool to measure the dependency levels of residents.26

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25 See further Chapter 8.
26 See further Chapter 10.
Nursing Home Inspector H has informed the Commission that she discussed her concerns regarding the skills mix with the matron, Grainne Conway, who reassured the inspectors that she had a three foreign nurses in orientation, who would be available for work in the near future. Nursing Home Inspector H says that the three promised nurses failed to materialise. Ms Conway has disagreed with that account of events. She denies being asked to increase the number of nurses at this time and denies telling the inspectors that there were three nurses in orientation.

The Commission finds it difficult to resolve this conflict of evidence in the absence of a definitive contemporaneous record of events. The inspection template completed by Nursing Home Inspector H in November, 2003 does not identify staff numbers or skill mix as a particular concern. Given the significant increase in resident numbers and the fact that the number of nurses had not increased, the Commission considers it likely that this would at least have been discussed by the inspectors with the matron.

Doctor A, who was the medical officer attending Leas Cross up to November, 2003 has made the following comment in written submissions to the Commission regarding this issue:

“I am of the opinion that there was inadequate nursing staff for the number of patients in Leas Cross in November 2003. I believed that as the number of in-patients increased, the level of dependency increased, there were insufficient nursing staff to look after the number of patients but at that time there was a severe shortage of nursing staff in Ireland.”

In a written response to the report of Professor O’Neill in 2006, Doctor A identified his concern about the number of patients he was required to care for as one of the reasons influencing his decision to resign in November, 2003. Doctor A has also told the Commission that the residents admitted in November, 2003 were more dependent and required greater nursing care than the residents previously admitted to the nursing home.

Inspectors paid an informal visit to the nursing home in December, 2003 as part of the review of a complaint, during which it was noted that there was “visibly more staff in place”.

At the following routine inspection on the 2nd June, 2004, there were 96 residents in occupation. Three nurses and seventeen care attendants were rostered for day shift and two nurses and six care attendants for the night shift. Nursing Home Inspector H informed the Commission that the fact that the three new nurses she was expecting had not arrived by July, 2004 caused her to question whether she could rely on the matron’s assurances regarding staffing. She stated that she remained concerned about the skills mix of nurses and care attendants. The question of appointing another manager to fill in for Grainne Conway when she was off duty was also discussed.

In August, 2004, at a meeting between members of the nursing home inspectorate and the proprietors and matron of Leas Cross was organised to discuss a complaint received by the Health Board regarding the nursing home. Staffing was discussed and the appointment of three additional nurses together with an assistant director of nursing was recommended.
No further routine inspection was held until April, 2005, when the new dedicated nursing home inspectorate carried out a two-day visit to Leas Cross. The inspectors were the Head of the Nursing Home Inspectorate, the Area Medical Officer and Nursing Home Inspector J. There were 96 residents in the nursing home on the days of the inspection. The inspectors found as follows regarding staffing:

“Staffing level / Skill Mix
Currently Leas Cross has a total of 12 staff nurses and 45 care assistants. In view of the complexity and dependency levels of the current residents we requested and gained the approval of the proprietor for the immediate employment of 3 staff nurses as an interim measure to support essential nursing care. However in order to optimise standards of care and based on the current dependencies of residents a senior nursing structure i.e. 2 clinical nurse managers grade 2 and one clinical nurse manager grade 3 are appointed as planned by the nursing home management.”

Nursing Home Inspector K and Nursing Home Inspector J visited the nursing home on the 30th May, 2005 at the request of Health Board senior management to determine staffing levels. Their report sets out the following staffing numbers:

“Registered general nurses on 30th May, 2005
5 registered general nurses – 8.00 a.m. to 2.30 p.m.
4 registered general nurses – 2.30 p.m. to 6.00 p.m.
3 registered general nurses – 6.00 p.m. to 8.00 p.m.
1 in Leas Cross 1
1 in Leas Cross 2
3 registered general nurses – 8.00 p.m. to 8.00 a.m.

Nursing attendants on duty
8.00 a.m. to 2.30 p.m. – 18 nursing attendants
2.30 p.m. to 5.00 p.m. – 9 nursing attendants
5.00 p.m. to 11.00 p.m. – 11 nursing attendants
11.00 p.m. to 8.00 a.m. – 5 nursing attendants”

In a statement to the Commission, Nursing Home Inspector K has analysed those figures as follows:

“Based on the information supplied by [the Acting Assistant Director of Nursing] and on receiving the duty roster we concluded that there was enough staff on duty to meet the needs of residents. We also drew on our experience from staffing numbers in other nursing homes.

The staff roster was as follows:
8 a.m. to 2.30 p.m. – 23 staff – ratio 1:4
2.30 a.m. to 5 p.m. – 13 staff – ratio 1:7
5 p.m. – 6 p.m. – 15 staff – ratio 1:6
6 p.m. – 8 p.m. – 14 staff – ratio 1:7
8 p.m. – 11 p.m. – 14 staff – ratio 1:7
11 p.m. – 8 a.m. – 8 staff – ratio 1:12
This included four registered nurses working 8 a.m. to 6 p.m. and three registered nurses working 6 p.m. to 8 a.m."

One of the inspectors in April, 2005 has made the following comments to the Commission regarding staffing at Leas Cross:

“In my opinion, the most significant issue at the inspection of Leas Cross was staffing. There was a major deficit in staff, both staff nurses and senior nurse administrators. The level of understaffing was worse than anything that I had encountered in any other nursing homes. I do not understand how the capacity of Leas Cross increased from 38 residents in 1998 to 96 in 2005, without a significant increase in the number of nurses. Although there were a large number of care assistants rostered to work in the home, they were no substitute for nurses and were not trained to provide or oversee the complex nursing care required by the residents.”

H.S.E. assessment of staff levels, June 2005

Following the broadcast of the Prime Time documentary regarding Leas Cross, and with the agreement of the proprietors, the H.S.E. sent a team to take over the operation of the nursing home. The team was headed by Mary Flanagan, who took up the role of acting director of nursing on the 1st June, 2005.

Ms Flanagan furnished a progress report to the H.S.E. on the 8th June, 2005. It stated the following regarding staffing:

“The total nursing compliment is 12 [nurses], including the Director of Nursing, supported by 45 care attendants and other support staff. This leaves large deficits in the provision of 24 hour care with care being delivered in task-orientated manner by untrained care attendants with limited supervision from [nurses]. This results in a lack of continuity of care for residents and families.”

The H.S.E. team met Mr Aherne on the 8th June, 2005 and informed him that twenty additional nurses, including middle and senior nurse management, needed to be engaged. Ms Flanagan has explained to the Commission that she was not proposing that twenty nurses be rostered for work at any one time, but that the employment of twenty additional nurses was required to ensure that a sufficient number was on the roster each day. She stated that there should be a nurse manager on duty at all times, with six to eight nurses on duty in the daytime and three nurses on night duty.

The Commission has encountered some conflict of evidence regarding the meeting of the 8th June, 2005. Ms Flanagan and Mr Michael Walsh, Chief Officer of the H.S.E.N.A, both of whom attended the meeting, have stated that the nursing home was asked to replace twenty care attendants with twenty nurses. Ms Flanagan told the Commission in oral evidence that she recalls telling Mr Aherne that he had the right number of staff but not the right mix of staff. Mr Aherne disputes this and has told
the Commission that he understood he was being asked to hire twenty nurses in addition to his existing staff complement.

The Commission has been unable to find any contemporaneous note of the meeting or any correspondence from the H.S.E. which sets out the staffing requirement. Accordingly, it is not possible to determine which version of events is correct, although the Commission notes that Ms Flanagan and Mr Walsh have provided consistent evidence. It is possible that the H.S.E.’s request was not clearly communicated or that Mr Aherne misunderstood what was being sought. In any event, the extra nurses sought were not engaged and the nursing home closed in August, 2005.27

Responsibilities of staff

Nurses

It was the responsibility of nurses at Leas Cross to administer medication to residents. This involved consulting the kardex which contained the residents’ prescription, removing tablets from the packaging and making sure that the resident in question took them. A number of nurses have informed the Commission that, when resident numbers increased at Leas Cross, this left little time for the supervision of care attendants.

Nurses were also required to maintain nursing notes, to check residents physically and to determine which residents needed to see the G.P.

The Commission has been informed by former staff of the nursing home that a handover took place at the end of each shift, when the departing nurses discussed each resident with the new shift and drew attention to any problems.

Care attendants

Care attendants changed and bathed residents, fed them where necessary, assisted in lifting residents, escorted them to and from their rooms to the day room and the dining room and assisted in toileting.

One former care attendant has provided the Commission with the following description of a typical day at Leas Cross:

“The first duties of the care attendants in the morning was to serve breakfast to the residents. Breakfast was delivered on dinner trolleys, two care attendants attended each trolley. Other care attendants would help the residents who were unable to eat without aid. During this time, nurses would administer medications.

27 See further Chapters 23 and 24.
After breakfast, the care attendants helped the residents get ready for the day. This included personal hygiene, toileting, dressing, grooming, etc. This would (or should) give the care attendants the opportunity check a person’s body for bruises, pressure sores, and the general condition of a resident. Anything of concern could be brought to the attention of a nurse. After these duties were complete, the care attendants would take the residents down to the lobby or entrance hallway. Some residents preferred to stay in their rooms a while.

At around 10 a.m., care attendants distributed biscuits and tea or coffee to the residents. Care attendants then tidied rooms, changed sheets, etc.

At dinner time (12.30) residents were taken to the dining room. Some residents preferred to dine in their rooms. Care attendants served dinner and helped some residents to eat. Nurses administered medications. After dinner, some residents were helped with toileting.

Then came 'the quiet time'. Care attendants would sit, chat, mingle and walk with residents. Some residents would take an afternoon snooze at this time. My own preference was to sit with some of the residents in the recreation room. There we would sing, tell stories and memories of bygone days … or perform passive exercises. There was a lovely lady who visited regularly. She chalked puzzles, conundrums, etc on the blackboard, and generally entertained the residents.

Shift change was 4 p.m. (I think) The first duties of the evening shift was to take the residents to the dining room for tea. The procedure was the same as dinner, followed by toileting.

Between 7 and 9 p.m., residents were helped to bed. Some residents, of course, preferred to stay up later. Others liked to sit up in bed and watch TV or read.”

Qualification and training of staff

The nursing home legislation makes no provision regarding the qualification of staff, other than to require that there be a nurse on duty at all times together with “a sufficient number of competent staff”.28

The staff files maintained at Leas Cross provide very little information regarding the qualification and training of staff. While some of the files are quite detailed, many contain only an application form or a C.V. For that reason, there is very little

28 As to the qualifications of matrons, see Chapter 9.
information available regarding the qualifications of staff before they were engaged at the nursing home and the training provided to them while they were there.

Qualifications of nurses

From the Commission’s investigations it appears that most of the nurses at Leas Cross were general registered nurses, without any particular specialisation in care of the elderly.

It appears that 54 nurses were employed over the lifetime of the nursing home, although that may not include agency nurses engaged temporarily. 48 of those employed had prior nursing experience before coming to Leas Cross, and seventeen of the nurses had over ten years’ experience.

Qualifications of care attendants

It does not appear that the care attendants at Leas Cross were required to have any qualifications or prior experience in order to be engaged by the nursing home. The records indicate that 40 of the 156 care attendants employed during the operation of the nursing home had previous experience in health care and that 30 of those had training in health care. The majority of these were foreign qualified nurses who had not been registered as nurses in Ireland.

The last matron of the nursing home, Denise Cogley, has informed the Commission that some of the care attendants employed there in 2005 had FETAC qualifications.

Training provided by Leas Cross Nursing Home

The principal training provided to staff at Leas Cross was in manual handling and fire safety. The records available to the Commission indicate that manual handling courses were provided in the years 2000 to 2005. Training by fire wardens was carried out in 1998, 2003 and 2004. All staff were required to undertake a fire drill and an emergency evacuation programme.

Other than the manual handling courses, the documents on file do not show any other in-house training of care staff or nurses in Leas Cross between 1998 and 2004. The records do show that one nurse attended a course in wound care and another trained in continence promotion.

A document has been disclosed to the Commission by the H.S.E. which states that in September 2004, the Hospital School of Nursing offered four places for a five-week course of general nurse training, which could be taken up by nursing homes in the Northern Area. According to this document, it was decided that two of these places would be offered to Leas Cross. The Commission has been unable to confirm whether
Leas Cross was offered the places, and whether any Leas Cross staff attended the course.29

Denise Cogley was appointed matron in 2005. She has told the Commission in a written submission that she arranged to introduce training in the following areas for staff of the nursing home:

- manual handling;
- fire safety and fire drills;
- care of dementia patients (to be provided by dementia services at St James’s Hospital);
- dysphagia in the elderly (to be provided by a dietician from a healthcare company);
- incontinence management in elderly patients;
- infection control management in nursing homes;
- pressure area control.

In oral evidence to the Commission, Mary Flanagan, who was assigned by the H.S.E. to take over as acting director of nursing in 2005, described Ms Cogley’s efforts at reform in this area as “minimal” and stated that she had organised one course in dementia care, which had been cancelled following the Prime Time documentary. However, Leas Cross records show that 25 care staff attended a course in nutrition and dysphagia in elderly patients in April, 2005 and that a C.P.R. overview was also provided that year.

Although the 1993 Regulations do not specify the need for specialist staff or require nursing homes to provide training, the Commission is satisfied that the reference to “competent staff” required Leas Cross to ensure that its nursing and care staff had the experience and training to provide adequate care to its residents. This means hiring suitably qualified staff and organising regular training. Given the profile of residents at the nursing home, it may also have required the provision of some specialist nurses.

In a written submission to the Commission, a consultant geriatrician attached to Beaumont Hospital (referred to in this report as ‘Consultant Geriatrician A’) offered his view that the provision of appropriate and adequate care entailed the following:

“... a high standard of nursing direction and input, adequate resources including staff, staff training, liaison with families and carers, input from general practitioners and/or medical officers and appropriate liaison and contact with specialist services in Old Age Medicine and Old Age Psychiatry.”

In his review of deaths at Leas Cross, Prof. O’Neill recommended that at least half of the nursing staff should have a diploma in gerontological nursing. The Commission notes this proposition that a defined minimum proportion of nursing home staff should be required to have some specialist qualification and considers that it should be given serious consideration. The Commission believes that had such a requirement existed when Leas Cross was in operation, some of the problems at the nursing home may have been avoided or addressed earlier.

29 For more information see chapter 17.
In a submission received by the Commission on the 7th May, the H.S.E. states:

“It is important to note that the process today is that the Nursing Home Inspectors review all personnel files of the staff working in the Nursing Home at the beginning of each inspection to ensure that the staff are appropriately qualified and experienced to deal with the relevant client group.”

**Supervision and discipline of staff**

**Supervision**

The Commission notes that management and supervision of staff was not identified as a problem by the nursing home inspectors until August, 2004, when the appointment of an assistant director of nursing was recommended. However, the Commission also notes that up until April 2005, nursing home inspections took place over a few hours only, during which time the matron’s attention was primarily with the inspectors. In the Commission’s view, it was not possible in such a short space of time for the inspectors to have drawn any meaningful conclusions as to how staff were being managed and supervised at the home.

The managerial appointment recommended by the inspectors in August 2004 did not materialise until three months later, when Denise Cogley was appointed assistant director of nursing. The issue of management was raised again following a two-day inspection of the nursing home in April, 2005, when the Health Board inspectors recommended the appointment of nurse managers at two grades.

In June 2005 Mary Flanagan and her team had the opportunity to observe the management of staff at Leas Cross at close hand over a two-week period. In oral evidence to the Commission, Ms Flanagan said that care attendants at Leas Cross were not properly supervised by nurses. She stated that this failure was due, in part, to the fact that most of the nurses were not Irish whereas many of the care attendants were. The language barrier often made it difficult for nurses to exercise control over the care attendants and also meant that residents and their families often spoke directly to care attendants about their concerns rather than to nurses.

Ms Flanagan has also criticised the lack of a management structure in the nursing home. This was also highlighted in a letter from Michael Walsh, Chief Officer of the H.S.E.N.A., to John Aherne in July, 2005, explaining the reasons for the decision to have Leas Cross removed from the register of nursing homes. The Commission understands that the matters referred to in that letter were based on Ms Flanagan’s findings.

Under the heading “general provision of care”, an appendix to the letter set out the following findings:

“General Provision of Care”
- Duties are allocated on a task by task basis and are undertaken with no apparent leadership or supervision.
- No particular system of work, i.e. key-worker or team nursing system, appears to be in use and therefore it is very difficult to determine who is responsible for which group of residents. The result is that nobody takes overall responsibility for any particular person’s care.
- The care attendants do not have the knowledge required to identify, at the earliest possible time, when nursing or medical input is required.

... Non-qualified staff do not always seek advice or direction from qualified staff when they are unsure of a particular practice, opting for advice from their unqualified peers instead.”

These findings relate to the nursing home as it was in June 2005. It is not possible to say how long these problems existed before their discovery by Ms Flanagan and her team.

The Commission notes that the Prime Time documentary and the additional recordings provided by RTE to the Commission include footage of staff meetings conducted by Denise Cogley at which staff were told that practices had to improve. At one meeting, which clearly followed an Health Board inspection, Ms Cogley admonished the staff to “behave as if the Health Board is here every day” and spoke about the need for a more structured management system:

“[The Assistant Director of Nursing] is now the head nurse manager and will be assisting me for the foreseeable future until we get more staff in place. The staff nurses are the people in charge. You have to respect their decision. Report any change in a resident’s condition to a staff nurse. It is their responsibility to act on it.”

Ms Cogley made it clear that failure to accept such new work practices would not be tolerated:

“There are a few people who aren’t interested in working as a team. Those people would want to think of working elsewhere.”

**Discipline**

A number of disciplinary issues are apparent from a review of the staff files. In general, it appears that discipline involved written or oral warnings to staff.

The files indicate that a number of staff were reprimanded for sleeping on the job and staff were disciplined from time to time for non-attendance. On one occasion, a member of staff was rebuked for working in another nursing home while employed on a full-time basis at Leas Cross.

The Commission is aware of only three occasions on which staff members were suspended from duty. One care attendant was suspended following an incident in which she used distasteful language to a resident in the presence of the resident’s
family. A second care attendant was suspended for doing her personal laundry at Leas Cross. The final suspension of which the Commission is aware occurred following the broadcast of the *Prime Time* documentary, when a care attendant who was shown asleep on duty was suspended pending an investigation of her conduct.

The staff files also record the refusal of one care attendant to carry out a task assigned to him by a nurse. Minutes of a meeting show that the matron informed the nurse that if anyone failed to carry out a reasonable request made by the nurse, the nurse was to contact the matron or inform the staff member to clock out and leave the premises until the matron could conduct an investigation.

**Fitness to practise**

A number of the nursing staff working at Leas Cross were referred to An Bord Altranais by the H.S.E. following the closure of the nursing home. In many cases the Fitness to Practise Committee determined that there was no sufficient cause to warrant holding an inquiry. A number of cases are pending. An Bord Altranais has asked the Commission not to reveal details of pending cases to avoid prejudicing any future inquiry. To date, An Bord Altranais has not found that any nurse working at Leas Cross was unfit to practise.

**Non-Irish nurses and care attendants at Leas Cross Nursing Home**

A number of the families of former residents who contacted the Commission stated that they encountered difficulties communicating with non-Irish nurses and care attendants at Leas Cross.

The following quotes are samples of what the Commission has been told in this regard. They have been taken from statements provided to the Commission by the families of various residents:

“There was an extreme language barrier between the patients and staff as most of them had very little English.”

“A large number of the staff seemed to have limited or no English and some of the staff looked as confused as the patients. It was most frustrating. Some of the nurses would also speak foreign languages in the presence of the residents, which was confusing for them. The lack of staff with a proper command of English was a major flaw in the care of all the patients at Leas Cross.”

“Although John retained the full use of his mental faculties up to the time of his death, he often became confused and distressed by many of the nurses talking in foreign languages in his presence. Again we raised this issue with the management and were told that although they agreed with us, that the advice they had received was that it would be against the ‘Human Rights’ of
Martin Hynes, who was commissioned by the Chief Officer, HSE Eastern Region to investigate the transfer of a resident to Leas Cross Nursing Home and later to review the inspections carried out at the nursing home for the purpose of registration, highlighted concerns regarding the recruitment of foreign qualified nurses in a letter to the Head of Quality at the Department of Corporate Governance in the H.S.E. in August, 2004:

"Many of the current nursing and care staff are non-nationals. Their experience of working with the elderly is not clear from the inspection reports. I have no indication as to how they were recruited or what their status is. ... My concern in this regard relates to one of the accepted, and fundamental, roles of the nurse which is that of advocate on behalf of their patients. Nurses who care for patients / residents who are dependent, or who are in long stay care, often have greater need to be vigilant and to exercise their advocacy role. Nurses who are themselves dependent or whose status is in doubt may be reticent in exercising their role as advocates. Equally, if they are not familiar with the customs and expectations of those for whom they are caring this can create problems if there is not strong leadership within the care centre."

Nursing Home Inspector H, together with the Head of Quality at the Department of Corporate Governance, met Martin Hynes in August, 2004 to discuss his concerns, including those quoted above. Nursing Home Inspector H responded to Mr Hynes’s concerns as follows in a written statement to the Commission:

"In line with all other nursing homes / acute units, a significant number of staff today are international staff. In Leas Cross it did not present as being any different to other units. In fact, they seemed better than most. On speaking to staff members during my inspections I did not encounter any difficulties with their English. They were always pleasant and in good form and helpful to patients when we were present.

There had been a significant increase in numbers throughout the country. We did discuss the difficulty of older persons not being able to understand their English and their accents and the cultural approaches, but as I said a lot of the staff had been there for some time and Grainne Conway always reassured us that it had not created difficulty for the residents. We did not see any difficulties on our visits but we would be watchful at all times for any signs."

There is a divergence on this issue between Nursing Home Inspector H’s comments and the experience of the families of residents as communicated to the Commission. While the Commission accepts Nursing Home Inspector H’s assurance that the inspectors were watchful for communication problems between staff and residents, it is evident that such problems did occur. The inability of nurses and care attendants to communicate in fluent English is of particular concern in the case of elderly, vulnerable and highly dependent residents.
The Commission notes with approval the introduction in 2003 by An Bord Altranais of an English language competency requirement in the assessment of non-E.U. qualified nurses. The continued absence of qualification requirements for care attendants, including competency in the English language, is regrettable, although the Commission notes that care attendants are not governed by An Bord Altranais.

**General practitioner services at Leas Cross Nursing Home**


A number of families of former residents have complained to the Commission about the standard of medical care provided by those doctors. In the course of its inquiries, the Commission asked both doctors to respond to each of those complaints and they have done so, often in considerable detail.

In preparing this report, the Commission has had regard to all relevant information received by it, including complaints regarding the provision of medical care. However, for a number of reasons, the substantive details of those complaints are not reproduced here.

In some cases, the complaints and responses have given rise to a conflict of evidence which the Commission cannot resolve. In other cases, the doctors have explained events complained of to the satisfaction of the Commission. It is not always apparent whether the complaints were made at the time, or whether they have been made for the first time to the Commission. The available information has not always been complete and the passage of time means that the parties’ recollection of events may not be entirely accurate.

**Doctor A**

Doctor A acted as medical officer to the residents of Leas Cross from its opening in 1998 until November, 2003. He described his role at the nursing home as follows, in his August, 2006 response to the report of Prof. O’Neill into deaths at Leas Cross:

“Leas Cross opened in 1997 (sic), the proprietor approached me to work in Leas Cross and to attend to the residents of Leas Cross on a needs basis. I was to attend on a daily basis and the nurses were to provide me with a list of the residents they required me to examine. I would also examine each new resident on admission. On a daily basis I would examine and treat the residents on the list as their clinical condition required.

I did not sign any contract with the proprietor, however, over time I negotiated an annual salary and my role evolved into that of medical officer treating patients on a daily basis, as required. I was not asked to deal with
record keeping, which was a matter for the administration and nursing staff, however I did make my own entries in the records and drugs kardex.”

Doctor A was paid a weekly fee of IR£10 per patient to provide a 24-hour service, seven days per week, with a locum service while he was away. He did not receive any extra fee for being called to the nursing home outside his usual visiting hours. When the nursing home expanded in 2002, he negotiated an annual salary of €50,000.

Following the expansion of the nursing home to accommodate up to 111 residents, Doctor A resigned in November, 2003. He has explained his resignation as follows:

“I resigned as Leas Cross medical officer in November 2003 and one of the reasons influencing my decision was my concern about the number of patients I was being asked to care for and the impact this would have on my ability to care for the patients in my general practice. That said, during my time at Leas Cross between 1997 and 2003, I believe that I provided a constant and complete medical care when I attended at the home.”

Following the closure of Leas Cross Nursing Home, a complaint about Doctor A was made to the Medical Council by the National Director of Primary and Continuing Care at the H.S.E. The Medical Council found that there was no prima facie case to hold an inquiry. A similar finding was made in relation to another complaint made by the family of a former resident of Leas Cross.

Doctor B

Doctor A was replaced by Doctor B. She acted as general practitioner to residents in Leas Cross from November, 2003 to the date of its closure in August, 2005.

Doctor B set out her involvement with Leas Cross as follows in a letter to Prof. O’Neill dated the 11th November, 2005:

“My involvement with Leas Cross Nursing Home began in November, 2003, when I was approached by the then matron, Ms Grainne Conway, and the owner of the nursing home, John Aherne, who asked me if I would attend the home as general practitioner. I was required to visit the nursing home daily from Monday to Friday, to attend patients for general medical problems which may arise. I would also provide out of hours cover, either by myself or a locum arranged by me.”

It was agreed with Leas Cross that residents wishing to avail of Doctor B’s services would be admitted onto her G.M.S. panel and treated in the same way as any of her other patients. She has explained to the Commission that the only difference between her patients at Leas Cross and those in her ordinary G.P. clinic was the likelihood of reduced mobility and chronic illness. The increased workload caused by those factors was reflected in the remuneration provided by the Health Board to G.P.s in respect of patients over the age of 70 and residing in a nursing home.
When she started providing services at Leas Cross, Doctor B was informed that approximately one third of the residents were patients of St Ita’s Hospital, Portrane. Those patients continued to be under the care of a consultant psychiatrist from that hospital, while Doctor B provided general medical care to them.

Doctor B began attending at Leas Cross on the 1st December 2003. She attended the nursing home on a daily basis from Monday to Friday, and saw the patients she was asked to see by the nursing staff. She also visited the nursing home at other times if an urgent problem arose with a patient, or if she had arranged to meet a patient’s family at their convenience. Doctor B estimates that she saw an average of six to eight residents per day. She usually visited Leas Cross in the morning and was given a book containing a list of patients to be seen or problems to discuss. The staff nurses would add residents to the list whom they believed were in need of medical attention.

Doctor B was paid an annual fee of €18,600 by Leas Cross to provide her services. That sum was in addition to the fees received by her from the Health Board for seeing the patients on her G.M.S. panel. This agreement with Leas Cross was conditional on 70 residents transferring to her G.M.S. list and included a provision to renegotiate her annual fee if a smaller number transferring transferred. Doctor B stated to the Commission:

“The purpose of this payment to me was so that I would provide separate medical services to temporary residents at Leas Cross nursing home, people resident for short periods, for respite care or convalescence whose own doctor’s centre of practice was a considerable distance away. It also covered providing urgent medical attention to members of staff who may have had accidents or become suddenly ill. It also covered providing general advice and support to the nursing home management as in the case of outbreaks of infection. The provision of such services has always been recognised as being separate and not conflicting in any way with any private or public contract of care to an individual patient. The Irish Medical Organisation have recognised this and have (or had at the time of my involvement with Leas Cross) a suggested fee structure for such medical services.”

In response to questions from the Commission, Doctor B has made it clear that she was at all times satisfied that she was in a position to fulfil her duties to her patients at Leas Cross. She pointed out that it is not uncommon for G.P.s to maintain two centres of practice. She also stated her belief that she could treat the nursing home residents more effectively because they all resided in one place, where she had the assistance of nursing and care staff, than if she had to see individual elderly residents separately at her surgery.

Two complaints about Doctor B were made to the Medical Council arising out of her time at Leas Cross: one by the husband of a former resident and the other by the National Director of Primary and Continuing Care at the H.S.E. In both cases, the Medical Council found that there was no prima facie case to hold an inquiry.
CHAPTER 12

COMPLAINTS MADE TO LEAS CROSS NURSING HOME

The Commission has received submissions from the families of over seventy former residents, many of whom have outlined numerous complaints made by them to the matron, staff or proprietor of the nursing home. Investigation of these complaints by the Commission has proved difficult, as in most cases there is no written record of the complaint or of its outcome. This means that in circumstances where the alleged recipient of the complaint denies any knowledge or memory of it, or rejects the allegations which formed the substance of the complaint, the Commission is left with a conflict of evidence which cannot now be resolved.

Because of the passage of time, family members often have difficulty remembering the date on which a complaint was made, or the name of the person to whom it was made. In the case of complaints made to or about staff members other than the matron, it has often been impossible to identify the member of staff to whom or about whom the complaint was made.

Further problems have arisen in relation to tracing former care attendants at the nursing home: as the nursing home closed in mid-2005, the most recent contact details available to the Commission are now some years out of date, leaving the Commission with no practical means of establishing contact with many former staff members. The scale of the problem is illustrated by the fact that despite its best efforts, the Commission has only been able to establish contact with 5 out of more than 150 former care attendants who worked at Leas Cross between 1998 and 2005.

For this reason, while regard has been had to all of the information furnished to the Commission, the emphasis in this chapter is on common themes and trends arising from these complaints and the existence or non-existence of systems and procedures to deal with complaints.

Complaints procedure at Leas Cross Nursing Home

Neither the Act of 1990 nor the Regulations of 1993 expressly require nursing homes to formulate or operate complaints procedures. The Code of Practice for Nursing Homes (Department of Health, 1995) recommends the following:

24.1 There should be a procedure within the nursing home to deal with in-house complaints, without prejudice to the formal complaints procedure provided in the Nursing Homes (Care and Welfare) Regulations. The resident and the person responsible [i.e. next of kin or other person most involved in the resident’s care arrangements] should be informed of his or her right to make a formal complaint and the procedures for making such a complaint. The resident or person
responsible should be reassured that if they make a complaint it will be dealt with confidentially.

24.2 When health board inspections take place residents should be offered the opportunity to speak in confidence with the designated officers of the health board.

In the case of Leas Cross, the standard form contract of care contained the following provisions relating to complaints:

“The registered proprietor, the person in charge, their servants or agents (duly authorised) undertake to:

7. Investigate insofar as possible, any bona fide complaint made by or on behalf of a dependent person and communicate the result to the complainant. The dependent person may make a complaint to the chief executive officer of the Health Board or a designated officer of the Health Board, in writing unless it is not possible to make a written complaint. Complaints may relate to any matter concerning the facility or the maintenance, care, welfare and well being of the dependent person.

General Conditions

10. Notwithstanding and without prejudice to the rights which a dependent person has under the Nursing Homes (Care and Welfare) Regulations 1991 [sic], a dependent person may make a complaint to the person in charge or the registered proprietor such complaint will be fully investigated by the person in charge or the registered proprietor and the result of such investigation shall be communicated to the complainant.”

It should be pointed out however that a number of residents at Leas Cross, for one reason or another did not sign contracts of care. Even for those who did, it is likely that some family members or friends who visited the home would not have seen or read the contract and so would not have been aware of the policy and procedure in relation to complaints.

According to Grainne Conway, who was matron of Leas Cross from June 1999 until January 2005, she was not asked to display information concerning the complaints procedure at the home until the 13th September, 2004, when the Manager of the Nursing Home Section in the NAHB wrote to Ms Conway in the following terms:

“For the benefit of patients and families, our Board would appreciate if all registered Nursing Homes clearly displayed their complaints procedure. The complaints procedure should inform clients / families of the named person within the nursing home to whom they can bring issues / complaints in an effort to resolve them at a local level. The procedure should also inform clients / families that should the complaint not be resolved at local level they can put their complaint in writing to the Nursing Homes Section, NAHB at the above address.”

111
The Nursing Home Section Manager has informed the Commission that this letter was sent to all nursing homes in the Northern Area, as the nursing home inspectorate had identified a general failure to display a complaint’s process. Ms Conway informed the Commission that following receipt of this letter, notification of the complaints procedure was displayed in the entrance hall of the nursing home.

On a visit to the former Leas Cross Nursing Home in 2008, the Commission observed a notice displayed in the entrance hall of the old building entitled ‘Charter of Patients Rights – Leas Cross Nursing Home’. The charter included the following:

“Complaints
You have the right to complain about any respect of service at Leas Cross Nursing Home, to have the complaint investigated and to be informed at the outcome as soon as possible. Any complaint you have may be communicated to any member of staff or you should communicate your complaint to the matron. You have the right, where your complaint is not resolved to your satisfaction, to have the matter referred to the Managing Directors of Leas Cross Nursing Home.”

It is not clear whether the phrase “Managing Directors” was intended to mean the owners of the nursing home, the person in charge of the nursing home (i.e. the matron) or both.

In a statement to the Commission Ms Conway summarised the procedure used by her to investigate complaints at the home as follows:

“I would receive a complaint and advise the person that they may write with same to the E.H.B. If they did not want to do this we would endeavour to work things out.”

In oral evidence to the Commission, Grainne Conway explained further how complaints from residents and their families were handled during her tenure as matron of Leas Cross (June 1999 to March 2005). Her evidence can be summarised as follows:

1) Ms Conway dealt with all “unofficial” complaints (i.e. those not made formally to the Health Board); complaints made to nurses and care attendants were brought to her attention by the staff.

2) There was no complaints book or other means of formally recording complaints made by residents or their families, although Ms Conway did keep any documents regarding complaints received through the Health Board.

3) Ms Conway did not provide a written response to any complaints by residents or their families, unless the complaints themselves had been made in writing.

From the foregoing it appears to the Commission that the management of Leas Cross Nursing Home had no formal policy or procedure in place to deal with complaints internally. This remained the case even after September 2004, when the Northern
Area Health Board requested that a complaints procedure be clearly displayed in the home. Residents and their families were told they could complain to any member of staff, but were not told how their complaints would be investigated or by whom. They were given no assurance that their complaints would be recorded in writing; nor were they guaranteed that a complaint made to a staff member would be passed on to the matron.

In the case of complaints made to the Health Board / H.S.E., the Commission has found that the matron did respond to such complaints when she was asked to do so. However, the submissions received by the Commission from families who made complaints indicate that most complaints were made, not to the Health Board but to the matron, nurses, care staff or proprietors of the nursing home.

Notwithstanding the absence of any statutory requirement for a complaints policy, the Commission considers that it would have been desirable for Leas Cross to have set out more comprehensively the manner in which complaints could be made by and on behalf of residents and how they would be investigated by the home. This was clearly envisaged by the Code of Practice and, in the opinion of the Commission, should be considered best practice when dealing with elderly people and their families, who are unlikely to be familiar with nursing home legislation and HSE procedures.

The Commission recognises that, for many nursing home residents and their families, the decision to make a complaint is not an easy one. Some people are naturally reticent and may be reluctant to ‘cause a scene’; others may fear being labelled as a ‘trroublemaker’ or ‘busybody’. The Commission was told of two residents who refused to allow their families to make complaints on their behalf, for fear that it would “come back on them”. The residents in question appeared to believe that complaining would have an adverse effect on staff attitudes towards them. The Commission received submissions from the families of two other residents who were in contract beds, stating that the families were afraid that if they complained their relatives might be asked to leave the nursing home.

Regardless of whether such fears and concerns were justified, the Commission believes that they were foreseeable, and that the publication of a detailed complaints procedure by the management of Leas Cross might have helped to allay such fears.

Complaints received by the nursing home

The Commission has been notified of many complaints made to the nursing home by the families of former residents. However, whereas the Commission understands that it has been provided with details of all complaints made to the Health Board / HSE, in the case of complaints to the nursing home the Commission has information only from those families who came forward voluntarily to give evidence. Less than one in five families of former Leas Cross residents provided the Commission with information, so any statistics derived from this information are of limited value.

30 See chapter 15.
The complaints of which the Commission is aware were made in a variety of formats. In a minority of cases, written complaints were made to the matron or the proprietor. However, most of the complaints were made orally. In some cases, the complainants sought out the matron to lodge their complaints at managerial level. In other cases, complaints were made to nurses or care workers and it is impossible to know for certain whether those complaints were passed on to the matron or the proprietor. For all these reasons, and in the absence of a comprehensive written record of complaints to the home, it is impossible to state with any accuracy how many complaints were made during the seven years Leas Cross was in operation.

Complaints in writing

The documents disclosed to the Commission by the owners of Leas Cross Nursing Home contain two letters of complaint written by the families of residents in 2004. The first, dated the 8th January 2004, is addressed to the matron, Grainne Conway and concerns the removal of sweets and biscuits from a resident’s locker, and the apparent disappearance of clothes belonging to the resident. It is not clear whether this letter received a response.

The second letter, dated the 11th November 2004, is addressed to Mr John Aherne, and contains a complaint about the designated smoking room for residents at the home, which the author of the letter considered to be poorly situated and badly ventilated. A handwritten note on the face of the letter indicates that Mr Aherne telephoned the author of the letter on the 17th November and informed him that Leas Cross was “looking into the situation”.

From information provided by the families of residents, the Commission is aware of a further five written complaints to Leas Cross made while the residents in question were in the home and prior to the Prime Time documentary. Only one of those letters yielded a substantive written response, while another resulted in a meeting with the proprietor at which the complaint was resolved. The letters are not amongst the documents disclosed to the Commission by the owners of Leas Cross Nursing Home. The substance of these letters is summarised below, according to the resident to whom they relate.

Kathleen Reilly

Ms Reilly, who suffered from Alzheimer’s disease, was admitted to Leas Cross in July 1999. In September 2000, members of her family found her wandering around the area in Swords where she used to live. On the 6th September her niece wrote a letter of complaint to the owner of Leas Cross in relation to the incident.

The letter of complaint was replied to by the matron Grainne Conway on the 11th September. The matron expressed regret on behalf of the nursing home for the incident and explained that that the transport section of the Eastern Health Board had sent a taxi instead of an ambulance to take Ms Reilly to Beaumont, and asked the taxi driver to bring her to the x-ray department. They informed him that her details were in an envelope in the resident’s pocket. When Ms Reilly left Beaumont, she was brought
to the taxi by a porter, but on hearing the price of the taxi, she told the porter that she
would take the bus. The letter concluded:

“It seems to me that it was unfortunate that the taxi driver did not inform
Beaumont staff that [the resident] was an Eastern Health Board Transport
patient. I accept that we are responsible for [her] care and safety and I am not
retracting from that............I apologise for the distress caused and by this
incident and I have assured your mother that [she] will attend her future
appointments in a taxi booked privately by us and with an escort.”

The matter was also investigated and reported on by the Northern Area Health Board,
to whom the family had also complained.31

Catherine Mullins

Ms Mullins was admitted to Leas Cross in June 2003. According to a statement
provided to the Commission by her daughter, Ms Mullins and her family were
initially happy with the nursing home but found that care standards “deteriorated
significantly” as the number of patients in the home increased. The family state that
they made several verbal complaints to the matron, but their concerns about the care
being received by their mother at the nursing home remained unresolved.

By a letter dated the 13th January 2004 the family informed the matron that they had
decided to remove their mother from Leas Cross as they were “...very unhappy with
the nursing care and management of our mother’s welfare at Leas Cross in recent
times...” On the 15th January 2004 the family wrote again to the matron setting out
detailed complaints regarding Ms Mullins’s care. Copies of this letter were also sent
to the owner of the nursing home, the Northern Area Health Board and a consultant
physician at Beaumont Hospital. The matter was subsequently taken up by the
Northern Area Health Board.32

Elizabeth Fleming

In February 2004 Ms Fleming, a resident of Leas Cross Nursing Home, discovered
that a wallet containing €900 had been taken from her handbag. She reported this to
staff in the morning and her family was informed when they visited that evening. The
family subsequently wrote to Mr John Aherne seeking a meeting to discuss the issue.
A meeting was held and the family accepted an offer by the management of Leas
Cross to replace the missing €900. Ms Fleming was happy to accept the offer and the
matter was considered closed by the family.

Resident P.S.

31 See chapter 15.
32 See chapter 15.
This resident arrived in Leas Cross in April 2004. Three months after his arrival, his daughter discovered that the majority of her father’s clothes were missing. She stated to the Commission:

“Dad had been involved in the clothing industry for much of his career and had some very nice clothes; He took great pride in his appearance and was always impeccably dressed. On investigation I was told that his clothes could not be found and that my father had probably thrown them away into a skip outside in the grounds of the nursing home. I was shocked at this explanation as my father could hardly hold a cup not to mention move ‘unnoticed’ 30 kgs of his belongings to a skip. His clothes were never found despite my many searches and repeated enquiries.”

The resident’s daughter wrote a letter of complaint to Mr John Aherne, the owner of Leas Cross:

“My letter was never acknowledged. Eventually after four months of phone calls. I was handed a personal cheque from Mr. Aherne by one of his staff for €300 but neither he nor Grainne Conway offered any form of apology to my father or our family.”

Resident J.B.

The family of this resident, who had been admitted to Leas Cross in April 2004, also found reason to complain in writing. They have chosen to remain anonymous in this report. Over a number of months, the family grew concerned about various aspects of their father’s care. The family told the Commission that they raised these concerns verbally on a number of occasions with staff at Leas Cross but received no response.

As the family were getting no response to their verbal complaints, the resident’s daughter wrote to the matron on the 26th October 2004. The letter detailed serious concerns regarding her father’s continuous diarrhoea, drastic weight loss and a lack of communication between the nursing home doctor and the family. The letter also raised questions concerning the use of physical restraint on the resident. The family delivered the letter personally:

“My brother and I handed this letter to Grainne Conway in her office. Ms Conway spoke to us about our concerns and said that she would reply to the letter. I asked Ms Conway whether the staff had training in dealing with patients with dementia. Ms Conway said that her nurses were extremely capable and well qualified. I did not receive any response from Grainne Conway to this letter.”

Patrick Crowley

Mr Crowley, who arrived at Leas Cross in May 2004 for two week’s respite following an operation at Beaumont Hospital, decided after one day at the nursing home that he did not want to stay there. He informed the matron and asked for the return of the
money paid by him which covered the remaining days of his respite booking. According to Mr Crowley’s statement to the Commission, the matron told him that she had no money with which to reimburse him. After he left the nursing home, he wrote to Mr John Aherne on two occasions looking for a refund, but received no answer. He also got the Citizen’s Advice Bureau to write to Mr Aherne, but again no response was received.

Complaints in person

The oral complaints made by families covered a wide variety of issues, of which the following is a representative sample. The quotations are taken from statements provided to the Commission by the families of various residents.

- Rough handling of residents by care staff:

  “My father complained that the man who showered him was very rough...”

  “On one occasion my mother complained of rough treatment by the staff, saying “I was bashed”. When I questioned the Matron ... about this incident, she passed it off as my mother not wanting to dress herself.”

- Unnecessary sedation of residents:

  “Prior to [my sister’s] transfer to Leas Cross, she was capable of speaking coherently and making intelligent conversation. During her time in Leas Cross, her speech was often slurred and she was unable to participate in conversation. I believe that this was due to an increased use of sedatives, and I would question whether this was warranted or appropriate...”

  “Our main concern was that my father seemed to be very sleepy and sedated when he was in Leas Cross. This regularly seemed to be the case and he was in this condition for long periods of time and at different times of the day, even in the morning...”

  “My mother was very often asleep or drowsy when we visited her, and my family and I are concerned that she may have been sedated unnecessarily...”

  “[Our mother] always seemed to be drowsy, as if sedated. Her family were not told what medication she was on...”

- Inadequate supervision of residents’ food / fluid intake:

  “During her later years at St. Ita’s Hospital [my sister] had problems with weight gain. She was placed on a special diet which involved close, daily monitoring of her eating and fluid intake. This diet continued up until the time of her transfer to Leas Cross... A short time
after [my sister’s] transfer to Leas Cross, her family noted that she had started to put on weight. [Her family] mentioned this on a number of occasions to the Matron, Gráinne Conway... I believe that [my sister’s] diet and fluid intake were not properly supervised.”

“My family and I were concerned that my father was losing a lot of weight and becoming depressed and dejected during his time in the nursing home... I raised these concerns with the matron, Ms Conway, who told me that she would have a doctor look at my father. So far as I am aware, this was never followed up...”

“[my sister and I] sought an appointment to see the Matron of Leas Cross (Grainne Conway) to express our concerns regarding our mother’s treatment at Leas Cross. She responded to our concerns about our mother’s food and fluid intake by saying ‘Don’t forget, your mother is very old.’ She said she would look into it, and that was that...”

- Lack of regard for residents’ hygiene and other personal care issues:

“...One day when I... visited our mother, she was wincing with pain and I could see that her foot was hurting her. I took off her sock and saw that a toenail was badly infected. I was astounded that the staff, when dressing my mother each morning and undressing her each evening, would not have treated this infection. I went up to the nurses' station to complain and found out that a chiropodist was in the nursing home that day. I asked the chiropodist would he take care of our mother, which he did...”

“I noticed over time that my father was deteriorating in his physical appearance and I had to repeatedly request visits to the chiropodist and also the optician. On another visit I had found Dad walking with difficulty and when I decided to change his shoes I found a very infected big toe, as the nail had been badly cut. On questioning the staff nobody knew anything about this, yet I was told he had a daily supervised shower...”

“The standard of hygiene in my mother’s room dropped dramatically. The room became dirty and there was often food from previous meals left under the bed...”

“On many occasions whilst visiting our father we would have to ask that his incontinence wear be changed. He would be (either alone in his room or on the corridor/landing outside his room) sitting in a very wet or soiled ones. As he had developed a very deep intensive bed sore on one of his buttocks we knew that it would not be good for him to sit in very damp wear for long periods...”

- Failure to check on residents or to respond to calls for assistance:
“We would sit with our father for hours and nobody would come to check in on him whilst we were there. Many times when we visited our father he would be isolated and alone in a buxton chair on the corridor with sun beaming in on his face and in a sweat...”

“One evening [a family member] heard cries coming from the elevator and it was going on for some time. When she went to investigate there was a man stuck in a wheelchair in the lift she had to go and get help to get him out...”

“On one occasion I visited my mother and when I got to the door of her room, which was open, I found her sitting on the floor beside her chair. She was in a dazed state and was not sure how she had fallen out of the chair. She was not sure what had happened. I called the staff and it took them some time to get my mother back into the chair. I asked how she could have been sitting in the room on her own, on the floor, with the door open, yet nobody had seen or heard her? The staff could not provide any answers....”

- Loss or mishandling of residents’ clothes;

“[My husband’s] clothes started to go missing bit by bit and he often had other people’s clothes on him. I was upset at this as I had put his name on all of his clothes. I spoke to the Matron and to staff about this a number of times. I also searched the laundry several times for his clothes, but to no avail. Most of the clothes in the laundry room were wet and damp. Eventually I spend over €100.00 on a set of new clothes to be bought for him but these also went missing...”

“After a number of weeks we noticed that the new clothes we had bought for [my mother] were starting to disappear. We raised the matter with staff at Leas Cross, but nobody seemed to know anything about the clothes...”

The Commission has been informed by a number of families that they encountered difficulties making complaints because the nurses station was frequently unattended, the matron was unavailable or because the available nurses or care staff did not speak fluent English.

Response of nursing home to complaints

Documentary record
Between 1999 and 2005, as a matter of both policy and practice, Leas Cross management and staff failed to keep a record of:

i) the complaints made to them by residents or residents’ families; and

ii) the response of the nursing home to those complaints.

The absence of such records fatally compromises any attempt to assess the performance of the nursing home management in dealing with the complaints of residents and their families. In the Commission’s view, however, the failure to keep proper records is, in itself, a sign that the management of Leas Cross did not treat residents’ grievances with the seriousness they deserved.

Not having any nursing home record of complaints, the Commission has had to rely principally on information supplied voluntarily by the families of former Leas Cross residents. As set out earlier in this chapter, the Commission has received information from a number of families concerning complaints made by them at various times during the history of Leas Cross. But the failure of Leas Cross to keep a record of complaints received makes it impossible to say whether the complaints of which the Commission is aware represent a majority or just a small portion of the complaints made to the nursing home over its lifetime.

The Commission is also aware that in circumstances where members of the public with varying experiences of Leas Cross are asked to volunteer information, the result may not be an entirely balanced picture: people who found no cause for complaint with Leas Cross, or whose complaints were heard and addressed by the nursing home, are less likely to contact the Commission than those who feel their complaints were never properly dealt with. When the Commission has been told of complaints that were satisfactorily resolved, those stories have generally come from people who contacted the Commission because of other, unresolved grievances.

The situation is further complicated by the fact that, owing to the passage of time, families who told the Commission of specific grievances were often unable to recall whether they had made a complaint to Leas Cross at the time; and if so, when and to whom their complaint was made.

**Responses to the Commission**

Where information has been given to the Commission about a complaint made to a named person (usually the matron or the owner of the nursing home), the Commission has put the substance of that complaint to the relevant person and sought information from them as to what, if anything, was done in relation to that complaint.

In oral evidence the owner of the nursing home, Mr Aherne, responded to the Commission’s questions by stating that as a rule, any complaints received by him were passed directly to the matron:

“…if a family member met me going down through the corridors in Leas Cross and made a complaint, I would go straight and inform the matron of the
Mr Aherne did recall one complaint, regarding a problem with drains and sewage, which he himself addressed, “because I was responsible for the structure of the building.”

The response of the matrons to complaints which the Commission brought to their attention varied. In some instances, the matron in question said she had no memory of the complaint, or denied that any such complaint had been made to her. In other instances, she claimed that the complaint in question had been addressed satisfactorily. In the absence of any documentary evidence however, it is impossible for the Commission to test such statements.

**Some observations on Leas Cross Nursing Home’s response to complaints**

Notwithstanding the difficulties caused by (a) lack of documentation and (b) unresolved conflicts of evidence between complainants and nursing home staff, the Commission considers that, having regard to the information available to it, the following, limited observations can be made:

1. Residents and visitors who wished to make complaints were frequently frustrated in their attempts to do so by the fact that key staff members, such as the matron or the duty nurse, could not be located.

2. Some complainants experienced difficulties in communicating with staff who lacked fluency in English. This left them uncertain as to whether their complaint would be understood or acted upon.

3. The difficulties experienced by people who attempted to complain were compounded by the fact that Leas Cross had no procedure for keeping written records of verbal complaints, or of the response to such complaints.

4. Three of the five written complaints of which the Commission is aware appear to have generated no response from the management of Leas Cross.

5. Most of the complaints of which the Commission is aware relate to an eighteen-month period beginning in late 2003, when the population of the nursing home had increased substantially following the intake of a large number of high / maximum dependency patients from St Ita’s Hospital, Beaumont Hospital and elsewhere. Whilst this might not be unexpected – even in the best of circumstances one might expect an increase in resident numbers to bring an increase in complaints – when combined with other evidence it suggests that the nursing home was not equipped to deal with the number and dependency level of residents in its care from September 2003 until June 2005.33

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33 On the concerns expressed by nursing home inspectors see chapters 8 and 13. On the concerns expressed by the Psychiatry of Old Age service see chapter 17.
6. A significant number of the complaints made during that period contain allegations which imply a lack of adequately skilled staff in the nursing home at that time. Those allegations include inadequate supervision of residents, unwarranted use of physical or chemical restraints, and lack of regard for residents’ hygiene and personal care.

7. If complaints received by the nursing home had been systematically recorded and available for inspection, it would have been much easier for both the nursing home management and the relevant health authorities to identify and deal with emerging patterns of inadequate care.
CHAPTER 13

HEALTH BOARD INSPECTIONS OF LEAS CROSS NURSING HOME

There are generally three reasons for the inspection of a nursing home by H.S.E. inspectors:

1) for the purposes of determining an application for registration or re-registration of a nursing home;

2) in response to a complaint; and

3) routine biannual statutory inspections.

This chapter is concerned only with the last of these.34

The nursing home inspection process

The legislative framework

Section 6 of the Health (Nursing Homes) Act 1990 requires the Minister for Health to make regulations “for the purpose of ensuring proper standards in relation to nursing homes”. The section states that such regulations may provide for “the inspection of premises in which nursing homes are being carried on or are proposed to be carried on ... for the enforcement and execution of the regulations by the appropriate health boards and their officers”.

The Nursing Homes (Care and Welfare) Regulations 1993 were made under that section and provide for inspections of nursing homes by ‘designated officers’ - defined in reg. 4 as “officers of health boards authorised by the chief executive officer or the deputy chief executive officer of a health board to carry out functions under the Act [of 1990] and these Regulations”. 35 The following provision is made regarding inspections:

Inspections by designated officer

23.1 The registered proprietor and any member of staff of the nursing home shall:—

34 As to inspections for the purposes of registration, see Chapters 7 and 8. Inspections of Leas Cross Nursing Home in respect of complaints are dealt with in Chapter 15.

35 Responsibility for the inspection of nursing homes was transferred to the Health Service Executive by section 59 of the Health Act 2004.
(a) permit designated officers to enter and inspect the nursing home and shall afford the said officers such facilities and information as they require for that purpose;

(b) subject to article 23.3, permit designated officers to examine records kept by the nursing home and to obtain copies of any such records or of extracts therefrom;

(c) subject to article 23.3, permit designated officers to conduct interviews (including interviews in private) with persons (including staff) in the home and to examine any dependent person in the home, where the officer has reasonable cause to believe that a person in the nursing home is not or has not been receiving proper care, maintenance or medical or other treatment;

(d) provide facilities for the conducting of interviews and the carrying out of examinations by designated officers.

23.2 Nothing in article 23.1 authorises any person other than a designated officer who is a medical practitioner to inspect any medical record relating to a person in a nursing home.

23.3 Nothing in article 23.1 authorises any person other than a designated officer who is a medical practitioner or a registered nurse to carry out an examination of a person in a nursing home.

23.4 In carrying out inspections a designated officer shall have regard to the religious beliefs or principles of dependent persons and the religious ethos of the home.

23.5 In carrying out inspections a designated officer shall act with due courtesy towards dependent persons and staff.

Frequency of inspections.

24. Inspections of a nursing home pursuant to article 23.1 shall be made by designated officers not less than once in every period of six months.

Guide to the Nursing Home Legislation

The Guide to the Nursing Home Legislation, produced by the Department of Health in 1995, contains some guidance in relation to inspections (at paragraphs 3.8.3-5).36

“In order to obtain a rounded and comprehensive view of a nursing home and the standard of care, the home will have to be inspected by professionals of various disciplines such as a public health nurse, medical officer and an environmental health officer. It is recommended that where possible

36 For further comment on the Guide to the Nursing Home Legislation, see Chapter 6.
inspections should be carried out by two officers to avoid later difficulties over what was found or recommended. Such inspections are particularly important where the health board is concerned about the standards of care or accommodation in a home.

An inspection should involve a systematic review of facilities, services and the care provided to ensure continuing compliance with the statutory requirements and with the conditions for registration...

After each inspection a comprehensive report should be prepared. The registered proprietor should be informed in writing as soon as possible of the outcome of the inspection. If a designated officer has found evidence of non-compliance with the Act or Regulations each instance of non-compliance and the date by which compliance is required should be given. The consequence of continuing non-compliance, such as prosecution for breach of the Regulations and/or a recommendation to the health board to refuse registration, to attach a condition to registration or to the removal of the home from the register should be referred to.”

Administrative structure

The administrative structure of the nursing home inspection system changed a number of times during the period that Leas Cross Nursing Home was in operation. The various systems in operation were outlined in the chapters dealing with the registration and re-registration of Leas Cross Nursing Home, but are summarised again here for convenience.

1995-2000

Under the Eastern Health Board, there were four ‘care programmes’, each led by a programme manager. Two of those care programmes were involved in nursing homes: Acute Hospitals and Services for Older Persons (AHSOP), which administered nursing home subventions, and Community Care Services (CCS), which administered nursing home inspections. There were ten community care areas within the EHB area, each of which had its own team of designated officers carrying out inspections. Leas Cross was located in Area 8. Local inspection teams were headed by the local Director of Public Health Nursing and were made up of assistant directors of public health nursing and senior area medical officers.

In 1995, responsibility for nursing home inspections was transferred from the CCS programme to the AHSOP programme. The Nursing Home Section dealt with the registration of nursing homes, routine inspections and complaints. It was administered by a Senior Executive Officer (SEO), who reported to the Co-ordinator of Services for the Elderly and, ultimately to the Programme Manager for AHSOP. The Nursing Home Section was separate to the Subvention Section, which had its own line manager, who also reported to the Co-ordinator of Services for the Elderly.

37 See chapters 7 and 8.
Applications for registration and complaints about nursing homes were forwarded by the SEO to the local inspection teams (still drawn from local public health nurses and area medical officers). Decisions regarding registration of homes and the imposition of conditions on registration were made formally by the Programme Manager, on the basis of the inspectors’ recommendations. This was a function delegated directly from the CEO of the Health Board.

2000-2004

The structure changed under the Northern Area Health Board. The General Manager for each Community Care Area – a post created in 1998 – reported to the Assistant Chief Executive for Community and Primary Care Services. Leas Cross was situated in Community Care Area 8.

Nursing home inspections continued to be carried out by local inspection teams from the relevant Community Care Area. Routine inspections were reported to the Nursing Home Section in the Acute Hospitals and Services for the Elderly Programme (formerly AHSOP). Those inspection reports were not seen by the General Manager for CCA8. The General Manager was however responsible for the registration of nursing homes.

2004-2005

In 2004, the system changed again, with the formation of a dedicated Nursing Home Inspection Team. According to the then Deputy Chief Executive of the NAHB Michael Walsh, the CEO and the management team were concerned regarding their ability to meet the requirements of the inspection process under the Nursing Home Regulations. The reasons for this concern included recruitment difficulties and the increase in the number and size of private nursing homes. In a response to the 2006 report of Professor O’Neill, Mr Walsh stated:

“NAHB management were particularly concerned regarding the Board’s dependence on the private nursing home section for continuing care beds and the level of dependency of patients being referred.”

At this time, no other health board in the country had a dedicated inspectorate of this type.

From January 2005, the new inspection team was based in St Mary’s Hospital, alongside the Nursing Home Section of the NAHB. In addition to the head of the Nursing Home Inspectorate, the team was permanently staffed by two Assistant Directors of Public Health Nursing (one of whom did not join the team until May, 2005 owing to illness, meaning that the inspectorate was initially short staffed), together with one part-time G.P. and a clerical assistant.

Inspection reports from the team were sent to the Nursing Home Section. Where particular concerns arose, the inspection team would also forward their reports to the offices of the Chief Executive Officer and Assistant Chief Executive Officer of the
NAHB. The Assistant CEO has informed the Commission that reports were not routinely sent to her office, but that she provided advice to the inspectorate where necessary and that her involvement in this regard really only began in 2005.

Complaints regarding nursing homes were investigated by a Director of Public Health Nursing and a medical officer, whose report would be sent to the head of the Nursing Home Inspectorate and, where necessary, to the CEO of the NAHB.

When the Health Service Executive replaced the Northern Area Health Board in 2005, the dedicated Inspection Team remained in place with the same staff. In July 2005, a multi-disciplinary group was assigned to provide specialist assistance to the inspection team. The group included a physiotherapist and a speech and language therapist. The first head of the Nursing Home Inspectorate retired from the inspection team in December 2005.

**Staffing shortages in the inspectorate**

Nursing Home Inspector H was a designated officer under the 1993 Regulations and was appointed to the post of Director of Public Health Nursing for Community Care Area 8 in December, 2002. Her responsibilities in that role included carrying out inspections and investigating complaints at nursing homes in CCA8. In 2004, Nursing Home Inspector H raised concerns regarding the inability of inspectors to comply with the statutory requirement to inspect nursing homes every six months. She has furnished the Commission with copies of correspondence in this regard.

By letter dated the 1st March, 2004, Nursing Home Inspector H wrote to the General Manager of Community Care Area 8 (CCA8). She pointed out that she had only 4.7 whole time equivalent Assistant Directors of Public Health Nursing out of the full complement of seven. She stated that there were sixteen nursing homes in CCA8 and that a large number of complaints were under investigation. Accordingly, she stated that “present staffing levels do not permit us in providing two routine inspections per year” and that only one routine inspection would be carried out for each home in 2004, unless staffing levels were increased.

Nursing Home Inspector H drew the attention of the General Manager CCA8 to staffing difficulties again in letters dated the 30th March and the 13th July, 2004. The second of these letters was sent following the decision to establish a dedicated inspectorate, but before anyone had been appointed to that body. The letter was copied to the head of the Nursing Home Inspectorate and the Assistant Chief Executive of the NAHB. It referred to the need for “urgent and proactive attention” for various reviews of nursing homes in the area arising from complaints and sought appointments to the inspectorate as soon as possible. The Assistant CEO has informed the Commission that she was aware of the shortage of public health nurses and that her office carried out a significant amount of work to recruit new public health nurses.

The Commission asked Nursing Home Inspector H at an oral hearing what impact these staff shortages had on inspections and the response of the Health Board to complaints. She said that the shortages did not have any major impact on routine
inspections, as she was able to rely on very good assistant directors of public health nursing, who took on the extra workload. However, the investigation of some complaints was delayed by a few weeks owing to staff shortages.

From October, 2004, inspections were carried out by the dedicated inspection team.

**Inspection procedures**

**Notice**

Inspections could be carried out with or without notice to the nursing home concerned. Designated officers were furnished with warrant cards, which could be produced at nursing homes to establish their authority to carry out inspections.

In her submission to the Commission Nursing Home Inspector A, who inspected Leas Cross Nursing Home a number of times between 1998 and 2000 stated that routine statutory inspections and spot inspections were always unannounced. In the case of inspections in response to complaints or issues requiring discussion with the matron or the proprietor, Nursing Home Inspector A stated that an appointment was made a few days in advance. This is borne out by submissions received by the Commission from other inspectors.

In contrast to this evidence, the Commission has received correspondence from a nurse who worked at the nursing home for eighteen months up to February, 2000 and who claims that during that period, “… there were no ‘spot checks’ [by the Eastern Health Board] or if there were, it appeared that we were aware they were going to happen.”

The evidence provided to the Commission in this regard gives rise to a conflict such that it is impossible to say for certain whether routine inspections were always unannounced. The preponderance of the evidence in this regard has been received from nursing home inspectors, all of whom state that routine inspections were unannounced. It is noteworthy that neither the 1993 Regulations nor the 1995 Guide addressed this issue. The Commission believes that inspections of nursing homes are most effective where they are unannounced, so that inspectors have an opportunity to see the actual conditions and standards in operation.

**Procedure**

Prior to procedural changes introduced in 2004, nursing home inspections generally lasted for approximately two or three hours. Nursing Home Inspector A has furnished the Commission with the following summary of the usual procedure for a routine inspection:

“I would agree a time and date for the inspection of the nursing home with the Supt PHN or Senior PHN. We would arrive at the nursing home unannounced and look for Matron or the nurse in charge. We always carried our Warrant Cards and identification and would produce them if meeting the nursing home
staff for the first time or if requested. Generally one of us would ask questions and the other would fill in the EHB Nursing Home Inspection Form as we walked around to each bedroom, bathroom, sluice room, day areas, dining room and kitchen. We would check that lights and bells worked in each room; that drinking water was available; that rooms were clean and that hot and cold water was available. Arrangements for linen and sluicing would be checked as well as refuse arrangements. Menus and food storage would be reviewed for nutritional content and variety as well as safe storage. We would document an overall assessment of the nursing home hygiene. Any issues would be mentioned to Matron/Nurse in charge and we expected her to take her own notes of matters requiring attention.

We would stop to chat with residents and explain who we were and that we were here to check on the nursing home. If a resident wished to speak to us privately we would arrange to do that.

If any resident was in bed during our inspection we would enquire whether the patient was bed-bound or just temporarily in bed. For bed-bound patients the Supt or Senior PHN would enquire about the mattress used, and discuss arrangements for the care of pressure areas. The Supt/Senior PHN and I have on occasion examined such bed-bound patients in nursing homes, but I don’t recall whether or not such a situation arose during my inspections of Leas Cross Nursing Home.

Having walked around the nursing home we would return to the office to review resident’s register, numbers of residents and their dependency levels, facilities available to residents (chiropody, physiotherapy etc.). Residents’ contracts of care were checked as well as assessments of subvented patients. Use of incontinence wear and disposal of clinical waste would be reviewed. Arrangements for care of dying patients would be discussed and check that medical officer of health informed within 48 hours of any death.

Staffing levels for nurses and care attendants would be reviewed by the Supt/Senior PHN doing the inspection with me and one of us would document this information. Duty rosters, nurse registration, staff lists would be checked. This information would be documented in summary form on the inspection form.

Patient case record system and drug recording, safe keeping administration arrangements and disposal arrangements would be checked. I would select a number of patient’s medical charts for review on relation to documentation of their diagnoses and medical consultations. I selected medical charts at random or specifically selected the chart of a patient who came to our attention during the inspection because they were in bed or we had chatted to them in relation to their specific needs.

Statutory requirements to display registration, have insurance and comply with fire regulations would be checked. We would also ask that changes in person in charge had been notified within that period.
Any issues would be mentioned to Matron/Nurse in charge and we expected her to take her own notes of matters requiring attention.

The completed EHB Nursing Home Inspection Form was signed by both inspectors and sent to [the] Senior Executive Officer, Acute Hospitals and Services for the Elderly, sometimes accompanied by a letter. Copies of the reports and correspondence sent to [the Senior Executive Officer] were retained for my file and the Supt PHN’s file.”

Documentation:

The Commission has been furnished with copies of the Eastern Health Board nursing home inspection form filled in by the inspectors during the time that Leas Cross was in operation.

The form contains basic information regarding the date and time of the inspection, the names of the nursing home, its proprietor and the person in charge. It requires inspectors to specify the number of rooms of different types in the home (e.g. single and double bedrooms, dining rooms) and the number of persons in residence, stating whether they were ambulatory, wheelchair-bound or bedfast.

The form also asks whether certain documents, including staff details, duty rosters, the current certificate of registration, an up-to-date patients register and fire safety documentation were available for inspection. Inspectors were required to specify the number of trained nursing staff, attendants and domestic staff rostered to be on duty for day and night shifts and the number actually on duty at the time of the inspection.

The inspection form contains a series of questions to be answered either ‘yes’ or ‘no’ by inspectors. The questions addressed a range of issues, including the fitness of the person in charge to carry on the nursing home, record keeping, safety standards, drug administration and recording and hygiene. The form then provides a short section for comments and for the signatures of both inspectors.

On separate pages, the inspectors are required to list each room number and state the number of approved occupants for each room. The form also provides for more detailed information on bedrooms, to be filled in by inspectors only if the details varied from the survey report of the technical services officer.38

The Commission notes that, some time after the establishment of a dedicated Nursing Home Inspectorate in October, 2004, the standard inspection form was replaced by a more detailed form, which provided space for comments in respect of each issue.

38 Such technical reports are made on the application for registration or re-registration of a nursing home. See further Chapters 7 and 8.
Problems with inspection process

In 2005, arising out of concerns regarding the oversight of Leas Cross, the Chief Officer of the HSE Eastern Region commissioned Mr Martin Hynes to review the nursing home inspection process in that region. In an Interim Report dated June, 2005, Mr Hynes made the following comments:

“There is an absence of agreed standards for many of the items on the inspection check list. At least such standards have not been written down. There is too much scope for individual interpretation of what is adequate and appropriate in terms of standards of care needs and other requirements of the legislation. Equally, the entitlements of those in nursing homes have not been made explicit. In other words there is no verifiable device/tool used to measure the quality of care being provided or of how the care provided meets the individual needs of residents.”

In a statement to the Commission one nursing home inspector described the nursing home inspection process in place in 2004 / 2005 as having “major deficiencies”, including the following:

- Staff involved in Nursing Home inspections were covering “many other duties” in addition to their inspection work.
- The Nursing Homes (Care and Welfare) Regulations 1993 were “vague and unspecific.”
- The guidelines provided to inspectors “…did not set out basic clinical standards to be expected in nursing homes and there were few clinical parameters by which nursing homes were to be assessed.”
- Staffing requirements for nursing homes “were not specified.”
- There was “a lack of regulation or clarity” with regard to the role of the inspection team in assessing medical care.
- The level of medical cover necessary in a nursing home was not specified in the Nursing Home Regulations or any HSE guidelines.
- There were no guidelines regarding training for the post of medical officer in a nursing home.

The same inspector also identified what she described as:

“... a major conflict of interest in the Nursing Home Inspection process, namely [that] the HSE section which was responsible for inspecting the homes was also the principal purchaser of beds in these homes. The senior administrators responsible for purchasing nursing home beds in the HSE were also responsible for overseeing the regulation of these homes.”

In relation to the examination of residents, the inspector stated:
“It was not common practice to examine residents during the course of an inspection unless it was deemed necessary to examine a resident for example because of a complaint. We did routinely speak to residents and where possible, their families, to ascertain whether they were being well cared for. However, inspection report forms did not provide much space to address the physical and mental wellbeing of residents. Instead, the forms emphasised issues regarding the infrastructure of the nursing home and the available services.”

The Commission notes that the format of the inspection form generally made provision for “yes / no” responses only, even for complex and important issues such as the adequacy of safety standards and hygiene. Further, the form omitted completely such issues as the dependency levels of residents and whether complaints had been received and dealt with in accordance with the complaints policy of the nursing home.

**Inspection reports**

Having completed an inspection, inspectors then usually prepared an inspection report to be sent to the Nursing Home Section in the Health Board or the HSE. The Guide to the Nursing Home Legislation, referred to above, states that “the registered proprietor should be informed in writing as soon as possible of the outcome of the inspection.”

In a letter to the HSE dated the 12th July, 2005, Mr Aherne states:

> “Furthermore, Leas Cross received NO INSPECTION REPORTS nor any negative verbal feedback from the Northern Area Health Board between October 1999 and April 2005, with one minor exception (report dated 22nd July, 2003).”

Former matron of Leas Cross Ms Grainne Conway also asserts that the nursing home received almost no inspection reports. In a submission to the Commission dated the 1st October, 2008, she states,

> “Please note: on a very rare occasion did I receive inspection reports.”

These assertions are incorrect. Amongst the documentation from Leas Cross furnished by Mr Aherne to the Commission is a folder marked ‘EHB Inspections’. That folder contains copies of inspection reports for inspections on the following dates:

- 24th September, 1998
- 20th November, 1998
- 16th February, 1999
- 18th June, 1999
- 9th July, 1999
- 18th August, 1999
- 15th October, 1999
In most cases, it is indicated on the reports or on attached correspondence that they were copied to the matron and/or the proprietor when they were being submitted by the inspectors to the Nursing Home Section in the Health Board. In addition, it should be noted that the inspection reports note that the matron, or another member of nursing staff, was present at every inspection. In most cases, the matron prepared a memo summarising the matters discussed and noting any action to be taken. The evidence disclosed to the Commission strongly suggests that the management of Leas Cross was informed by the inspectors – both at the time of the inspection and subsequently, in writing – of the issues which the inspectors felt needed to be addressed.

Inspections of Leas Cross Nursing Home, 1998-2004

July 1998

The first routine inspection of Leas Cross after its initial registration took place on the 31st July, 1998. This was the first time that the home was inspected by the Health Board with people in residence. The inspection was carried out by Nursing Home Inspector A and Nursing Home Inspector C.

The Commission has been furnished with a copy of the handwritten inspection form completed by the inspectors on the 31st July, 1998 but has not seen a copy of the inspection report.

The inspection took place at 2.30 p.m. The inspection form records that the person in charge on the day of the inspection was matron Veronica McNamara. At the time of the inspection the home was registered for 31 beds, but there were only six persons in residence, five of whom were ambulatory and one of whom was wheelchair bound. There were two nurses and two care staff on duty at the time of the inspection. Positive responses were entered for each of the questions on the inspection form. A comment was included regarding the storage of certain medication (pethadine) for a named patient and a follow-up note was appended indicating that Nursing Home Inspector A had spoken to the G.P., Doctor A in relation to the issue and that Doctor A had agreed to store the medication himself.

The Commission has also been furnished with a copy of the memo of the inspection prepared by the matron, Veronica McNamara. The matron’s memo is consistent with the inspection form and sets out in more detail some of the issues examined by the inspectors. The memo states that one section of the residents’ contract of care, regarding summary termination, was to be reviewed by the inspectors.

The inspection form completed by the inspectors concluded as follows:
February 1999

Leas Cross was inspected on the 16th February, 1999, again by Nursing Home Inspectors A and C. The same inspectors had visited the home on the 15th January, 1999 in connection with an application to register an additional seven beds. At that time, they found that Leas Cross was not in compliance with recommended staffing levels, although an anticipated need for extra staff to care for a highly dependent resident had not materialised, as the resident did not require to expected level of observation. The inspectors also found that Mr Aherne had furnished incorrect information to the Health Board in relation to staffing. The certificate of registration was formally amended to reflect the increase in beds on the 16th February, 1999: the same day as the routine inspection took place.

The inspection took place at 10.15 a.m. and the inspectors were accompanied by the Co-ordinator of Services for the Elderly for Community Care Area 7. The person in charge was the matron Mary Chance. The inspection form shows that there were twenty people in residence on the day of the inspection, fifteen of whom were ambulatory, four of whom were wheelchair bound and one of whom was bedfast. There were two nurses, including the matron, and three care attendants on duty when the inspectors visited.

The inspectors concluded that the residents appeared well cared for, but they raised a number of concerns regarding hygiene and drug recording arrangements. They were concerned about the storage and preparation of raw meat and stated that the matter had been referred to the appropriate Environmental Health Officer. In relation to drug recording, the inspectors stated that it was unclear “whether the doctor’s signature refers to patient’s commencement of medications or the discontinuation of medication”. The inspectors advised the matron regarding changes to the charts and also gave advice regarding the administration of medicines from the drugs trolley. They also noted that a number of bulbs were missing from lights over beds and recommended the installation of towel rails in shared rooms.

The same issues were referred to in the matron’s memo of the inspection. The memo sets out in more detail the matters discussed regarding drug recording and administration.

The matron’s memo also reveals that the inspectors addressed certain issues which were omitted from the inspectors’ own report, including laundry, disposal of incontinence wear and an issue regarding a resident smoking in corridors. The omission of these matters from the inspectors’ report meant that the next inspectors to visit the home would be unaware that those issues had been discussed. However, Nursing Home Inspector A has pointed out to the Commission that these matters on

“All residents appeared well cared for and content. Items which were to be completed to bring all aspects of the nursing home up to standard have been completed.”

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39 See further Chapter 7.
which the inspectors offered advice to the matron did not concern compliance with the Nursing Homes Regulations. In addition, Nursing Home Inspector C has indicated to the Commission that she carried out the following inspection and was aware of any issues requiring follow up.

In addition to the matters referred to above, the inspection report also stated that the inspectors discussed recruitment procedures with the matron and emphasised the importance of obtaining written references for all employees, including a reference from the most recent employer, before they take up duty. The Commission has also been furnished with Nursing Home Inspector A’s notes from the inspection. They reveal that, while reviewing staff lists, the inspectors noticed a new care attendant, who was known to them as having been involved in an “incident” in another nursing home. The note concluded as follows:

“From our discussion after the inspection [Nursing Home Inspector C] and I have concerns that this C.A. has been employed to go on night duty without obtaining a reference from her previous employer – the matron in [her previous nursing home]. A number of other staff have also been employed to go directly to night duty. Hopefully matron takes the comments on board.”

The documents available to the Commission do not indicate the nature of the incident in which the care attendant in question was previously involved. It is clear that the inspectors were concerned about this particular care attendant and about the recruitment of staff generally. The Commission notes that this was not addressed in detail in the inspection report submitted by the inspectors and that Nursing Home Inspector A concluded in her own notes merely that she “hoped” the matron would take their comments on board. The Commission considers that recruitment of appropriate staff is a critical element of operating a nursing home and is surprised at the inspectors’ understated response to what they clearly perceived to be a problem.

In response to this, Ms Chance has informed the Commission that it was her practice to interview prospective staff members and to check their references either by telephone or in writing. As noted elsewhere in this report, the staff files furnished to the Commission by the former proprietors of the nursing home provide very little detail regarding the recruitment and qualifications of staff. As such, it is impossible for the Commission definitively to assess staff recruitment procedures at the nursing home.

April 1999

Nursing Home Inspectors A and C visited Leas Cross on the 21st April, 1999 at 9.30 p.m. This was not a routine statutory inspection, but was carried out for the purpose of ensuring compliance with issues raised on previous occasions. According to Nursing Home Inspector A’s statement to the Commission, the visit was unannounced. Nursing Home Inspector C reported the visit to Senior Executive Officer A in a letter dated the 23rd April, 1999:

“Our primary functions in visiting [were] to ensure the staff complement as agreed was being implemented, that medications were being administered by
a Registered General Nurse and that residents were receiving appropriate care.

There were 28 residents. Staff Nurse ... was on duty and administering medicines. Three care attendants were on duty as agreed and residents were receiving appropriate care.”

Despite the positive comments in the report to Senior Executive Officer A, Nursing Home Inspector A’s handwritten notes do record two other matters. In one bedroom, the inspectors found a resident’s medication on the windowsill and advised that they should be stored safely. In another room they encountered a “confused” and “agitated” patient, who had a tablet in his or her mouth. The nurse told the inspectors that no medicine had yet been given to the patient. The Commission notes that these incidents were not recorded in the inspectors’ report to Senior Executive Officer A and that inspectors on subsequent occasions might not, therefore, have been aware of their occurrence.

June 1999

Nursing Home Inspectors A and C visited the nursing home by appointment on the 18th June, 1999. This was not a formal inspection, but was principally for the purpose of discussing the resignation of the matron, Ms Mary Chance. They also discussed an incident between a care attendant and a resident.

In their report on the visit to Senior Executive Officer A, dated the 20th June, 1999, the inspectors stated that they reviewed staff rosters during their visit and found that there were frequently only two care attendants on duty between 6 p.m. and 8 a.m. They advised the matron that a minimum of three care attendants were required at all times, as previously advised on the 15th January, 1999.

July 1999

The next routine statutory inspection of Leas Cross was carried out by Nursing Home Inspectors A and C on the 9th July, 1999 at 10.20 a.m. The inspection form records that the person in charge on the day of the inspection was Ms Grainne Conway. There were 31 residents: 24 ambulatory, six wheelchair bound and one bedfast. The matron and one other nurse were on duty at the time of the inspection, together with three care assistants.

The inspection form indicated the inspectors’ dissatisfaction with hygiene and food storage and with drug recording arrangements. It also stated that the sluice was blocked and needed to be fixed.

An inspection report was sent to Senior Executive Officer A on the 12th July, 1999. In relation to staffing, the inspectors stated:

“We were particularly interested in reviewing the staffing arrangements following our findings at a visit on 18th June and as reported in our letter of 20th June.”
We found, at this visit on 9/07/99 that the staffing arrangements met our minimum recommended levels and we discussed with the new matron Ms Grainne Conway the need to ensure that staffing levels are always sufficient to meet the needs of the residents.”

The inspection report reflected the inspection form in referring to two major problems. First, the drug recording system was unsatisfactory in that the chart used for some patients had no space for a doctor’s signature, while in others the doctor had not signed at all or had given one signature for multiple drug orders. In her handwritten notes of the inspection, furnished to the Commission by the H.S.E., Nursing Home Inspector A wrote, “Almost all the drug charts had some problem or other.” This was pointed out to the matron, who agreed to contact the doctor and rectify the drug charts as a matter of urgency.

Secondly, the inspectors found problems with food storage in the kitchen. They were informed by staff that an environmental health officer had visited the premises and again notified the principal environmental health officer of their concerns.

The inspectors also noted that there were two residents using walking frames who experienced difficulties using toilets where they were resident in the new wing of the home, which had been registered on the 16th February, 1999. The inspectors pointed out that their recommendation for registration of the new wing, dated the 15th January, 1999, had drawn attention to the fact that certain residents would have difficulty accessing the toilet facilities. They stated that they had discussed the restriction with the previous matron, Mary Chance, on a previous visit and raised the issue with Grainne Conway on this visit.

Ms Chance has informed the Commission that she did not allow the new wing to be used to accommodate residents using walking frames who might encounter difficulties using the toilets in that area. She states that her notes and records regarding the operation of the nursing home were made available to her successor when Ms Chance left Leas Cross Nursing Home.

The matron’s minutes of the inspection do not refer to the issue of food safety or the restrictions on the use of toilet facilities by immobile residents. However, they do set out in more detail what was discussed regarding staffing:

“Inspectors informed of difficulty in getting RGNs [i.e. Registered General Nurses] and lack of same with the nursing agencies. Twilight care attendant can be used if short of care attendant on night duty. I requested details of the legislation on staffing in Nursing Homes. The inspectors informed me there was nothing in it referring to staffing numbers and they themselves give the recommended staffing numbers.”

The Commission notes that similar issues, namely food hygiene and drugs recording were raised by the inspectors at the previous routine inspection. Also, although staffing was found to be adequate on this visit, it clearly remained a matter of concern and it is surprising to note that the matron was not aware of the basis on which appropriate staffing levels were fixed. Given the emerging pattern regarding staffing, the Commission is concerned that the matron may have placed undue emphasis on the
fact that the nursing home legislation did not expressly prescribe specific staffing levels. Article 10.5(d) of the Nursing Homes (Care and Welfare) Regulations 1993 places responsibility on the person in charge of a nursing home to ensure that “a sufficient number of competent staff are on duty at all times having regard to the number of persons maintained therein and the nature and extent of their dependency”.

August 1999

Nursing Home Inspectors A and C carried out an “unannounced spot check” at Leas Cross at 2.40 p.m. on the 18th August, 1999. They were accompanied by the area medical officer, who attended as an observer for training purposes. This was not a routine inspection and no inspection form was filled in by the inspectors. The Commission has been furnished with Nursing Home Inspector A’s notes of the meeting, together with a letter to Senior Executive Officer A dated the 19th August containing a report of the visit.

The inspectors noted a number of problems but also found that some problems from the previous inspection had been resolved. The principal issue of concern on this visit was staffing levels. This was addressed in the inspectors’ report, copies of which were sent to Ms Conway and Mr Aherne, as follows:

“The most important issue is the level of staffing. We expressed our dissatisfaction with care attendant staffing levels on our visit on 18th June and subsequently noted at our visit on 9/07/99 that staffing arrangements then met our minimum recommended levels. At that visit we advised the new matron Ms Conway that she needed to ensure that staffing levels are always sufficient to meet the needs of residents. It is therefore with great concern that we note the staffing levels over a 24 hour period are falling seriously below the minimum levels we have repeatedly recommended in that there are only 2 care attendants on duty from 11.00 p.m. to 8.00 a.m. and a second nurse is not rostered for 8.00 a.m. to 1.00 p.m. when matron is off duty.

We welcome the increase in care attendant staff during the day to 4 or 5 as occupancy of the nursing home has increased considerably since we originally set the minimum staffing levels and we recommend this new level of staffing is continued and increased appropriately as matron considers necessary reflecting dependency of residents.”

The inspectors went on in their letter to restate the minimum staffing levels previously advised to the nursing home. They stated that they referred the matron to the relevant sections of the 1993 regulations regarding adequacy of staffing and pointed out that it is an offence under section 6(3)(a) of the Health (Nursing Homes) Act 1990 to contravene the regulations.

The inspectors also documented other findings from the spot inspection, including a smell of urine in two bedrooms. They noted that the sluice had been cleared, that

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40 See also Guide to the Nursing Home Legislation (Department of Health, 1995) at para. 3.5.
food storage had improved and that only mobile residents were housed in the new wing as previously recommended.

October 1999

Another unannounced spot inspection was carried out by Nursing Home Inspectors A and C on the 15th October, 1999 at 10 a.m. Again, this was not a routine statutory inspection.

In their report to Senior Executive Officer A dated the same day as the inspection, the inspectors say that they reviewed the staff rosters for nursing and care attendants and found them satisfactory. One extra RGN (registered general nurse) was rostered at all times and another extra RGN when the matron was off-duty. There were five care attendants scheduled for duty in the morning, four in the afternoon and three at night. The other items identified on the previous visit had also been attended to.

The inspectors concluded that they “found staffing levels and the care and welfare of residents in the nursing home to be quite satisfactory”.

February 2000

The next routine statutory inspection occurred on the 15th February, 2000 at 2.20 p.m. It was carried out by Nursing Home Inspectors A and D. The Commission has not been furnished with the inspection report but has seen a copy of the inspection form.

There were 36 residents in the home on the date of the inspection. Of those, 24 were ambulatory, 12 wheelchair bound and none were bedfast. There were two nurses and four care attendants on duty. The following comments were included on the inspection form:

“All residents appeared comfortable and well cared for.

We requested that policies on drug administration, physical and chemical restraint be developed over the next few months. ... 

There seems to have been some difficulty adhering to our recommendations that 2 nurses are on duty in the a.m. due to staffing shortages and we reiterated the importance of this staffing level. We are pleased to note that care attendant staffing levels have increased as the nursing home approaches full occupancy and reflecting dependency levels.”

The matron’s memo of the inspection, furnished to the Commission by Mr and Mrs Aherne, addresses these issues as follows:

“Policy to be done on medication administration and physical and chemical restraint.”
There is some conflict on the evidence received by the Commission regarding the existence of policies for drug administration and chemical and physical restraint. In a letter to the Commission dated the 11th September, 2008, Ms Conway states that such policies were in place at the time of the inspection on the 15th February, 2000. By contrast, in her submission to the Commission, Nursing Home Inspector D states that the matron was requested to develop such policies at that inspection. Nursing Home Inspector D states, “There was no specific issue in relation to physical and chemical restraint other than the absence of a policy document ...” This is consistent with the matron’s own memo of the inspection.

October 2000

A routine inspection was carried out on the 16th October, 2000, at 2 p.m. by Nursing Home Inspectors C and D. The Commission has not been furnished with the inspection report but has seen a copy of the inspection form. The form records that there were 35 residents: 27 ambulatory and 8 wheelchair bound. There were two nurses and four care attendants on duty at the time of the inspection.

There are no negative comments on the form and it concludes that all residents appeared well cared for.

March 2001

A further routine inspection was carried out on the 25th March, 2001 at 2.30 p.m. by Nursing Home Inspector C and Nursing Home Inspector L. Again, the Commission has not been furnished with the inspection report but has seen a copy of the inspection form. There were 32 residents in the home at the time of the inspection: 24 ambulatory and eight wheelchair bound. Two nurses and four care attendants were on duty.

The form reveals no problems and states that all residents appeared well cared for.

June 2001

Another inspection took place on the 18th June, 2001 at 1.30 p.m. It was carried out by Nursing Home Inspectors C and F. This inspection appears to have been for the purpose of determining an application for re-registration.41 However, it also seems to have served as the second routine inspection in 2001. Again, the Commission has not been furnished with the inspection report but has seen a copy of the inspection form.

41 See chapter 8.
There were 36 people in residence (25 ambulatory, eight wheelchair bound and two bedfast) and two nurses and five care attendants on duty on the date of the inspection.

The form was positive in its findings and the inspectors stated that all residents appeared well cared for.

May 2002

The next routine inspection took place at 11.30 a.m. on the 20th May, 2002. The Commission notes that this inspection took place eleven months after the previous one. This was in contravention of article 24 of the Nursing Homes (Care and Welfare) Regulations 1993, which provides that inspections shall be made “not less than once in every period of six months”.

The inspection was carried out by Nursing Home Inspectors E and D. The inspection form states that there were 35 persons in residence, of whom 24 were ambulatory and 11 were wheelchair bound. The form includes the following comments:

“Basic cleanliness of nursing home discussed – contract cleaners employed. Advised that an improvement is required. Advised re storage of drugs. Patients appear well catered for.”

These comments have been explained to the Commission by Nursing Home Inspector E in her submission as follows:

“During this visit, [Nursing Home Inspector D] and I identified unclean floors in a number of areas, i.e. sticky floors as a result of spillages and a stale odour in some of the bedrooms. On enquiry into this matter, Ms Conway informed us that the proprietor had recently changed from in-house domestic staff to contract cleaners. Ms Conway admitted that this change was proving to be unsatisfactory and I informed Ms Conway that such uncleanliness was unacceptable and that corrective action was required. Ms Conway agreed to discuss this with the proprietor and I indicated that this would be entered in our report.

On passing the Nurses’ Station downstairs, both I and [Nursing Home Inspector D] noted that a controlled drug (also referred to as a DDA) was sitting on top of the desk with no nurse present. On enquiry into the reason for the unattended presence of this drug, Ms Conway informed us that the drug had been prescribed for a recently deceased resident and that it had been taken out of the drugs cabinet in order to be returned to the pharmacy for disposal, as was the practice with unused drugs in the nursing home. I reminded Ms Conway of care required with such drugs as stipulated in the Misuse of Drugs Act and the Code of Practice in relation to Medication Management (An Bord Altranais). I reiterated the importance of correct storage and record keeping in relation to these dangerous drugs and indicated that the incident would be noted in my inspection report.”
The Commission asked Ms Conway to comment on the issues raised in the inspection form. In relation to drug storage, Ms Conway stated that drugs were stored in a drug cupboard and drug trolley and that, following the inspection on the 20th May, 2002, “a blister pack system was put in place”. The Commission finds it difficult to understand how a blister pack system would address the problem of controlled drugs being left unattended.

In relation to cleanliness, Ms Conway stated:

“Basic hygiene / cleanliness faults could be an odour in a bedroom. Hygiene was always very good in the nursing home.”

This is not entirely borne out by the inspection reports. Issues of hygiene and/or cleanliness were raised on a number of occasions by the inspectors, although not always during Ms Conway’s time as matron. On such occasions, the issues varied from the unsafe storage of food to odours in bedrooms.

**November 2002**

Leas Cross was inspected by Nursing Home Inspectors E and G on the 20th November, 2002 at 2.15 p.m. The routine inspection on this date coincided with an inspection for the purpose of determining an application to register an additional 73 beds at the nursing home. The Commission has been furnished with both the inspection form and a report dated the 22nd November, 2002 to the General Manager, CCA8 on the Northern Area Health Board. The report deals only with the issue of registration and does not address the routine inspection, but the Commission has been informed that a copy of the form would routinely be sent together with the report.

The inspection form states that there were 36 residents in the home: 22 ambulatory and 12 wheelchair bound. Two nurses and seven care attendants were on duty. The inspectors commented that it was an “overall satisfactory inspection” and that all residents appeared well cared for. They stated that hygiene had “improved greatly”.

However, the inspectors also stated that drug prescribing was discussed with the matron and that she was advised to ensure that the G.P. signed and dated all prescriptions. In her submission to the Commission, Nursing Home Inspector E points out that this was required by An Bord Altranais guidelines on medication management by nurses for all prescription medications delivered to a patient by a nurse.

**July 2003**

A routine inspection took place on the 9th July, 2003 at 11 a.m. It was carried out by Nursing Home Inspectors H and G. The acting person in charge on the day was Ms Maria Ryan. The inspection form records that there were 60 residents on the date of

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42 See further Chapter 8.
the inspection. 34 of these were ambulatory, 24 were wheelchair bound and two were bedfast. There were three nurses and five care attendants on duty.

The inspection was not completed owing to the unavailability of relevant information. On the 22nd July, 2003, Nursing Home Inspector H wrote to the matron, Ms Conway, and the proprietor, Mr Aherne, in the following terms:

“I refer to the inspection carried out on the 9th July, 2003 by myself and [Nursing Home Inspector G]. We were accompanied by Ms Maria Ryan, [Acting] Dir. Of Nursing. Ms Ryan was very helpful on the day of inspection but we were unable to complete the inspection due to difficulties accessing information.

We also identified a no. of potentially serious areas of concern. These include:

- Date of most recent fire inspection not available
- Contracts of care not in place for inspection
- D.D.A.s [i.e. controlled drugs] not accounted for
- Incident reported by staff in nursing home
- P.I.N. nos. for qualifies R.G.N.s
- Subvented patient list”

Ms Conway replied on the 15th August, 2003 enclosing the requested P.I.N.s and the subvention list. She stated that inspection reports and contracts of care were available for inspection in her office and that the certificate for the most recent fire inspection was on display at the nurses station in the home. In relation to the unaccounted drugs, the matron explained that they had been supplied for a particular patient, who was being treated for a terminal illness: “These should have been recorded in our controlled book, but somehow got overlooked.”

The Commission asked Ms Conway to explain why the relevant documentation was not available for inspection on the 9th July, 2003. In her response, she explained that she had been on holiday and the items were in a locked press: “Mr Aherne had the key and the inspection team would not wait for him to come to the home.” In response, Nursing Home Inspector H has stated that the inspectors were “not offered the facility” to wait for Mr Aherne.

Nursing Home Inspector H refers to this inspection in a submission to the Commission, stating that Nursing Home Inspector G followed up the outstanding issues. This is also stated by Nursing Home Inspector G in her submission to the Commission. In relation to the controlled drugs, Nursing Home Inspector G states that, as far as she can recall, the matron submitted a report to Nursing Home Inspector H and that they worked together to put in place a procedure regarding the safe administration of drugs. In fact, Nursing Home Inspector H has informed the Commission that that the matron did not report to her, but that the matron’s assurances that the issue would be addressed were accepted by the inspectors.

The Commission notes that Leas Cross was not visited again until the next routine inspection on the 17th November, 2003. This is in spite of the fact that the inspection on the 9th July, 2003 was incomplete and that no conclusions were provided on the inspection form regarding the state of the home or the wellbeing of the residents.
Given the fact that concerns regarding the storage, recording and administration of drugs had been raised on a number of previous occasions, it is surprising that this particular issue was not followed up by the inspectors immediately. It is also noteworthy that important documentation was not available to the acting director of nursing while the matron was on holiday and that it took the matron almost a month to respond to the inspectors’ letter.

November 2003

Nursing Home Inspectors H and G carried out another routine inspection on the 17th November, 2003 at 3.30 p.m. There were 93 residents in the home on the day of the inspection, of whom 62 were ambulatory, 29 were wheelchair bound and two were bedfast. There were two nurses, together with the matron and sixteen care attendants on duty.

In a submission to the Commission, Nursing Home Inspector H states that she recalls “being struck by the relatively fast increase in resident numbers in such a short space of time. Ms Conway explained to us that some of the residents had been transferred from St Ita’s since our last inspection.” The increase in numbers did give rise to staffing concerns, according to Nursing Home Inspector H’s submission. These concerns related, not to the overall numbers of staff employed, but to the skill levels of those staff, as Nursing Home Inspector H explains:

“Given the increased number of residents, I considered the staff/resident ratio and concluded that it was within the appropriate range. However, I noted that while care attendant numbers had increased significantly (to 41) since our last visit, the RGN numbers had not increased (10). So while the total number of staff to residents may have been acceptable I felt there might have been an imbalance of skill mix even though 62 of the residents were mobile. In order to confirm this, however, I would have had to measure the dependency levels of the residents at that time using a formal dependency tool.

However, I did discuss with Ms Conway that, in my view, the skill mix may be imbalanced and I impressed upon her the need to have enough nursing expertise. Ms Conway reassured us that she had a number (3 was my understanding) of international RGNs in orientation and that they would be on duty fairly quickly (a few weeks was my understanding) although I don’t recall the exact date they were intending to take up post. Induction for nurses coming from another country usually takes 6 weeks. We advised her to employ agency nurses in the interim, if required. There was no reason for us not to accept that Ms Conway would increase the skilled staff numbers as we had requested.”

Ms Conway has informed the Commission that she does not agree with this version of events. This issue is addressed in Chapter 11.

The inspection form records that three items were to be “reviewed”: overall basic hygiene, one PIN number and contracts of care. In relation to the last of these, the form records that only 76 contracts of care were available for the 93 residents. The
issue of hygiene was addressed by Nursing Home Inspector G in her submission to the Commission:

“As far as I can recall overall basic hygiene was highlighted because there was a smell of urine in some areas of the nursing home, the issues that arose were, as far as I can recall, (1) how waste (incontinent wear) was disposed of and (2) the cleaning arrangements in the nursing home and the time of day that cleaning was being carried out. As far as I can recall hygiene at the nursing home was satisfactory by the time of the following inspection on the 2nd June, 2004 …”

In relation to the same issue, Nursing Home Inspector H has informed the Commission that they could not identify any reason for the smell of urine other than the fact that, according to the matron, some residents had been changed prior to the inspection. Nursing Home Inspector H states that “it was reasonable to note it and check again on the next visit”. She says that the notes on the inspection form were essentially reminders for inspectors at the next inspection and that the most important of these was to review overall basic hygiene:

“Although I accepted Ms Conway’s explanation for the cause of the smell of urine, I wanted the inspectors at the next visit to make sure that there was no repeat of the smell and to ensure that hygiene standards generally were adequate.”

December 2003

The Commission has been furnished with a handwritten note referring to a visit to the nursing home on the 22nd December, 2003. Nursing Home Inspector H has informed the Commission that the visit was not planned and was not a formal inspection. It was arranged at short notice at the request of the Head of Quality at the Corporate Governance Department of the Health Board, who wished to visit the nursing home and to meet with the matron.43

The handwritten note states that the visit was notified to the nursing home at 11 a.m. and took place at 2.10 p.m. It records that the nursing home was “much cleaner – no smell” and that there were “visibly more staff in place”. The note concludes by stating that an appointment was made for another visit on the 7th January, 2004, on which date the inspectors would “bring own assessment tools”. However, Nursing Home Inspector H has informed the Commission that that planned visit was cancelled, owing to the illness of one of the people involved. The visit ultimately took place on the 12th January, 2004.

June 2004

Leas Cross was again inspected on the 2nd June, 2004 by Nursing Home Inspectors H and G. It appears that the routine inspection coincided with an inspection for the

43 See further Chapter 15.
purpose of re-registration. There were 96 people in residence at the time of the inspection: 60 ambulatory, 34 wheelchair bound and two bedfast. Three nurses and the matron, together with 10 care attendants were on duty.

Aside from the issues relating to registration, the form records that P.I.N.’s for registered general nurses were unavailable for inspection and that a small number of repairs were given to the matron to be attended to. These are referred to in the matron’s memo of the inspection.

Although the issue is not referred to in the inspection form, the Commission has been told that concerns regarding staffing were raised again at this inspection. This is set out in Nursing Home Inspector H’s submission to the Commission dated the 25th September, 2008:

“One area of concern that I did have on the day related to the issue of staffing. I recall that I discussed this issue again in detail with Ms Grainne Conway. I noted that the home now had 96 residents. At the end of the inspection, I noted that two patients were bed bound and 34 were wheelchair bound.

I discussed the staffing levels with Ms Conway because the numbers of RGNs (10) still had not increased since the previous two inspections. In particular, I noted that in November 2003, Ms Conway had informed me that three new RGNs were in orientation but that on this inspection, there was no increase in the number of RGNs. I asked Ms Conway about this and she explained that since November 2003, three nurses had left the home but that she had recruited three new care attendants. I told Ms Conway again that it would be necessary to employ three new RGNs. Ms Conway said that she considered that Leas Cross was managing well and noted that she had again increased her care attendant numbers (three). We requested that she employ agency nurses to support permanent staff while waiting for new staff to be taken on. She again agreed to do this.

I took a copy of the roster so I would have a benchmark for the next inspection because my plan at that stage was to carry out a measurement of the dependency ratio to enable me to formally confirm the staffing requirements for the home using a research-based tool rather than the historic measurement tool which was being applied by Ms Conway. By way of explanation, historic measurements only measure staff/resident ratio and does not measure skill mix. Therefore, while Ms Conway’s staff numbers were adequate, in my view the skill mix was not adequate. I put my views in this regard to Ms Conway but, as I have said above, she disputed it because she felt that the home was managing well. Without a measurement of patient dependency, it was not possible to certain whether the home had an adequate number of trained staff.”

Nursing Home Inspector H’s submission goes on to explain that she engaged in some research as to the appropriate tool to assess dependency at Leas Cross. She states that she was aware that “it takes up to six months to get clear, valid and reliable data in relation to the dependency levels”. She eventually met Ms Conway on the 5th July,
2004, accompanied by Nursing Home Inspector G, to show her how to use the tool that had been selected. She states that they also spent some time with Ms Conway’s replacement as matron, Ms Denise Cogley, in March, 2005 showing her how to use the tool.

**August 2004**

According to the submission from the Head of Quality at the Department of Corporate Governance, owing to a shortage of staff, no further formal inspection occurred in 2004. However, Nursing Home Inspector H has informed the Commission that a meeting was held at Leas Cross on the 4th August, 2004. Ms Conway and Mr and Mrs Aherne met with Nursing Home Inspector H, and the Head of Quality at the Department of Corporate Governance. The latter attended the meeting on behalf of his line manager, the Assistant CEO with responsibility for Corporate Governance. The matron’s diary at Leas Cross confirms that the meeting took place but provides no further details.

In her submission to the Commission dated the 25th September, 2008, Nursing Home Inspector H explains the reason for the meeting as follows:

“Although there was no concrete evidence of poor care or poor management, I had a general feeling of concern in relation to Leas Cross, although it certainly was not the worst nursing home I had seen by any means. Because of my general feeling of concern, I arranged a meeting to take place on the 4th August, 2004 ... The purpose of this meeting was to intervene early with a view to getting the home back on track. As outlined above, there were by that time indicators that the level of care could diminish – i.e. the high patient numbers and poor skill mix ratio, together with the outcome of complaints ...”

A number of general issues had arisen in investigating a complaint in relation to the home by the family of a resident, Catherine Mullins. The issues outlined in that complaint were used as the basis for the agenda of the meeting on the 4th August, 2004. In relation to staffing, the appointment of three additional RGNs together with an assistant director of nursing was recommended.

Other issues discussed at the meeting included care planning, which the matron agreed to follow up. The dependency tool referred to above was also discussed and Ms Conway agreed to use the tool. The remaining issues discussed related to the previous complaint.

On the 8th November, 2004, three months after the meeting of the 4th August, Ms Denise Cogley commenced employment at Leas Cross Nursing Home in the role of assistant director of nursing.

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44 See further Chapter 15.
Inspections by Nursing Home Inspectorate, 2005

Concern about the efficacy of nursing home inspections in the Northern Area Health Board led to the creation of a dedicated Nursing Home Inspection Team. The team began work in October 2004.

April 2005

It was the policy of the new team to arrange the first inspection with the nursing home, so that new inspections procedures could be discussed. Thereafter, it was intended that routine inspections would be unannounced. It was also the policy of the new team that homes with more than 50 residents would receive inspections lasting two days. The first inspection of Leas Cross by the new nursing home inspection team took place on the 7th and 8th April, 2005 and was arranged in advance.

The inspection was carried out by the newly appointed head of the Inspectorate, along with the area medical officer and Nursing Home Inspector J. The Commission has been furnished with the inspection form, the inspection report dated the 11th April, 2005 and the handwritten notes of two of the inspectors.

Nursing Home Inspector H joined the inspection team on the 8th April at a meeting with Mr Aherne. The acting matron at the time, Ms Denise Cogley, has told the Commission that she was expressly asked not to attend this meeting.

Dependency

At the time of the inspection, there were 96 people in residence and three nurses, the matron and nineteen care attendants on duty. The inspection report referred to the dependency tool provided to the nursing home, on the basis of which the matron had determined the following dependencies:

- Low dependency: 8 residents
- Medium dependency: 31 residents
- High dependency: 42 residents
- Maximum dependency: 12 residents

By this estimation, more than half of the residents at Leas Cross at that time were of high or maximum dependency.

In his submission to the Commission of October, 2008, the head of the Nursing Home Inspectorate recalls that when he and his inspection team visited Leas Cross on the 7th April 2005, the matron had not yet put the dependency tool into operation. The matron’s assessment of dependency levels, using the tool, was carried out while the two-day inspection was in progress.
Staffing

The inspection report raised a number of issues. In relation to staffing, the report states that the home employed a total of twelve nurses and 45 care assistants at that time. The inspectors sought the engagement of additional staff:

“In view of the complexity and dependency levels of the current residents we requested and gained the approval of proprietor for the immediate employment of 3 staff nurses as an interim measure to support essential nursing care. However in order to optimise standards of care and based on the current dependencies of residents a senior nursing structure i.e. 2 clinical nurse managers grade 2 and one clinical nurse manager grade 3 are appointed (sic) as planned by the nursing home management.”

In a response dated the 24th September, 2008 to questions from the Commission on this issue, Ms Denise Cogley stated that she made it a precondition to the proprietor of the nursing home, in accepting the role of matron, that staffing levels would increase. The head of the Nursing Home Inspectorate has informed the Commission that Ms Cogley did not discuss this with the inspectorate.

Medical care

The inspectors also noted their concern that medical care was provided by one G.P. for potentially 111 residents. They asked the proprietor to “engage with the G.P. to ascertain if this level of input meets current residents needs”. In her response to the O’Neill report the Area Medical Officer stated that this issue was raised by her and that the proprietor of the home undertook to respond within two weeks. The Area Medical Officer states that the proprietor was in a position to provide details the extent of medical care provided by the G.P. on the occasion of the next inspection, on the 6th May, 2005.

A meeting between the G.P., Doctor B, and the Area Medical Officer was mooted but did not take place. Doctor B has informed the Commission that “no meeting between me and [the Area Medical Officer] was arranged and if any meeting was planned, no further arrangements were made with me.”

The issue of G.P. cover was also of concern to the Senior Area Medical Officer at Community Services in the H.S.E. Northern Area, who apparently saw the inspection report. She wrote to the head of the Nursing Home Inspectorate on the 20th April, 2005 in relation to G.P. services. She noted the reference in the report to the fact that medical care at Leas Cross was provided by one G.P. for all of the residents and pointed out that, under the Nursing Homes (Care and Welfare) Regulations 1993, residents were entitled to medical care by a practitioner “of the person’s choice or acceptable to the person”. She asked the head of the Nursing Home Inspectorate to clarify that this was the position in Leas Cross and elsewhere. The head of the Nursing Home Inspectorate has informed the Commission that he discussed the issue with the Senior Area Medical Officer and explained that it was not unusual for one G.P. to service the needs of residents in a nursing home, as their own G.P.s may not be able to provide that care once they have moved to the nursing home.
In relation to this issue, the Commission notes that in a letter to the proprietor of Leas Cross dated the 17th November 2003, Doctor B described the arrangements for G.P. cover at the home as follows:

“...patients who are permanently resident at Leas Cross Nursing Home, whose current general practitioner does not attend them at the nursing home, will arrange transfer to my GMS list. Where a patient or their family specifically requests that their own doctor attend them at the nursing home, this request will, of course, be respected. The nursing home staff will then be instructed to call that designated doctor to attend their patient when necessary.”

Other issues raised by the inspectors

The inspection report arising from the inspection of the 7th / 8th April 2005 states that “communication / continuity of care” emerged as a “significant deficit” in the home. The issue was highlighted by the matron Denise Cogley, who had formed nursing teams and arranged weekly staff meetings and in-house training for care assistants by staff nurses. The inspectors recommended involving medical or psychiatric services in team meetings for complex cases. They acknowledged that the matron had been in place for only two weeks and were “encouraged by her pro-active approach” to this issue.

The inspectors reviewed a sample of residents’ records and concluded that “a complete review of records needs to be undertaken immediately”. Particular reference was made to the need to rewrite drug records at least every six months, when reviewed by the G.P. and the need to maintain written records of nursing signatures and initials. Accurate recording of a number of care issues was required, namely fluid balance charts, wound and pressure sore prevention and treatment and residents’ nutritional status including weight. The inspectors acknowledged the matron’s plans to develop care plans. The inspectors also recommended the development of care policies for issues such as pressure sore prevention and treatment, continence promotion, promotion of optimum nutrition and fluid intake and care of dementia residents.

Various other matters were noted in the inspection report, including the need to repair a bath and to ensure that all residents had contracts of care. The inspectors acknowledged the willingness of the matron and staff to work on the issues outlined above and welcomed initiatives already introduced.

The Commission sought information from the matron, Denise Cogley as to how the nursing home responded to the issues arising from the inspection in April 2005. Ms Cogley provided the Commission with a submission dated the 24th September, 2008. In relation to staffing, the submission states that she made it a precondition of taking the role of director of nursing that staffing would increase.

Ms Cogley acknowledges that the medical notes examined by the HSE, which related to recently ill patients, were disorderly and states that she implemented a review of
this documentation, which met with the inspectors’ approval on their next visit. Regarding the need for recording matters such as fluid balance and pressure sore prevention, Ms Cogley states that she had already commenced implementing these steps and brought them to the attention of the inspectors, who included them in their list of recommendations.

Ms Cogley states that care policies were already in existence, but that following findings regarding the death of a former resident, she agreed to develop more comprehensive policies for pressure sore prevention and wound management. She states that this was implemented in May, 2005.

Request to limit admissions

Although not reflected in the inspection report, a decision was made by the inspection team to request Leas Cross not to admit patients for a period of four weeks after the 8th April, 2005. This is referred to by both the Area Medical Officer and Nursing Home Inspector H in statements disclosed to the Commission, dating from 2006. However, the Area Medical Officer goes on to state that “it was absolutely clear to me that any decision that could effect further changes to Leas Cross or closure of the unit would require more senior administrative action”. In his submission to the Commission the head of the Nursing Home Inspectorate explains the decision to request a temporary cap on admissions to the home as follows:

“Although I can’t remember the full details of what was discussed with Mr Aherne and the Director of Nursing [on the 8th April, 2005], I do remember that I and my colleagues were very concerned about a number of issues in relation to the home namely, there was a new director of nursing who had very little support, the dependency level tool revealed a deficit in staff numbers to provide adequate care, there was also a very high mortality rate in the home, 14 deaths had occurred in a four month period. Because of these very serious issues, we requested that Mr Aherne agree not to take any new admissions for a four week period until we reviewed matters and he agreed to this.”

In her submission to the Commission, Nursing Home Inspector J gives her view of the team’s concerns arising from the inspection:

... Following the inspection by the ... inspection team our conclusion was that the standard of care being delivered to the residents was inadequate. Senior management in the Health Board were advised of our inspection findings in a telephone call by [the head of the Nursing Home Inspectorate] on the 8th April, 2005 during the course of which he advised that all further admissions to Leas Cross were to be suspended with immediate effect.”

One of the inspectors has told the Commission that she was unaware at the time of the inspection that complaints had been received by the H.S.E. from Psychiatry of Old
Age regarding care at Leas Cross and that those complaints would have influenced her approach to the inspection had she been aware of them at the time.45

Follow-up to inspection

On the 4th April, 2005, shortly before this inspection of the nursing home, Mr Michael Lyons, Chief Officer of the H.S.E. Eastern Region, had written to Mr Michael Walsh, Chief Officer of the H.S.E. Northern Area seeking information on the standards of care at Leas Cross. His request arose out of an investigation into the death of a resident. Mr Lyons asked whether, in light of inspections to date, Mr Walsh was “satisfied that Leas Cross meets the standards of care to continue providing care for residents and for patients currently in the contract bed scheme”.

Mr Walsh replied on the 13th April, 2005, following the inspection. He stated that “from the limited review of the medical/nursing notes on the inspection of the 7th and 8th April, our team concluded that there was no immediate risk to the current residents”. Mr Walsh has informed the Commission that this conclusion was communicated to him verbally by the head of the Nursing Home Inspectorate.

The Commission notes that the inspection report makes no finding regarding any immediate risk to current residents. One of the inspectors has informed the Commission that she did not communicate any such finding to the H.S.E. While she does not go so far as to state that there was any immediate risk to residents, she points out that what she calls the “limited review” in April, 2005 was “not intended to be a ‘clean bill of health’ for the home”. She continues:

“The report was not conclusive and was part of a process of assessing the home that was to include further inspections and deliberations and input from senior administrative staff.”

The Commission is of the view that the conclusion communicated to Mr Lyons by Mr Walsh did not convey the extent to which care standards at Leas Cross had fallen below acceptable levels. This was subsequently demonstrated in the major criticisms of Leas Cross made just two months later by Mary Flanagan, the matron assigned by the H.S.E. to take over the nursing home after the Prime Time documentary.46

However, the Commission lacks sufficient evidence to draw any firm conclusion as to what effect, if any, Mr Walsh’s response to Mr Lyons might have had on events at Leas Cross Nursing Home over the following months and, in particular, whether it had any impact on the ultimate decision to close the nursing home. Mr Lyons has informed the Commission that, in his opinion, it was a matter for Mr Walsh to deal with any concerns regarding standards at Leas Cross, once Mr Lyons had raised the issue with him.

The effects of the decision made on the 8th April, 2005 to request the management of Leas Cross to temporarily cease admissions are somewhat unclear. In her submission

45 See further Chapter 17.
46 See below and Chapter 21.
to the Commission, the Area Medical Officer states that “we requested the home to stop all new admissions to the unit”. Nursing Home Inspector H states, in her submission to the Commission, that “the home agreed to close admissions for the present in order to consolidate care and employ three more RGNs”. The head of the Nursing Home Inspectorate states, in his submission, “… we requested that Mr Aherne agree not to take any new admissions for a four week period until we reviewed matters and he agreed to this.” Despite this, the patients register shows ten admissions between the 11th April and the 14th June, 2005, two of whom were admitted for respite care during the four-week period referred to by the head of the Nursing Home Inspectorate. Each of these admissions was for a short period and may have been for respite.

By letter dated the 21st April, 2005, the Psychiatry of Old Age team for Community Care Area 847 wrote to General Manager A in the following terms:

“Currently we use five respite beds [at Leas Cross] every week for community patients whose families are in urgent need of respite care. ... Now because of investigations into the running and standard of care in Leas Cross we (on consultation with Michael Walsh by [Consultant Psychiatrist A]) can only use three respite beds for patients who have already availed of respite there before.”

Accordingly, it appears that admissions were not entirely closed, but that a limited number of beds were made available for respite care for patients who had formerly stayed in Leas Cross.

May 2005

6th May

Following the meeting between the inspectors and the proprietor on the 8th April, 2005, a follow up meeting was arranged for the 6th May, 2005. The head of the Nursing Home Inspectorate explains this high level of focus on the home at this time as follows in his submission to the Commission:

“Leas Cross Nursing Home was considered a high priority because of the issues that were identified not only on the 7th/8th April but also because of the number of complaints received in the previous year and that is why the home was being kept under continual review.”

In attendance were Mr John Aherne, Mr Ray Aherne and Ms Cogley, the head of the Nursing Home Inspectorate, the Area Medical Officer and Nursing Home Inspectors H and J. The meeting was reported to the Manager of the Nursing Home Section by letter dated the 11th May, 2005.

47 For more information on the Psychiatry of Old Age team and its involvement with Leas Cross see chapter 17.
The agenda for the meeting included staffing and medical care. In relation to staffing, Ms Cogley’s appointment as matron was agreed. An acting assistant director had been appointed as an interim arrangement pending the recruitment of an assistant director and two out of three new nurses had taken up their posts. Three care teams, each headed by a nurse, had been established and the matron had initiated weekly meetings with care staff, nurses and kitchen staff.

In relation to medical care, it was noted that the Area Medical Officer intended to meet the G.P., Doctor B, to discuss the issue. A letter from Nursing Home Inspector J to the Manager of the Nursing Home Section, dated the 13th June, 2005 confirms that meeting did not take place, owing to the imminent showing of the Prime Time documentary on Leas Cross.

The report of the meeting between the inspection team and Leas Cross on the 6th May 2005 also indicates that work was in progress on the review of medical and nursing notes and that efforts were being made to have contracts of care signed for all residents. In this regard, although the 1993 Regulations require nursing homes to execute contracts of care with each resident or their families (art. 7), Ms Cogley has pointed out in response to questions from the Commission that families were not obliged to sign contracts of care and, therefore, a contract was not in place for every resident. Grainne Conway, who preceded Ms Cogley as matron of Leas Cross, has stated to the Commission that the families of patients in contract beds were “totally unwilling to sign contracts of care for fear they may have to pay for the service.”

Nursing Home Inspector J has informed the Commission that she recommended that the nursing home review its policies on restraint, pressure area care and wound care. She also made recommendations regarding the drug recording system, which she found difficult to follow.

In her submission of the 25th September, 2008, Nursing Home Inspector H describes the meeting of the 6th May, 2005 as follows:

“The meeting was very difficult, with Mr John Aherne stating the home had no obligation to close beds under legislation. From my memory the work agreed in April had not been fully completed as agreed.”

In a written response to the Commission, the solicitors for Ms Cogley stated:

“Since the meeting in April several new policies had been put in place by our client. [Nursing Home Inspector H] advised our client that she should proceed with change slowly as she was concerned that the staff would not be able to cope with the rapid change.”

Nursing Home Inspector H denies giving that advice to Ms Cogley.

In his submission to the Commission, the head of the Nursing Home Inspectorate states in relation to this meeting that he was “impressed with Denise Cogley that there was a willingness on her part to work with the inspectors to continue [the] improvement”.

154
28th and 29th May

The head of the Nursing Home Inspectorate visited Leas Cross on Saturday the 28th and Sunday the 29th May, 2005. This was not an official inspection. He explains in his submission to the Commission that he had seen a preview of the *Prime Time* programme, due to air on the 30th May. He reported what he had seen to the Chief Executive, Michael Walsh, who asked him to visit the nursing home.

The head of the Nursing Home Inspectorate met John Aherne on both days. He visited one of the residents who featured in the television programme and inquired about staffing levels. A meeting was arranged for the afternoon of the 29th May, 2005 between the proprietors of the nursing home, John and Ray Aherne, and representatives of the HSE, namely the Chief Executive Officer (Michael Walsh), the head of the Nursing Home Inspectorate, , the Assistant CEO of the HSE NA and General Manager A.

30th May

Nursing Home Inspectors J and K visited the nursing home on the 30th May, 2005. They sent a report of the visit to the Nursing Home Section Manager on the 1st June, 2005. The report records the fact that the home had 94 residents, including two for respite care. One respite admission was booked for the 30th May and another for the 2nd June, 2005. The report lists the number of staff rostered, the number of patients seen by the G.P. that day (eight) and the number of patients with bedsores (five).

In the absence of the matron, the inspectors were accompanied by the acting director of nursing, Marie Ryan. She was concerned to ensure that somebody would assist her when the matron went on leave the following month.

HSE staff visited and inspected Leas Cross after this inspection on the 30th May, 2005. However, those visits and inspections took place in the wake of the *Prime Time* documentary and led to the ultimate decision to close the home. They are addressed elsewhere in the Commission’s report.  

**Issues raised by inspections of Leas Cross Nursing Home**

**Following up inspections**

The Commission has received somewhat conflicting evidence from inspectors regarding the policy on following up matters raised at nursing home inspections. It is

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48 See chapters 20-22.
clear from the documentation disclosed to the Commission that matters needing to be addressed following an inspection were generally set out in the inspection report, which was sent to the matron and/or the proprietor, as well as to the relevant Health Board personnel. In some cases a follow-up visit took place to ascertain whether appropriate steps had been taken, whereas in others the next visit was six months later when the next routine inspection occurred.

In her submission to the Commission dated the 25th July, 2008, Nursing Home Inspector A, who was involved in inspections of Leas Cross from April, 1998 to February, 2000, addressed this issue as follows:

“I do not recall being given a set time period for follow up inspections...

My recommendations were included in my report. I considered it my professional responsibility to follow up with a further inspection to see if recommendations had been implemented. If unavailable myself I would arrange for a colleague to follow up. The time period for follow up depended on the seriousness of the issue.”

Similarly Nursing Home Inspector C, who was involved with Leas Cross from November, 1998 to June, 2001, stated as follows in her submission of the 25th July, 2008:

“If during the course of the inspection I identified matters that required follow up, I always carried out a further follow up visit. ... if I identified any shortcomings in the nursing management or in the provision of patient care then I would discuss my findings with the person in charge and inform him/her that I would be revisiting the home to ensure matters of concern had been addressed.”

On the other hand, Nursing Home Inspector E, who inspected Leas Cross in May and November, 2002, stated in her submission that she did not carry out follow up visits at Leas Cross, because she was not asked to do so and did not consider it necessary in light of her findings, although in the cases of some other nursing homes, she did carry out follow up inspections where necessary:

“I was never instructed to follow up on any of my findings. I followed up on findings in relation to my inspection [of Leas Cross] of the 20th May 2002 at my subsequent inspection on the 20th November, 2002 [i.e. at the next routine statutory inspection].”

Nursing Home Inspectors F and G stated that they did not follow up on their findings otherwise than by noting them in their inspection reports.

It appears to the Commission that the general approach of inspectors was to follow up matters at the next biannual inspection. While some inspectors did make additional follow-up visits, this appears to have been on their own initiative rather than as part of a standard policy. While such initiative is commendable, a more consistent policy would be desirable, to ensure follow-up visits within a short period whenever inspections required remedial action to be taken by the nursing home. The
Commission recognises that such a policy would place considerable demands on the resources of the public health nurses. However, dedicating such resources to assessing compliance with the inspectors’ recommendations would help to ensure that important issues are addressed without undue delay.

The Commission notes a divergence in practice between the early years of the operation of Leas Cross and the years after the new wing opened in 2002. In 1999, there were three follow-up inspections to ensure adequacy of staffing and, on one occasion, to ensure that medication was being administered properly. The effect of this was that the inspectors eventually satisfied themselves, by the end of 1999, that there was an adequate number of staff in the nursing home and that their recommendations were being adhered to. In contrast, when the nursing home expanded to over 90 residents in 2003, the inspectors did not carry out spot checks to ensure compliance with their recommendations. Indeed, in 2004, there was only one routine inspection, owing to staff shortages in the inspectorate. Admittedly, there was intense H.S.E. activity in the nursing home in May, 2005, but that appears to have been mainly in response to the *Prime Time* documentary.

### Staffing issues in Leas Cross Nursing Home

The adequacy of staffing was repeatedly raised by inspectors from the time Leas Cross was initially registered to 2000 and again between 2003 and 2005. The Commission asked Nursing Home Inspector C, who had raised the inadequacy of staffing in inspection reports of the 15th January, the 20th June and the 19th August, 1999, what steps were taken to address that issue. She replied as follows in her submission dated the 25th July, 2008:

*I considered that every possible effort was being made by the matron of Leas Cross Nursing Home to meet the recommended staffing levels. ... My recommendations in relation to staffing levels were the ideal levels based on having an adequate number of staff to cover contingencies such as sick leave or sudden absence. However ... at no time was I concerned that nursing care was being compromised and to my knowledge ideal staffing levels were not at that time being achieved in any health facility because of difficulties in recruitment of staff. If I felt that nursing care was being compromised I would certainly not have recommended re-registration.*

The Commission finds it difficult to reconcile this submission with the inspection report of the 19th August, 1999, which was signed by Nursing Home Inspector C. That report refers to the inspectors’ “great concern” at the home’s failure to meet minimum levels and pointed out that matron’s duty “to ensure that staffing levels are always sufficient to meet the needs of residents”. The inspectors went so far as to point out to the matron that failure to provide adequate staffing was an offence. It is not unreasonable for Nursing Home Inspector C, with hindsight, to point out that other health facilities also had difficulty recruiting staff. However, it is clear from successive inspection reports that the recommended levels in question were “minimum” levels, not “ideal” levels.
Nursing Home Inspector A’s response to the Commission, dated the 25th July, 2008, states that staffing levels “to meet minimum standards of care, to meet the care needs of patients with a variety of dependency levels and taking account of the layout of the nursing home” were determined by the inspectors. However, Nursing Home Inspector A also states that it is the responsibility of the proprietor and the person in charge to ensure adequate staffing. She lists the inspections carried out by her at which staffing was considered and concludes as follows:

“The inspections carried out were certainly adequate. All reports of above inspections or visits were sent to EHB senior management – [the] Senior Executive Officer, Acute Hospitals and Services for the Elderly.

Two matrons and the proprietor were advised about their responsibility to provide adequate staffing to meet the needs of patients. The issues relating to staffing issues were followed up repeatedly, even when staffing levels were on some occasions found to be satisfactory. On no occasion did I find staffing levels to be recorded in a misleading way.”

It is clear from the inspection reports that the inspectors had very serious concerns regarding staffing levels between 1998 and 2000, to the extent that they found it appropriate in August, 1999 to point out the provisions of the legislation regarding criminal offences. In light of this, it is surprising that the inspectors considered it adequate to recommend on the 18th August, 1999 that staffing levels increase “as matron considers necessary reflecting dependency of residents”, particularly given the signal failure to comply with minimum recommendations to date. On the other hand, the inspectors did monitor the situation closely in 1998 and 1999 by carrying out a number of spot checks until they were satisfied that there was adequate staffing in place and the problem did not recur until the nursing home was expanded in 2003. Unfortunately, when staffing levels were again identified as a problem in 2003 and 2004, the level of monitoring by inspectors did not increase, as it had done in 1998 and 1999. It has been pointed out to the Commission that a shortage of public health nurses affected the ability of the inspectors to follow up this issue in 2003 and 2004.

The Commission notes the provisions of section 4(8) of the Health (Nursing Homes) Act 1990, which empowered the Health Board to attach conditions to the registration of a home “at the time of registration or subsequently”. The pattern of insufficient staffing levels at Leas Cross from its initial registration in June, 1998 to the end of 1999 might reasonably have prompted a decision to impose conditions when the proprietor sought to register seven extra beds in 1999, limiting the number and/or dependency of residents or formally including minimum staffing levels as a condition of the home’s registration. The need for such conditions was even more acute when staffing problems recurrent in 2003, following the expansion of the nursing home to accommodate up to 73 additional residents.

The Commission raised the possibility of such conditions with Nursing Home Inspector H. In a written response, she stated that she had informally requested the matron, Grainne Conway, to “suspend / slow down admissions” in March or April, 2004 while the inspectors looked at the increase in resident numbers, staff numbers and the skill mix of staff. As the documentation available to the Commission does not include any written record of this request or the nursing home’s response, it is not
possible to be certain of precisely what was discussed. In any event, it appears that admissions to the nursing home were not suspended at that time.\textsuperscript{49} The Commission considers that, if the inspectors believed a limit on admissions was necessary, it would have been more appropriate to have asked Health Board management to impose a condition under the nursing home legislation, to ensure compliance.

The Commission also notes that it was not until 2005 that an assessment of dependency levels was carried out to determine the adequacy of staffing. Nursing Home Inspector H, who introduced the assessment tool to the nursing home in 2004, informed the Commission that “\textit{without a measurement of patient dependency, it was not possible to be certain whether the home had an adequate number of trained staff}”. In light of this, the Commission considers that such assessments should be routinely and regularly carried out in all nursing homes. Had the assessment been carried out earlier in Leas Cross, it is possible that staff numbers and the skill mix of staff might have been addressed and that many of the problems leading to the closure of the nursing home could have been avoided.

\textbf{Examination of residents and medical records}

The Nursing Homes (Care and Welfare) Regulations 1993 require the proprietor and staff of a nursing home to permit inspectors to interview and examine residents where the inspector “\textit{has reasonable cause to believe that a person in the nursing home is not or has not been receiving proper care, maintenance or medical or other treatment}” (article 23.1(c)).

However, the Regulations also limit the examination of residents and medical records to certain inspectors. Article 23.2 provides that only a designated officer who is a medical practitioner (i.e. a medical doctor) may inspect medical records relating to a person in a nursing home. Article 23.3 provides that only a designated officer who is a medical practitioner or a registered nurse may carry out an examination of a person in a nursing home.

The standard nursing home inspection form in use when Leas Cross was in operation did not require inspectors to make any comment on the physical or mental health of residents. Despite this, some inspectors have expressly informed the Commission, in their submissions, that they spoke to and/or examined residents during inspections.

Nursing Home Inspector A, in her submission dated the 25\textsuperscript{th} July, 2008, stated that she “\textit{would stop to chat with residents}” during inspections. In relation to bed-bound patients she stated:

\begin{quote}
\textit{If any resident was in bed during our inspection we would enquire whether the patient was bed-bound or just temporarily in bed. For bed-bound patients the Supt or Senior PHN would enquire about the mattress used, and discuss arrangements for the care of pressure areas. The Supt/Senior PHN and I have on occasion examined such bed-bound patients in nursing homes, but I don’t}
\end{quote}

\textsuperscript{49} See further Chapter 17.
recall whether or not such a situation arose during my inspections of Leas Cross Nursing Home.”

Nursing Home Inspector A, who is a doctor, also stated that she would randomly select a number of residents’ medical records “for review in relation to documentation of their diagnoses and medical consultations”.

Inspection reports in relation to Leas Cross Nursing Home often concluded that residents “appeared well cared for”. It is not clear from inspection reports what criteria are used in reaching that conclusion. This was explained by Nursing Home Inspector F in her submission to the Commission dated the 4th July, 2008 as follows:

“Where an inspection report states that all patients / residents appeared well cared for, this meant the following:

(a) The inspection team would have spoken to a number of patients.

(b) The inspection team considered the number of patients that came to the dining room for their meals and the number that took their meals in their rooms.

(c) The inspection team considered the number of patients that were on special diets.

(d) The inspection team examined patients’ menus and considered the choice and range of food offered to patients. In relation to long-stay patients in the nursing home the inspectors might observe if patients had lost a lot of weight.

(e) The inspection team considered the number of incontinent patients and what toileting programme was in place for each patient. Sometimes it was recommended that the nursing home staff attend one of the health board’s continence courses.

(f) It was always asked if there were any pressure sores or other types of wounds. Sometimes the treatments of same were discussed.

(g) Patients’ care plans were looked at and suggestions were made on how to improve and develop patient care.”

Nursing Home Inspector G, in her submission to the Commission, stated that inspections involved “a holistic approach to resident care including observation of both the residents and the nursing home environment”. She explained this as follows:

“Whilst talking to the residents I would observe their overall appearance, I noted if they were clean and tidy or if their hair and skin was in good condition or their nails were clean and cared for. We also identified the number of residents confined to bed and we would visit those residents in their rooms. Whilst there, we would note the type of pressure relieving equipment being used, for example, the type of pressure relieving mattress and cushions (if any) and make sure that these were being used correctly. Any resident who
was confined to bed was discussed with the director of nursing as to the state of their skin and pressure areas. If a resident had a pressure sore, his/her nursing care plan was looked at and type of dressing being used was discussed. I would also enquire as to the resident’s appetite if it was poor then I would generally recommend the use of supplements to the diet as this would improve the healing process.”

Similar comments were made by Nursing Home Inspector E in her submission to the Commission dated the 7th July, 2008:

“… I would observe the general physical wellbeing of the resident and also enquire from the [person in charge] re the health status of the resident inclusive of skin integrity, diet, special needs, socialization, and use of aids in manual handling and transfer from bedroom to other living areas in the nursing home. When I came upon a bedbound resident I would in addition to the above observe the resident’s facial features and feel his/her skin to ensure adequate hydration. I would enquire into the prevention of pressure sores and the maintenance of skin integrity. I would observe for the use of pressure relieving mattress as bedbound residents are vulnerable to pressure sores. Where it was clear that a resident suffered contractions of the limbs I would pull back the bed clothes and examine the bony prominences at the knees and the ankles and also examine the skin at the joints and skin hidden behind the contractures to ensure sufficient care and attention was being given to these usually very moist areas by the nursing and care staff.

When the [person in charge] identified a resident with a leg ulcer or wound I would enquire into the cause, the type of wound, the medical reviews of the wounds, the nursing management of the wound and the current stage of the healing process of the wound. I would take note of the particular residents’ names with wounds and would pay particular attention to their nursing records when I had completed the inspection of the facilities and had met some of the residents.”

Nursing Home Inspector H also explained the manner in which she had regard to the wellbeing of residents, in her statement to the Commission dated the 25th September, 2008. She set out nine items which she would usually check, as a minimum, during inspections:

1. whether residents appeared comfortable and why any specialist equipment such as a special mattress was in use;
2. whether residents’ clothes were clean and well-fitting;
3. the general expressions of residents;
4. whether residents had easy access to a bell and a drink;
5. whether residents showed any sign of dehydration, such as dry skin or inability to converse, and whether any residents were being tube fed;
6. whether chairs were being used appropriately;
7. how long it took staff to respond to requests for help;

8. whether residents appeared occupied or bored; and

9. what accidents or incidents had been reported and how they were handled.

Another inspector has stated the following in a written submission to the Commission in relation to medical examinations:

“It was not common practice to examine residents during the course of an inspection unless it was deemed necessary to examine a resident for example because of a complaint. We did routinely speak to residents and where possible, their families, to ascertain whether they were being well cared for. However, inspection report forms did not provide much space to address the physical and mental wellbeing of residents. Instead, the forms emphasised issues regarding the infrastructure of the nursing home and the available services.”

The 1993 Regulations did not require inspectors to examine residents and empowered them to insist on doing so only where they had reasonable cause to believe that a person was not receiving proper care or treatment. Further, the standard nursing home inspection form in use during the operation of Leas Cross Nursing Home was notably lacking in detail regarding the physical wellbeing of residents. This was recognised by Martin Hynes in a letter dated the 6th August, 2004 to the head of the designated nursing home inspectorate:

“The pro-forma inspection check list used focuses to a large extent on the physical facilities of the premises. Equally the ERHA application form for registration deals mainly with physical facilities and the services provided. Neither form deals, nor allows much space to deal with, the quality of care. Perhaps it would be timely to review the standard inspection form and to allow, and require, much more comment on the quality of care as it is witnessed by the inspectors.”

A similar point was made by Prof. Desmond O’Neill in his review of deaths at Leas Cross (November, 2006), where he stated:

“Prior to the new format of inspection [i.e. the form introduced by the designated inspection team in 2005], the reports for Leas Cross were relatively brief with a significant focus on physical surroundings”.

It appears from the information furnished to the Commission, referred to above, that inspectors at the time were not necessarily constrained by the contents of the inspection form in reviewing care standards in nursing homes. Some have stated that in some instances they examined residents and their medical records.

It is not clear whether, in all instances, the inspectors complied with the restriction in article 23.2 of the 1993 Regulations, which limited the inspection of medical records to medical practitioners only. Of the inspectors who visited Leas Cross Nursing Home, most were nurses while only two were doctors. This meant that the
opportunity to examine medical records in accordance with the Regulations was limited. However, Nursing Home Inspector H has told the Commission that, in her experience, it was often possible to carry out a full inspection of a nursing home without recourse to medical notes. She states that article 23.2 was adhered to at all times.

The Commission considers that the 1993 Regulations, the 1995 Guide and the standard inspection form should have placed much greater emphasis on the physical and mental wellbeing of residents. The inspection form in use during the operation of Leas Cross was primarily concerned with the adequacy of the facilities and record keeping in nursing homes. It appears that the custom and practice of inspectors was to examine residents from time to time. This was in spite of the absence of any such requirement and, therefore, may not have occurred as often or as consistently as would have been desirable, although the Commission acknowledges that it would be appropriate for inspectors to examine residents only where there was an indication to do so and with their consent.

The Commission is satisfied that the H.S.E. had a duty of care to nursing home residents. This was clearly recognised by the H.S.E., as evidenced by its decision to take over the operation of Leas Cross Nursing Home in May 2005 and ultimately, by the decision to remove the nursing home from the register – a decision which, according to Mr Walsh’s letter of 15th June 2005 to Mr Aherne, was taken by the H.S.E. because “the H.S.E. must fulfil its duty of care and obligations... to the patients in Leas Cross”, and which arose from “…concerns in relation to patient safety and the overall level of patient care”. It is not appropriate for the Commission to define the limits of this duty, but the Commission is satisfied that the duty, which was exercised principally through the medium of nursing home inspections, included a duty to monitor and address concerns in relation to patient safety and the overall level of patient care.

The Commission considers that, in the exercise of the duty of care identified above, a more consistent approach during inspections to examining residents would have identified care-related problems such as pressure sores and dehydration earlier and would have enabled inspectors to ensure that adequate steps were taken by the nursing home to develop prevention procedures and to treat residents where necessary.

The dedicated nursing home inspection team, established in October, 2004, introduced a new inspection form. That form does not appear to have been used in relation to Leas Cross Nursing Home. The Commission notes that the new form was considerably more detailed than the earlier version. However, the statutory regime at that time was unchanged and inspectors were under no greater legal duty to examine patients and medical records.


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51 S.I. No. 57 of 2008.
for the appointment of authorised persons to assess compliance with regulations and standards applicable to nursing homes.

The Commission notes that the 2007 Act does not expressly require authorised persons to examine residents in nursing homes. However, it does empower such persons to “enter any designated centre [e.g. a nursing home] ... and examine, as he or she thinks fit, the ... care or treatment of residents of the centre ...” (section 71(3)(a)). The Act empowers the Minister for Health and Children to make regulations regarding standards of care in nursing homes (section 101). To date, no such regulations have been made.

Some observations regarding the inspection process

The Commission has noted a marked difference in the findings of the inspection team who visited Leas Cross for two days in April, 2005 and those of Mary Flanagan’s team who took over the nursing home on behalf of the HSE in June, 2005. Although it was not expressly stated in the inspection report from the earlier inspection, the head of the Nursing Home Inspectorate informed H.S.E. management that it had resulted in an overall finding that there was no immediate risk to the residents. Whether or not this accurately reflected the inspectors’ findings, they did recommend that three additional nurses and three clinical nurse managers be employed. The later report of the team managing the home identified many significant problems not identified two months previously and recommended the employment of twenty additional nurses. These findings, set out in a report dated the 8th June, 2005, are addressed in detail elsewhere.52 They included the following:

- **Staffing** – The team identified “large deficits” in the provision of 24-hour care, which was delivered by untrained care attendants with limited supervision by nurses.
- **Clinical practice** – Care standards were described by the team as being very poor in areas such as continence and personal care. Pressure are and wound management were also gave cause for concern.
- **Fire safety** – The bedrooms were not equipped with evacuation sheets and the beds did not fit through bedroom doors.
- **Infection control** – There were no facilities for staff hand washing.

In oral evidence to the Commission, Michael Walsh was asked to comment on this discrepancy. He pointed out that there were significant differences between the two teams, in terms of the time spent in the nursing home and the number of staff undertaking the inspections. Ms Flanagan had a team of nine people, specifically chosen for their expertise in various relevant disciplines, who then worked full-time at the nursing home for a period of two weeks. The head of the Nursing Home Inspectorate, on the other hand, came into the nursing home as a visitor for a two-day inspection, with a team of two inspectors. Mr Walsh had no doubt that if the inspection team in April 2005 had the same level of time and resources as Ms

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52 See Chapter 21.
Flanagan’s team, their findings would have been more in line with those of Ms Flanagan and her team.

It is clear from the discrepancies between the two sets of findings that there were deficiencies in the inspection process. This is acknowledged by Mr Walsh, insofar as he accepts that greater resources would facilitate a more thorough inspection. The Commission finds it troubling that the ordinary inspection process should have failed to identify so many significant problems in Leas Cross Nursing Home.

The head of the Nursing Home Inspectorate has informed the Commission that he considers a comparison of the two sets of findings to be unfair, as the roles and experiences of the two teams were so different. However, the Commission considers that a comparison is useful insofar as it highlights the shortcomings of a standard inspection, which may fail to reveal matters of concern at a nursing home.

Of course it is possible – although impossible to establish now – that some or all of the issues raised by Ms Flanagan had not occurred in previous years. However, the proximity of the Inspectorate’s visit in April to Ms Flanagan’s report in June gives rise to the inference that the earlier inspection failed to detect a number of serious problems in the nursing home. The fact that the inspection in April was by the new dedicated inspectorate, and that it took place over two days rather than one as was the previous practice, casts even more doubt on the efficacy of the old inspection regime which was in place between 1998 and 2004.

Reading the reports of routine inspections, the Commission is struck by the fact that a number of significant issues, such as staffing levels and hygiene, recurred relatively frequently. Such issues were raised with the nursing home each time they were encountered by the inspectors and in some cases they were followed up by the inspectors. This was particularly evident in relation to the staffing problems identified by the inspectors in 1998 and 1999, which were eventually resolved.

Problems at Leas Cross became more serious after the expansion of the nursing home to accommodate 73 additional residents in 2003. Even if no previous complaints had been made concerning Leas Cross, the decision to allow the 111-bed nursing home to be registered without conditions is open to question.

When the routine inspection reports are taken together with the inspections carried out for the purposes of registration and the investigation of complaints, it becomes clear that the H.S.E. had in its possession detailed information regarding Leas Cross Nursing Home, covering a number of years, which included evidence of recurring problems. Taken as a whole, the accumulated inspection reports on Leas Cross should have alerted the H.S.E. to impending problems, which could have been avoided.

The number of residents in Leas Cross increased dramatically from 36 in November 2002 to 93 just one year later, and many of the new residents were highly dependent. The adequacy of the skill mix of staff had been questioned by the inspectors, but the matron had failed to carry out an assessment of residents’ dependency levels in 2004 as requested. There were nine complaints made to the H.S.E. between 2003 and

53 See Chapter 8.
2005, one of which, alleging serious deficiencies in the standard of care, remained unresolved when the decision was made to re-register the home in 2004.

In the opinion of the Commission, it was not sufficient merely to have the inspectors drawing attention to their concerns: action should have been taken by the H.S.E. in 2004 when it became evident that the nursing home was not addressing the inspectors’ concerns. Such action could have included the imposition of conditions requiring an increase in staff numbers, a reduction in resident numbers or resident dependency levels or a limit on the rate of increase in resident numbers, coupled with more frequent inspections to ensure that staffing and standards of care were adequate.

The Commission recognises that the inspectors had limited time and resources at their disposal and that the nursing home legislation and the standard inspection form failed to address many of the problems identified at Leas Cross Nursing Home. It may be unduly harsh to criticise those inspectors who adhered to the parameters of that framework, although the Commission does consider that there was a duty of care owed by the inspectors to residents to monitor and address concerns in relation to patient safety and the overall level of patient care, irrespective of the formalities of the inspection process.

The Commission notes that a number of inspectors were not constrained by such limitations: they carried out spot checks at Leas Cross in addition to the routine inspections and drew attention to problems not necessarily anticipated by the framers of the standard inspection form. A clear example of this can be seen in the conduct of the inspectors in 1998 and 1999, whose attention to Leas Cross eventually achieved acceptable staffing levels at that time. In the opinion of the Commission, the inspection system overcame its obvious limitations only where inspectors were prepared and able to act in that manner and those who did are to be commended for having done so.

The Commission also notes that the establishment of the dedicated inspectorate in 2004 resulted in more thorough inspections and more detailed reports. While that was a welcome development, inspection reports are meaningless unless they are put to some use. A report prepared for the HSE on complaints received in relation to Leas Cross Nursing Home (November, 2006) includes the following recommendation:

“(6:5) Develop a central registry to collate data from the Nursing Home Inspectorate visits and identify poorly functioning nursing homes: The results of Nursing Home Inspectorate visits should be forwarded to a proposed central registry. The inspectorate reports should include surrogate markers of care standards such as mortality rates, pressure ulcer rates, falls rate, critical incident rates, rates of referral to local emergency departments and antibiotic prescription rates. The central registry should collate this data and produce a confidential report calculating firstly the national mean or average for these markers and secondly using this data, identify those nursing homes whose statistics fall two or more standard deviations outside these means. The identified nursing homes should then be contacted and an investigation undertaken by the Nursing Home Inspectorate to determine the cause for problems in that setting. Measures should then be put in place to address identified care deficits.”
The Commission considers that a system of that nature, or even a less sophisticated but regular analysis of inspection reports, would have alerted the HSE to potential problems at Leas Cross and possibly averted the closure of the home.
Separately to the nursing home inspection process, the Health Board / HSE is responsible for inspections relating to food hygiene. These inspections are administered by the office of Environmental Health. The Commission has received a submission, dated the 12th September, 2008, from the Acting Principal Environmental Health Officer in Fingal Food Control Section, which explains the operation of this regime generally and with particular reference to Leas Cross. He responded to written questions from the Commission on behalf of the Office of Environmental Health and the Commission understands that he contacted current and former staff who had dealings with Leas Cross where necessary to assist in answering the Commission’s questions.

The principal legislation governing this regime when Leas Cross was in operation was the European Communities (Hygiene of Foodstuffs) Regulations 2000 and the European Communities (Official Control of Foodstuffs) Regulations 1998. Under these statutory instruments, authorised officers are empowered to inspect premises at which food is being stored, distributed, etc. to ensure compliance with the relevant regulations.

The principal duty of the proprietor of a ‘food business’ (which includes nursing homes) is set out at regulation 4(1) of the Regulations of 2000:

“The proprietor of a food business shall ensure that the preparation, processing, manufacturing, packaging, storing, transportation, distribution, handling and offering for sale or supply of foodstuffs shall be carried out in a hygienic way.”

Regulation 4(2) goes on to specify in detail the principles to be applied in ensuring that “adequate safety procedures are identified, implemented, maintained and reviewed”. The second schedule to the Regulations of 2000 sets out minimum requirements or ‘prerequisite programmes’ to ensure adequate food safety where food is prepared. In addition to the Regulations, the Environmental Health service has developed a quality management system and standard operating procedures, which are applied in the inspection of premises.

The frequency of inspections is determined on the basis of a risk assessment of the premises in question. This is set out in a code of practice issued by the Food Safety Authority: ‘Code of Practice No. 1 for the Health Service Executive on the Risk Categorisation of Food Businesses’. Under that code of practice, ‘high risk businesses’ include those where there are food business operations where the potential exists to put vulnerable groups (e.g. elderly people) or large numbers of consumers at serious risk. All nursing homes are considered to be in the high risk category.
Under the code of practice, the recommended frequency of inspections for high risk businesses is one full inspection and two surveillance inspections per year. The Acting Principal Environmental Health Officer explains that this is subject to available resources and can be varied depending on matters such as the history of compliance. However, at a minimum it is intended that “no high risk premises will have greater than 12 months between inspections”.

Where an inspection takes place, authorised officers record any infringements of statutory requirements. These are divided into three categories: minor, significant and serious. A minor infringement is one where “the risk to food safety is of low magnitude and can be rectified and contained easily”. Where a minor infringement is identified, the follow-up action will be by way of verbal communication and/or written advice.

**Correspondence between nursing home inspectors and environmental health officers**

The Commission has been furnished with correspondence sent by nursing home inspectors to the office of Environmental Health in 1999. In these letters, the nursing home inspectors referred matters of concern to environmental health officers.

By letter dated the 19th February, 1999, Nursing Home Inspector A and Nursing Home Inspector C wrote to the Office of Environmental Health, to notify findings made during a routine inspection on the 16th February, 1999. They listed three issues regarding food hygiene and asked that an inspection be carried out as soon as possible. Subsequent correspondence indicates that an inspection was carried out, but no report was sent to the nursing home inspectors, because the office of environmental health was precluded by relevant legislation from disclosing its findings.

On the 12th July, 1999, the same inspectors wrote to the then Principal Environmental Health Officer. Again, issues of food safety were raised and an inspection was sought. One of the issues, namely the storage of raw meat, had arisen previously. A handwritten note on the letter, added by Nursing Home Inspector A, states the following:

“14/7/99. Spoke to [the Principal Environmental Health Officer]. Due to lack of staff it could be 3-4 wks for visit.”

The Commission can find no evidence that a visit was carried out on foot of the request. However, the Principal Environmental Health Officer has informed the Commission that, in his opinion, it is “inconceivable that an inspection was not carried out”.

On the 13th December, 1999, Nursing Home Inspector A wrote to the then Principal Environmental Health Officer regarding four nursing homes where problems had arisen. In relation to Leas Cross, the letter states the following:
“There was a problem earlier in the year (see letter 17/2/99) (sic.) which was followed up by your department. Subsequently at a statutory inspection in July there was again a problem with the storage of some raw food in the fridge above cooked food. I notified of this on 12/07/99. Two further spot checks were carried out in August and October to follow up on unrelated matters and I was informed that there had not been any EHO inspection since my request. I would appreciate if you could let me know when an inspection has taken place.”

The documents received by the Commission from the Office of Environmental Health include handwritten notes from an inspection of Leas Cross on the 8th March, 1999 but not other documents from that year. The Acting Principal Environmental Health Officer states in his submission that a review of the file for Leas Cross revealed limited information for 1999 and 2000. He explains that “it is possible that all relevant documentation from this period is not on file, possibly due to a move [of] office from the city centre and/or the introduction of a new filing system for all food premises in 2000/2001”.

Inspections of Leas Cross by environmental health officers

1999-2001:

The first inspection of which the Commission is aware took place on the 8th March, 1999. The handwritten notes furnished to the Commission include a rough map of the kitchen and details of the storage of food. There do not appear to be any adverse findings made, although no formal report has been made available to the Commission.

The Acting Principal Environmental Health Officer states that an inspection was carried out in January, 2000. No report of this inspection has been furnished to the Commission. The Acting Principal Environmental Health Officer states that “the infringements found on inspection were minor in nature and communicated to the person in charge at the time of the inspection”. As stated earlier, the guidelines allow for verbal rather than written warnings to be given in such circumstances.

The next inspection occurred on the 15th June, 2001. The Senior Environmental Health Officer wrote to the proprietor of the nursing home, Mr Aherne, on the 19th June, 2001. Copies of the letter were sent to Ms Conway and the head cook. The letter pointed out non-compliance with the Regulations of 2000, in that no Hazard Analysis Critical Control Points (HACCP) System had been implemented. The letter stated that certain documents had to be completed before the next inspection, namely temperature records, hygiene checklist and cleaning schedules, supplier lists, staff training records and pest control reports.

In relation to staff training, the letter from the Senior Environmental Health Officer stated that all food workers were required to complete “a food safety training course commensurate with their responsibilities”. This, the letter pointed out, was a legal requirement and included care staff and nursing staff involved in serving food and feeding residents.
The letter stated that the “fundamental structural and operational hygiene” required for an effective HACCP system was not present in the home. The layout and design of the premises was “not completely conducive to food safety, as there are some areas where a risk of crossover, contamination and cross contamination exists”. Staff other than food workers, who may have been involved in high-risk activities, had free access to the kitchen without protective clothing. There were no suitable areas for the storage of cleaning agents in the kitchen and foodstuffs were being stored in the staff smoking room. The letter recommended “zoning” areas to ensure no crossover of raw and cooked foods, etc.

A detailed report containing 33 issues of concern was furnished with the letter. The letter concluded by stating that the premises was due for re-inspection in September. That follow-up inspection did not take place. This is explained by the Acting Principal Environmental Health Officer as follows:

“The scheduled follow up visit for later that year to assess the level of improvement in the implementation in the HACCP system was not carried out as the Senior Environmental Health Officer was promoted to the position of Principal Environmental Health Officer. The premises was assigned to a new Senior Environmental Health Officer in May, 2002.”

The Commission does not understand why the promotion of an E.H.O. should have led to the cancellation of an inspection. It is apparent from the report of the 19th June, 2001 that there were a number of serious issues of concern regarding food hygiene at Leas Cross, which should have been followed up within a short period. In fact, the next inspection did not take place until November, 2002.

2002-2005:

In 2002, the new wing of the nursing home was built. The office of environmental health carried out four inspections on the 18th July, 25th October, 7th November and 11th November, 2002. The first of these was a meeting with the proprietor and matron, together with a hygiene consultant engaged by Leas Cross, to ensure that the new kitchen facilities would be sufficient to meet food safety requirements. The two inspections in November followed the completion of the building works but took place before the new wing was opened.

The Commission has received no detailed reports of the first three inspections in 2002. The Commission has been informed that no such reports were produced, as the findings were discussed with the person in charge on each occasion.

The final inspection, on the 11th November, was reported in a letter to Mr Aherne from the Senior Environmental Health Officer, dated the 12th November, 2002. A copy of the letter was sent to Nursing Home Inspector E. The report stated that the layout of the kitchen, food storage areas and equipment were all satisfactory. Three items required to be attended to: first, a full HACCP plan was to be drawn up for the home; secondly, staff training was required for all food handlers; and thirdly a pest control company needed to be engaged to carry out an audit and follow-up
inspections. The letter stated that a further inspection of the new wing would be carried out “in the near future” to observe the operational hygiene of the kitchen once it was in use.

The next inspection took place on the 30th April, 2003, and a written record of the inspection was sent on the 31st July, 2003, in a letter from the Senior Environmental Health Officer to Mr Aherne and Ms Conway. The report identified ten items requiring attention, including inadequate segregation of raw and cooked meats and the fact that catering and care staff were sharing toilet facilities.

The nursing home was next inspected on the 27th January, 2004. Six matters of concern were set out in a report to Mr Aherne and Ms Conway dated the 17th February, 2004. These included a number of matters raised on the previous occasion, including inadequate segregation of raw and cooked meats.

On the 9th July, 2004, the Senior Environmental Health Officer wrote to Mr Aherne and Ms Conway regarding an inspection carried out on the 9th June. The report noted that a “full and detailed cleaning schedule” had not be drawn up for the premises and stated that this needed to be completed as soon as possible. A further six items of concern were listed, including a build up of ice in a chest freezer and a defective seal on a sink unit.

A summary of events provided to the Commission by the office of environmental health includes the following reference to a complaint in September 2004:

“24/9/04 Called to investigate complaint

27/9/04 Phone call from Grainne Conway re complaint”

In response to a question from the Commission, the Acting Principal Environmental Health Officer has explained that the complaint related to a blocked drain in a resident’s room. The complaint was made by telephone to the Senior Environmental Health Officer, by a member of the nursing home inspection team. The Acting Principal Environmental Health Officer states that the matter was resolved as follows:

“While the statutory obligation for the Environmental Health Section was to inspect premises for compliance with Food Safety legislation, in the interest of protecting public health, [the Senior Environmental Health Officer] called to the nursing home on the day to investigate the complaint. The drainage problem had been satisfactorily resolved by the owners of the home prior to [the Acting Principal Environmental Health Officer’s] visit.”

On the 20th June, 2005, the Office of Environmental Health wrote to Mary Flanagan, the then matron of the home, regarding smoking in Leas Cross. The letter states that a complaint had been received alleging that smoking was permitted throughout the home and refers to an inspection carried out that day. The letter refers to the Public Health (Tobacco) (Amendment) Act 2004, which allows a nursing to be exempt from

54 See further Chapter 15.
the ban on smoking in public places. However, the Environmental Health Officer “strongly advised” the introduction of a policy to identify when and where smoking is permitted. The Environmental Health Officer noted that Leas Cross had a smoking room and advised that the room should be well ventilated and that the doors to the room should remain closed at all times.

The final EHO inspection was carried out on the 22nd June, 2005 and reported to Mr Aherne by the Senior Environmental Health Officer on the 8th July, 2005. Again, it was noted that no cleaning schedule had been completed. Fifteen items requiring action were listed, including some items that had been raised previously.

In his submission to the Commission, the Acting Principal Environmental Health Officer summarises the EHO inspections (with the exception of the smoking-related inspection, to which he does not refer) as follows:

“I have discussed the history and outcomes of inspections with the officers who have inspected the premises. Their overall view was that there were no major concerns in relation to the hygiene standards in this premises. Particularly since the extension of the home and the installation of new kitchen facilities in 2002, the standard of both structural and operational hygiene was satisfactory with the result of inspection being either ‘satisfactory’ or unsatisfactory ‘minor’.”

The Commission understands that, on each occasion, the infringements found were ‘minor’, within the definition provided by the Acting Principal Environmental Health Officer (see above). Although some infringements occurred more than once, the Senior Environmental Health Officer has stated to the Commission that the environmental health officers ensured that infringements were addressed. She has stated that, in her professional opinion, at no stage did matters arising from environmental health inspections at Leas Cross warrant enforcement action.

Martin Hynes commented on the relationship between environmental health officers and nursing home inspectors in his Interim Report on Review of Nursing Home Inspections (June, 2005):

“There is a fragmented reporting relationship for, and between those who carry out inspections. For example, Environmental Health Officers do not accompany the other inspectors on their site visits. They carry out separate inspections under food hygiene regulations. The EHOs have claimed that current legislation does not allow them to share these reports with others. It is an offence, punishable by six months imprisonment, to disclose information received during an inspection carried out under the Food Safety Authority Act and Food Hygiene Regulations. It would seem perverse if employees of the HSE (EHOs) were to have information regarding problems, or potential problems, in nursing homes which they could not disclose to their employer or to fellow employees of the HSE who have responsibility and authority to deal with nursing home issues. More recently, a separate form for reports by EHOs to be made under nursing home legislation has been brought into use by the NAHB. Medical and nursing inspectors do not visit kitchens during their inspections.”
The fragmented nature of the supervision procedures for nursing homes, of which this is one example, is a matter that concerns the Commission generally.

**H.S.E. tender for intermediate / high dependency care services**

In December 2004 the Minister for Health & Children announced a ‘10-Point Action Plan’, conceived to address ongoing difficulties in the effective delivery of acute hospital services. As part of an effort to alleviate pressure for beds in acute hospitals, the plan required that “the scope for using greater numbers of private nursing home beds to alleviate pressure on acute hospitals be actively pursued”. To this end, the H.S.E. Eastern Region was given approval in 2005 to transfer 100 high dependency patients into private nursing home care, and to negotiate with private nursing homes regarding the placement of other patients for intermediate care.

In 2005, a public procurement process was carried out by the H.S.E. for the provision of intermediate and high dependency beds in nursing homes. This was a new method for contracting nursing home beds and involved a tendering process. The process was conducted by an evaluation team overseen by the Senior Commissioner in the Eastern Regional Health Authority. She has furnished the Commission with a submission.

The evaluation team identified twenty nursing homes to go through to the second stage of the tendering process. Members of the team then visited each of the twenty homes on the shortlist. Each home was evaluated on the basis of ten award criteria. The homes were given scores out of ten for each of the criteria, giving a possible maximum mark of 100. Any home scoring below five for any criterion was eliminated from the process.

Leas Cross Nursing Home was one of 85 homes that responded to the request for expressions of interest in February, 2005. It was subsequently shortlisted, on the basis of its written expression of interest. Four members of the evaluation team visited Leas Cross on the 15th March, 2005. The home failed the assessment on the following criteria:

(a) quality of premises;

(b) acceptability to users and referrers;

(c) versatility, including ability to adapt to different patient needs in a patient centred way

The Senior Commissioner has informed the Commission that Leas Cross was one of six homes visited that “raised sufficient concern about standards of care that the evaluation group agreed that direct contact should be made with the relevant health board to advise them of the concerns and observations on care standards”. The Senior Commissioner has informed the Commission that she brought her concerns to the attention of senior Health Board management:
“We were particularly concerned by the following issues in Leas Cross:

- The lack of staffing, in particular the number of trained nurses
- The overcrowding
- The lack of activities for residents
- The visibly distressed residents
- Record keeping

At this stage I also advised ... the Director of Planning and Commissioning and Michael Lyons, Chief Executive, ERHA of the concerns. I was aware that there was an ongoing investigation into Leas Cross and considered that it was prudent that they were made aware of our assessment. At the monthly IMR meeting between the ERHA and the NAHB these concerns were again raised and assurances were provided with regard to the standards of care in Leas Cross and the intervention of the nursing home inspection team.”

Mr Lyons has informed the Commission that the Senior Commissioner’s concerns “fed into the HSE – Eastern Regional other concerns regarding Leas Cross, as emerging through the investigation [into the transfer of a resident to Leas Cross from St Michael’s House] and the media”. The concerns were raised with the HSE – Northern Area in April, 2005. Mr Lyons explains that, arising out of the concerns raised from these various sources, he asked Martin Hynes to undertake a review of the nursing home inspection process.

Mr Hynes had been previously engaged by Mr Lyons in 2003 to investigate a number of issues relating to St Michael’s House, a voluntary organisation which provides services and support to people with intellectual disabilities. The issues included a complaint regarding the transfer of Peter McKenna, a client of St Michael's House, to Leas Cross in October 2000. In February, 2004, following receipt of Mr Hynes’s initial report, Mr Lyons asked Mr Hynes to meet relevant personnel from the Northern Area Health Board “to clarify the inspection arrangements in relation to Leas Cross Nursing Home”.

Mr Hynes met members of the nursing home inspectorate in August, 2004 to discuss the issue and reported to Mr Lyons in June, 2005. He was then asked by Mr Lyons to undertake a further review, with the following terms of reference:

- To review the current approach to nursing home inspections in terms of preparation work undertaken, assessment tools used, methodologies employed during inspections, guidelines employed to announce/arrive unannounced and procedures to assess the quality of care.
- To review the current extent of knowledge of nursing home legislation and use by inspection teams (e.g. using conditions on registration).
- To review the current documentation and business processes employed to monitor follow up actions following nursing home inspections and to identify more effective mechanisms to review outcomes of inspections.

55 See further Chapter 16.
To review the necessary formal linkages that need to be established or review the current effectiveness of linkages between complaints) including PG processes) and the nursing home inspection process.

To review the current staffing levels/skill mix, training, induction processes and effectiveness of deployment of nursing inspection staff.

To review how the inspection team conducts its own audit on its won practices.

To assist in implementing any findings/actions from your review identified above.

Mr Hynes furnished an interim report and a final report on these issues in June, 2005. His findings are referred to at relevant places throughout this report.

**Pharmaceutical Society of Ireland**

The Pharmaceutical Society of Ireland (PSI) is the statutory body charged with the regulation of the practice and profession of pharmacy in Ireland. Although the PSI has no direct role in the regulation of nursing homes, its jurisdiction over pharmacies included supervising the provision of pharmacy services to nursing homes. In this regard, the PSI has issued a document entitled ‘Best Practice Guidelines on the Provision of Pharmacy Services to Residential Homes by Community Pharmacies’. The guidelines state that residents’ needs are optimally served by the engagement of a full time pharmacist in all nursing homes. However, where that is not done, the guidelines state that residents’ pharmaceutical needs may be provided by a community pharmacy.

The guidelines provide detailed advice on the supply of medicinal products to nursing homes. They state that only a registered medical or dental practitioner can prescribe or order medication for a nursing home resident. This cannot be done by nurses or other care workers, save in exceptional circumstances. A pharmacist is entitled to dispense medication only when he is in possession of the original prescription for the patient concerned and not on foot of an order placed by telephone or fax, except in an emergency.

The guidelines also provide that a pharmacist providing services to a residential home “will attend on a regular basis at the home at a frequency determined by the needs of the residents and as agreed with the home, but not less than once per week”. During such visits, the pharmacist shall, among other things, provide counselling to residents to encourage compliance with the prescribed drug regimen, review residents’ medication charts at least once per month and ensure that sufficient quantities of drugs are supplied.

The Commission has been furnished by the PSI with copies of correspondence with John Aherne. On the 20th June, 2005, the PSI wrote to Leas Cross enclosing a copy of the guidelines and seeking information on the supply and dispensing of medicines at the home. Mr Aherne replied on the 19th September, 2005, pointing out that the home had been taken over by the HSE in June, 2005 until its closure in August, 2005.
Following a request on the 18th October, Mr Aherne sent copies of the home’s drug control policies to the PSI on the 25th October, 2005. The PSI again wrote on the 5th November, 2005, stating that it had “significant concerns in relation to the documentation provided regarding the provision of pharmacy services at Leas Cross Nursing Home”. Information was sought regarding protocols in place for pharmacy services and the name of the pharmacy providing services to the home was also sought. Mr Aherne replied on the 9th November, 2005, again enclosing drug control policies. He identified the pharmacy providing services to Leas Cross.

The pharmacy was inspected by the PSI on the 13th December, 2005 and certain findings were made regarding the provision of services to Leas Cross:

“Delivery of medicines to the residential unit was undertaken every evening by a delivery driver – the PSI guidelines state that the pharmacist who dispenses the medicinal products for the residents of the residential home in question should deliver the dispensed medicinal products to a designated person(s) at the home in question on a regular scheduled basis. The pharmacist initially attended a number of times (4/5) but this practice did not continue regularly as according to discussions, the home authorities did not want this. The process recommended by the PSI was not followed....

The pharmacist in the pharmacy providing pharmacy services to a residential home will attend on a regular basis at the home at a frequency determined by the needs of the residents and as agreed with the home, but not less than once per week. ... This process as recommended by the PSI was not adhered to, however the pharmacist was available by phone to residents and staff if so required.”

On the 19th January, 2006, the pharmacy wrote to the PSI to respond to issues raised during the inspection. In relation to the findings set out above, the pharmacy stated, “With regards to pharmacist visits to this home it was offered to them and they declined”.

In correspondence with the Commission, the pharmacy has pointed out that the PSI’s guidelines did not exist when the pharmacy commenced providing services to Leas Cross Nursing Home. It also points out that the PSI’s guidelines set out best practice but do not constitute binding regulations. The pharmacy has informed the Commission that it introduced standard operating procedures to govern its dealings with nursing homes and states:

“Nothing that [the pharmacy has] done or failed to do could be viewed as a diminution of its responsibility of professional care to the patient. The pharmacy always conducted its services ethically, responsibly and with great care.”

The Commission has no reason to doubt the accuracy of this statement.

The Commission asked Grainne Conway why Leas Cross did not permit visits from the pharmacist. She replied as follows:
"We were never offered the service and I did not know of the P.S.I. Of course I would have wanted a pharmacist to provide counselling training, reviewing medical prescriptions. It was never offered."

The pharmacy has informed the Commission that this is incorrect. From the outset of the pharmacy’s involvement with Leas Cross, the Chief Pharmacist offered to visit the nursing home whenever necessary. Further, the nursing home had access to a pharmacist by telephone for 75 hours per week and two pharmacists were on duty at the pharmacy on weekday afternoons to ensure the availability of a pharmacist to attend at the nursing home if required.

**ISO Standard 9001:2000**

Leas Cross Nursing Home was awarded ISO 9001:2000 certification in 2003 for the area of “residential and convalescent care”. ISO standards are developed by the International Organization for Standardization. The ISO 9000 standards, of which ISO 9001:2000 is one, set out quality requirements for management systems. These are generic standards, which means that they are designed to be applied to any organisation in any sector of activity. They are not specific to nursing homes.

A ‘management system’ is defined by the ISO as what an organisation does to manage its processes, or activities, so that its products or services meet the objectives it has set itself, such as satisfying customers’ requirements or complying with regulations.56

There are a number of organisations which award ISO certification in Ireland. The Irish National Accreditation Board (‘INAB’) gives accreditation to such bodies, who are thereby deemed competent to award ISO certification. ISO 9001:2000 certification was awarded to Leas Cross Nursing Home by EQA (Ireland) Ltd (‘EQA’), which is an INAB accredited organisation.

EQA first awarded ISO 9001 certification to Leas Cross Nursing Home on the 21st November, 2003. This was renewed for a further twelve months on the 23rd November, 2004. EQA has explained the process involved to the Commission in the following terms:

> “Initial certification was approved by an independent assessment committee, following a recommendation by the EQA audit team, in respect of an assessment audit which took place on the 31st October, 2003.

> Certification was approved and maintained by the assessment committee following a recommendation from the audit team in respect of a surveillance audit which took place on the 23rd November, 2004.

> The ISO 9001:2000 certificate was awarded following an initial review of the nursing home’s documented quality systems, followed up by a visit to Leas

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56 Further information regarding ISO 9001 is available at www.iso.org and at www.nsai.ie.
Cross Nursing Home, where a sample audit of the system in practice took place.

All site audits included a registered nurse and an IRCA [i.e. International Register of Certified Auditors, which certifies auditors of management systems] licensed auditor.

Audits included the checking of records and interviews with staff, management and residents. As the ISO 9001:2000 standard is voluntary, Leas Cross Nursing Home would typically receive four to five weeks’ advance notice of the audit.”

The first visit of the audit team to Leas Cross was on the 31st October, 2003. One of the assessors on that date was a registered nurse and a number of staff members were interviewed, including the matron, nurses, care assistants and domestic staff. The Commission has been furnished with copies of notes made and forms completed by the audit team, which include the following overall comments from the assessors:

“Well run nursing home by the owner / investor. Bright facilities with very good focus on food and hygiene standards.

Staff appear to be working the standard into their patient care delivery.”

The assessors initially found that the documentation at Leas Cross did not meet the ISO 9001:2000 requirements. Certification was subsequently recommended and awarded following the submission of a number of outstanding documents, including a standard operating procedure for the care of pressure sores.

A second visit to Leas Cross took place on the 23rd November, 2004, for the purposes of renewing certification. Prior to this inspection, it appears that residents and/or their families were invited to fill in questionnaires, rating aspects of the nursing home for the purposes of ISO certification. Documents furnished to the Commission include a folder containing 65 completed questionnaires, the vast majority of which rate issues such as nursing care, medical care and cleanliness as “excellent” or “very good”. On the occasion of the inspection by the audit team, no significant problems were noted and certification was approved for a further twelve months.

The ISO 9001:2000 scheme operated by EQA provides for the termination or suspension of certification “if any organisation has, in the reasonable view of EQA brought certification into disrepute”. Following the broadcast of the Prime Time documentary, EQA notified Leas Cross that its board was carrying out an investigation and seeking a written response to allegations raised by Prime Time. No response having been received, on the 11th July, 2005, EQA issued a ‘certification withdrawal notice’ to Leas Cross, requesting the return of its certificate. John Aherne wrote to EQA following receipt of the withdrawal notice to query the grounds for the withdrawal of the certificate. EQA responded pointing out that no response had been received to its initial correspondence and indicating the availability of an appeal procedure. Leas Cross Nursing Home closed in August, 2005 and the Commission is not aware that any formal appeal was taken by Mr Aherne.
CHAPTER 15

COMPLAINTS MADE TO THE HEALTH SERVICES

This chapter addresses complaints made to the health services in relation to Leas Cross Nursing Home. In accordance with the Commission’s terms of reference, the purpose of the chapter is not to analyse in detail the substance of every complaint, but rather to examine the procedures in place to deal with complaints, the roles of relevant persons in relation to complaints and the manner in which such persons responded to complaints when they were made. The chapter does not deal with complaints made to the Commission by the families of former residents, which were not specifically raised previously with the Health Board / HSE.

In considering the issue of complaints in relation to Leas Cross Nursing Home, it is necessary to appreciate an important distinction. This is the distinction between those complaints made in respect of residents while they were in Leas Cross and those made later in the wake of the *Prime Time* documentary. While the latter are no less valid than the former, it is those complaints made during the operation of the nursing home that are of most interest to the Commission, as they reflect the complainants’ immediate concerns and cannot be said to have been prompted by negative publicity or made with the benefit of hindsight. Further, because Leas Cross closed shortly after the *Prime Time* documentary, it was not always possible for the HSE to investigate fully complaints received in that period.

**Procedure for complaints to the Health Board**

**Legislative framework**

Article 26 of the Nursing Homes (Care and Welfare) Regulations 1993 governs the investigation of complaints made to the Health Board / HSE. It provides the following:

1. A dependent person being maintained in a nursing home or a person acting on his or her behalf may make a complaint to the chief executive officer or a designated officer of the health board.

2. A complaint shall be made in writing, save as provided in article 26.3.

3. A chief executive officer may cause a verbal complaint to be considered and investigated, where he or she is satisfied that it is not possible to make a written complaint and that the complainant is acting in good faith.

4. A complaint may be made in relation to any matter concerning the nursing home or the maintenance, care, welfare and well being of a dependent person while being so maintained.
5. The chief executive officer shall cause a designated officer of the health board to consider and investigate any complaint made by or on behalf of a dependent person being maintained in a nursing home.

6. The chief executive officer shall cause a designated officer of the health board to inform the registered proprietor or person in charge of the nursing home of the complaint that is being investigated and shall give the registered proprietor or person in charge the opportunity to make his or her case.

7. Where a complaint is upheld by a chief executive officer following consideration and investigation, the chief executive officer may issue a direction to the registered proprietor of the nursing home concerned, requiring such proprietor to take specified action in relation to the matter complained of.

8. A registered proprietor of a nursing home shall comply with a direction of a chief executive officer under article 26.7.

9. A chief executive officer, following consideration and investigation of a complaint under this article, shall inform the complainant of the outcome of the consideration and investigation.

It is important to note that a formal complaint may be made by a nursing home resident or by a person acting on his or her behalf. There is nothing in the regulations to suggest that those who complain on behalf of a resident must be a family member or relative. However, the Commission has received correspondence from the principal social worker at Beaumont Hospital asserting that complaints from healthcare professionals have been rejected by the Health Board on that ground. The letter states:

“The gap that exists there at present is that the nursing home inspectorate replies on each occasion to say that under legislation the only people who can make a complaint are the patient or their family. Very often the family does not want to rock the boat in case their loved one is transferred back. There are also some occasions where the patients are admitted from nursing homes, die in hospital and the relatives ask you not to contact the next of kin because they are so upset in relation to making a complaint. It would be better if the law could be expanded to allow health care professionals to make a complaint as well.”

The Commission asked Nursing Home Inspector H in evidence whether the nursing home inspectors imposed restrictions on who could make complaints. She denied this, saying:

“Basically anybody could make a complaint. It’s important that you listen to every complaint that comes in because they could have come from anybody. I mean, in relation to Leas Cross we had family members, we had a visitor, we had the principal social worker in Beaumont and in another nursing home we had a town commissioner. So basically we look at every complaint. We’d have to check it out to see if it was valid but basically most of them are.”
Nursing Home Inspector H said that, in her experience, complaints rarely came from acute hospitals. In the case of Leas Cross, she said that only one complaint was received from an acute hospital.

In response to this, the principal social worker at Beaumont Hospital has acknowledged that one complaint made by him in relation to Leas Cross Nursing Home was investigated by the H.S.E. However, that investigation was conducted by the investigation team set up following the broadcast of the *Prime Time* documentary and not under the usual arrangements for investigating complaints. The Commission has been informed that Beaumont Hospital has since encountered difficulties making complaints in respect of other nursing homes: the principal social worker has cited, as an example, a complaint made by the hospital in October, 2007 regarding a nursing home resident whose family had no complaint but whose condition on admission to the hospital gave cause for concern. The H.S.E responded to say that it required “written evidence that the patient/resident was aware” that a complaint was being made. That was not possible in circumstances where the resident had died, but the hospital nonetheless considered that his treatment in the nursing home in question warranted investigation.

The statements of Nursing Home Inspector H and the principal social worker from Beaumont Hospital give rise to a conflict of evidence which the Commission cannot resolve. Whatever procedure is used, the Commission considers that it should be understood that the purpose of investigating a complaint is not merely to vindicate either party, but to ensure that all residents receive adequate care and that problems do not recur. Accordingly, the source of a complaint is largely irrelevant and the H.S.E. has a duty to investigate any credible allegation regarding the care of nursing home residents.

It is evident that some confusion exists regarding the manner in which complaints may be made and the Commission considers that this could be remedied by the amendment of the relevant legislation. In particular, the wording of article 26.1 could be clearer, where it refers to a complaint being made “on behalf of” a nursing home resident. That provision is open to the interpretation that the resident must have sanctioned the making of the complaint. The Commission considers that it would be preferable to provide more clearly that a complaint may be made by any interested person. A number of the submissions received by the Commission from the families of former residents of Leas Cross state that residents arrived at acute hospitals with ailments such as dehydration and pressure sores. The Commission considers that a clear procedure should exist for hospitals in such instances to make known to the HSE any concerns regarding standards of care at nursing homes so that such concerns can be investigated.

It is also noteworthy that Martin Hynes, who was commissioned by the Chief Officer of the E.R.H.A. to review the nursing home inspection process in that region, identified the sources of nursing home complaints in 2004 as follows:

> “Fourteen complaints in respect of six homes were received in 2004. Ten complaints were made by relatives, two were anonymous (believed to be staff) and one was from a GP. The fact that a resident or other person can make a complaint to the HSE-Northern Area is not well publicised.”
In light of that comment, the Commission believes that all nursing home residents and their families, as well as hospitals and other referring agencies, should be notified of the complaints procedure and that relevant contact details should be readily available.

Article 26 provides that complaints may be made to the CEO or a designated officer of the relevant Health Board. Under the Regulations, designated officers are defined as “officers of health boards authorised by the chief executive officer or the deputy chief executive officer of a health board to carry out functions under the Act [of 1990] and these Regulations”. The designated officers under the regulations are the nursing home inspectors.

In practice, however, complaints were made by members of the public to a variety of individuals in different parts of the health services. Nursing Home Inspector H listed for the Commission some of the persons to whom complaints were made:

“Well, they could be made to anyone. They could have come to the general manager, they could come to the senior area medical officer, they could come to me, they could come [the Nursing Home Section Manager]. Now, when the independent inspectorate came in, everybody was informed that if a complaint came in to them, they all had to go straight to [the Nursing Home Section Manager] because it appeared that they were possibly getting lost en route or they weren’t documented in a proper database.”

The Commission considers that article 26 of the 1993 Regulations should be more comprehensive. Nursing home residents and members of their families may not appreciate the need to complain to a particular person in order to ensure that their complaints are investigated. This could be remedied by the imposition of a positive duty on all healthcare professionals and HSE employees to refer any complaint received regarding a nursing home to the Nursing Home Section.

One final point to note about article 26 is the requirement that complaints be made in writing, unless “it is not possible to make a written complaint and that the complainant is acting in good faith”. Again, Nursing Home Inspector H has clarified the practice in relation to this:

“... the legislation clearly says it’s better if [the complaint] is in writing so if somebody phoned up and spoke with me ... I would say is it possible for you to put this in writing because it would be better if you did. But if they were anxious not to put it in writing, we would still take it and look at it most definitely.”

Again, the Commission considers that this provision is not adequately framed to ensure that every valid complaint is investigated by the HSE. Clearly nursing home residents may not always be willing or able to commit their concerns to writing. Although this is recognised in article 26.3, a more inclusive rule might provide that where a complaint is not made in writing and the person making the complaint is unwilling or unable to make the complaint in writing, the person to whom it is first made shall be required to record it in writing and send it to the Nursing Home Section.
Procedure for complaints to the Health Board / H.S.E.

Article 26 of the 1993 Regulations requires that complaints received by the HSE be referred to a designated officer for investigation. In her initial written submission to the Commission, Nursing Home Inspector H set out the procedure for investigating complaints as follows:

“It was part of my remit to investigate complaints in relation to nursing homes. The protocol for the investigation of a complaint in relation to a resident being maintained in a nursing home was strictly informed by Article 26 of the Nursing Homes (Care and Welfare) Regulations 1993. All complaints investigated by me with reference to Leas Cross Nursing Home were sent in writing to me. They came from a number of sources, the CEO’s office, Nursing Home Section, St Mary’s, Senior Area Medical Officer or directly to me. ...”

With reference to all complaints, I would contact the relevant nursing home and confirm with the PIC [person in charge] that the person referred to in the complaint was or had been a resident in the home. I would then post on a copy of the complaint to the proprietor / PIC as outlined in the legislation.

I would generally receive instructions to carry out such an investigation from the Office of the CEO or the Nursing Home Section, St Mary’s. If the complaint was sent directly to me, I would inform the Nursing Home Section, St Mary’s. Following the completion of my investigation, I would then send my report back to the CEO’s office. From July, 2004 ... all complaints were processed through [the Head of the Nursing Home Inspectorate] who dealt with the CEO’s office. My responsibility was to carry out the investigation and to complete the report. I had no further input unless I was asked to clarify any issues. The response to the family issued from the CEO’s office.”

In an appendix to a report on complaints received by the HSE in 2005 and 2006 regarding Leas Cross Nursing Home (November, 2006), Nursing Home Inspector H explained that the system was altered to ensure that all complaints are submitted in writing to the Regional Manager of the Nursing Home Inspectorate because it had been identified that “many health professionals and health board officials were receiving complaints”.

In that report, Nursing Home Inspector H set out in more detail the format for investigating a complaint:

“The format for investigating a complaint generally includes:

Pre-planning stage: The designated officers review the complaint and plan the investigation. The nursing home is advised of the complaint and given an opportunity to respond to the issues therein. The majority of the homes respond in writing. Pre-planning includes the review of all relevant data
pertaining to the particular home e.g. recent inspection reports. Any previous complaints are also reviewed.

It may be necessary to contact and meet the person who wrote the complaint to clarify or discuss the issues under review. Due to time constraints and resources in the earlier complaints investigate, families were not generally met with but now all families are given the opportunity to discuss the complaint if appropriate. The complaints procedure has continued to develop over the last two years. It is now reasonable to interview and meet the complainants/residents on at least one occasion during the investigation.

A planned visit to the home is organised to meet and interview with the relevant staff, e.g. proprietor/person in charge/staff. If appropriate it may be necessary to meet the resident. Under the Act “A resident’s medical record may be inspected by a medical officer of a health board who is designated for the purposes of the act. A designated officer may interview in private any resident or any member of staff where the officer has reasonable cause to believe a person in the nursing home is or has not been, receiving proper care (article 23.1). It may be necessary to visit the home more than once.

Each complaint is completed on each individual issue, the possible regulation breech, the risk score and the action taken (Appendix c). Risk reflects the likelihood that harm will result and the effect that harm will have on a resident or other residents in the home. A risk assessment tool is in the development process.

A report is compiled by designated officers for the CEO upholding the complaint or otherwise. A response to the complaint is then sent to the complainant with an opportunity to appeal if they are unhappy with the outcome.”

According to former HSE Chief Officer Michael Walsh, the majority of complaints regarding nursing homes were dealt with at the community care level, and senior management were not appraised of those complaints.

**Complaints regarding Leas Cross Nursing Home**

As far as the Commission can ascertain, eleven complaints were made to the Health Board in relation to Leas Cross prior to the broadcast of the RTE *Prime Time* documentary. This information has been obtained by the Commission from families of former residents of the home and documentation furnished by the HSE, including a report on complaints prepared by the HSE in November, 2006. The numbers of complaints made each year to the Health Board / HSE are as follows:

- 2000 – 1
- 2001 – 1
Complaints in 2000

Kathleen Reilly

The first complaint to the Health Board of which the Commission is aware was made on the 9th September, 2000 in relation to Kathleen Reilly, a resident of the home suffering from Alzheimer’s Disease, who was found wandering around in Swords by members of her family. The complaint also referred to issues regarding personal hygiene and laundry.

A written complaint was made by Ms Reilly’s niece, Anne Bissett to the proprietor of the nursing home and a copy was sent to the Northern Area Health Board (NAHB). The NAHB acknowledged receipt of the letter and referred the complaint to the Co-ordinator of Services for the Elderly. She wrote to Ms Bissett on the 18th October, 2000, stating that the incident had been discussed with the matron during a routine inspection of Leas Cross and that the inspectors were furnished with a copy of the matron’s response to the complaint. The Commission can find no reference to the issue in any inspection report, but an inspection was carried out on the 6th October, 2000.

The Co-ordinator of Services for the Elderly, together with Nursing Home Inspector C, subsequently met Ms Bissett. A report of the investigation was prepared on the 14th December, 2000, two months after the complaint was made.

An explanation regarding the incident was given by the matron to both Ms Bissett and the investigation team. The matron stated that Ms Reilly had been due to attend Beaumont Hospital and that the nursing home booked an ambulance to take her there. However, the Health Board sent a taxi instead and the driver would not allow any member of staff to accompany Ms Reilly, as he had other patients to collect. Accordingly, Ms Reilly was sent unaccompanied in the taxi with a letter in her pocket explaining why she was attending the hospital. Following her appointment, she apparently chose to take the bus home and ultimately ended up walking around in Swords.

The investigation report on the complaint set out the matron’s explanation and noted her assurance that a similar incident would not occur in the future. The investigation team also noted that hygiene levels were acceptable and laundry facilities adequate during their visit and stated their intention to monitor those issues at future routine inspections.

Martin Hynes in his report to the Chief Officer of the HSE Eastern Region in June, 2005 regarding the nursing home inspection process, criticises the handling of this complaint:
“The explanation given was that the taxi arrived to take her to the hospital for her appointment but the driver would not let anyone accompany her. This excuse should have been regarded as nonsense. Leas Cross allowed her to go unaccompanied and cannot pass the problem on to a taxi driver. The duty of care rested with Leas Cross and they should have been reminded of that.”

The Commission agrees that the response to this serious complaint appears to have been inadequate. The investigation team did, within a short time of the complaint being made, carry out a thorough investigation to ascertain what happened, but then merely accepted the assurances of the nursing home that the incident would not recur. Some form of monitoring, such as spot checks on the transfer of residents to hospital for a number of months, would have been appropriate, to ensure that the matron’s assurances were reliable.

Complaints in 2001

In 2001 a complaint was made regarding the care of a resident, Peter McKenna, who had been transferred to Leas Cross from St Michael’s House. This complaint is addressed in the chapter of this report dealing with transfers from St Michael’s House.57

Complaints in 2003

Resident M.K.

The Commission is unaware of any complaints to the Health Board regarding Leas Cross in 2002. Four complaints were made in 2003. The first of these was made in May, 2003. The family involved in this complaint prefer to remain anonymous. The resident in question was admitted to a contract bed at Leas Cross in January, 2003. Her daughter had serious concerns regarding the resident’s treatment. She found that mistakes were frequently made in administering her mother’s medication and she was concerned at a lack of communication and continuity of care. On one occasion, she witnessed a care worker shouting abuse at her mother.

The resident’s daughter visited the offices of the Health Board in Swords on the 12th May, 2003 to report her concerns. She has informed the Commission that she found the staff there very helpful. She requested that her mother be transferred to another home. She was asked to put her request in writing, which she did the following day, by way of a letter to the Nursing Home Section Manager. The complainant had brought her concerns to the attention of the Health Board when she spoke to them in person, but has informed the Commission that she did not set them out in any detail in her letter, for fear of the effect this might have on her mother as long as she remained at Leas Cross. Her mother was transferred on the 21st May, 2003.

57 See Chapter 16.
The Commission considers that this complaint was dealt with efficiently and effectively from the complainant’s point of view. However, there is no evidence to suggest that the Health Board took steps to investigate the standard of care at Leas Cross as a result of this complaint.

**Dympna and May Monks**

The next complaints related to two sisters staying at Leas Cross, Dympna and May Monks. Another sister of the two residents, Chris Green, met General Manager A and a Senior Manager of the Health Board on the 3rd December, 2003 to discuss her concerns regarding her sisters’ care at the nursing home. She complained that there was an insufficient number of staff to care for the residents. She told the Health Board that her sisters were not properly dressed by staff, that they received only limited assistance to use the toilet and were regularly served cold food and drinks. One of her sisters was not given her nebuliser as required.

Ms Green also described an incident in which the home failed to call a doctor for her sister, who was in pain and unwell, until she attended the home herself and demanded that a doctor be called. It transpired that her sister had a kidney infection. Ms Green also reported that one of her sisters had been left sitting in a wheelchair for long periods.

Minutes of the meeting were sent to the complainant by General Manager A, with a letter asking her to sign them so that they could form the basis of her complaint. The letter was copied to the Head of Quality at the Department of Corporate Governance.

General Manager A has explained to the Commission that she was not ordinarily involved in the investigation of complaints. Her involvement on this particular occasion arose only because she was present in the offices of the Health Board when Ms Green called in to raise her concerns. She referred the matter to the appropriate personnel within the Health Board, but marked the file “not pursued” some time later on the basis that Ms Green had not returned the signed minutes.

Amongst the documents disclosed to the Commission by the H.S.E. is a copy of a memo dated the 4th December 2003 from the Senior Manager to Nursing Home Inspector H and headed “Leas Cross Nursing Home”. The memo states:

“A meeting has been called for 4 pm on Tuesday 9th Dec in HQ in relation to a number of issues which have arisen in respect of the above nursing home.

[An NAHB staff member] has forwarded copies of the two most recent inspection reports. If there is any other relevant information pertaining to previous inspections I would be grateful if you could bring them to the meeting.”

There is a handwritten note on the face of this document which is signed by Nursing Home Inspector F and dated the 5th December 2003. The note reads as follows:

“(1) Verbal complaint re May Monks. Awaiting [sic] for written details.”
(2) [Consultant Psychiatrist A] / [Director of Nursing] (St Ita’s) have concerns re St Ita’s pts in Leas Cross e.g. loss of weight also. They seem to have a complaint from 1 family re – a pt in Leas Cross also.

I informed the Senior Manager that we would appreciate getting the details as soon as possible.”

The Commission has not been able to establish whether the proposed meeting on the 9th December actually took place; or if it did take place, what was discussed and decided there. In a written response to the Commission on this issues, Nursing Home Inspector H, the intended recipient of the memo, stated:

“I did not receive this fax myself as I was on leave from Tuesday 2nd December 2003 and returned to work on Thursday 11th December. [Nursing Home Inspector F] has recorded on the fax that she contacted [the Senior Manager] and also identifies the issues. We did not receive any further contact in relation to the issues and did not attend any meetings in relation to the matter.

I do have a vague memory of talking to [the Senior Manager] by phone some time later in which she inform[ed] me about the [M.M.] complaint and again my vague recollection is that [she] told me that if we were required that we would be contacted, but we were never contacted.”

From the documents disclosed to the Commission by the H.S.E., the next mention of the complaints made concerning Dympna and May Monks is in March, 2005, when their sister met a person from the Consumer Affairs Department of the H.S.E. as part of an investigation by that department. The Commission has been furnished with minutes of this meeting, at which Ms Green again outlined her concerns regarding the care of her sisters at Leas Cross, both of whom had died in 2004.

On the 13th November, 2006, a letter was sent to Ms Green, signed by members of the Complaints Review Group, apparently containing the result of an investigation of the complaint. The letter is headed, “Your enquiry dated 4th December, 2003 regarding your late sisters … and the care they received during their stay in Leas Cross Nursing Home”. The letter states that “this team received your complaint in June, 2005” and could not carry out a full investigation owing to the closure of the home in August, 2005. The investigators state that they were unable to visit the home but reviewed documentation from the home and from Beaumont Hospital regarding one of the sisters. They conclude that “it is not possible to confirm that adequate care was provided as outlined in section 5 of the care and Welfare legislation of 1993” in respect of RGN staffing levels and pressure sore prevention.

One member of the Complaints Review Group has informed the Commission that his involvement in the investigation of this complaint began in June, 2006, when he was asked to assist the H.S.E. in the investigation of complaints by reading nursing and medical notes from Leas Cross and, where applicable, from Beaumont Hospital. He states that his involvement was in an advisory capacity only and he points out that by the time he became involved, the nursing home had already closed.
The information available to the Commission suggests that the complaints made by Ms Green in 2003 were not properly addressed by the Health Board within a reasonable time. Whether or not the complainant signed the minutes of her original meeting with General Manager A in December, 2003, she had brought serious issues to the attention of the Health Board which should have been investigated immediately. Having been made aware of alleged problems at Leas Cross, the Health Board, in the opinion of the Commission, was under a duty to investigate to ensure compliance with the 1993 regulations, irrespective of the attitude of the complainant to the procedure.

The ultimate report on the complaints, issued in November, 2006, is wholly inadequate. The Complaints Review Group explain this on the basis that they received the complaint in June, 2005 and the home closed in August, 2005. Although these investigators were not assigned to deal with this complaint until 2005, and in the case of one member of the group, 2006, the complaint was originally received by the H.S.E. in December, 2003 and should have been addressed earlier by appropriate H.S.E. staff, when the nursing home was still in operation.

Dorothy Black

On the 12th December, nine days after receiving the complaints regarding Dympna and May Monks, General Manager A received a written complaint from the family of Dorothy Black, who had arrived at Leas Cross from St Ita’s Hospital in September 2003.

In their letter to General Manager A, Ms Black’s daughters outlined a series of events since their mother’s admission to the nursing home in September, 2003, culminating in her admission to Beaumont Hospital suffering from serious pressure sores and weight loss. They reported that they had had to request their transfer of their mother to hospital as the nursing home and G.P. had apparently not considered it necessary. The letter concluded with an express request for action on the part of the Northern Area Health Board:

“We would appreciate if you could give your urgent attention to the circumstances that led to our mother’s admission to Beaumont Hospital.”

By letter to Ms Black’s daughters dated the 16th December, 2003, General Manager A informed them that a review group had been set up to examine the complaint and that the complainants’ mother would be transferred to a different nursing home on her discharge from Beaumont. In fact, their mother died in Beaumont Hospital in January, 2004 as a result of her pressure sores. Her death was the subject of an inquest, whose verdict was “death by medical misadventure”.

The Head of Quality in the Department of Corporate Governance, NAHB has told the Commission that he was asked to co-ordinate the NAHB review into the care of Dorothy Black at Leas Cross. He and Nursing Home Inspector H made an unannounced visit to Leas Cross on the 22nd December, 2003. According to Nursing Home Inspector H, the visit was “a general visit with no specific agenda. The meeting
An appointment was made for a further visit, which took place on the 12th January, 2004. The Head of Quality in the Department of Corporate Governance was accompanied on that occasion by Nursing Home Inspector H and the Senior Area Medical Officer. According to Nursing Home Inspector H, the complaint regarding Ms Black was investigated by her and a Senior Area Medical Officer. The Head of Quality accompanied them in order to familiarise himself with their procedures: “He did not partake in the investigation as such.”

In the course of their investigation, the Head of Quality at the Department of Corporate Governance and the review group also requested and received a written response from Leas Cross to the complaint. On the 22nd January, 2004 Nursing Home Inspector H wrote to the Assistant Chief Executive Officer, NAHB with some observations arising from her review of the Leas Cross response.

On the 26th January, 2004 General Manager A wrote to Ms Black’s daughters with an update on the review of their mother’s care at Leas Cross.

The final report of the review group into the care of Dorothy Black was sent to General Manager A on the 9th March, 2004. By letter dated the 28th April, 2004, she reported the findings of their investigation to the complainants. General Manager A stated that, in general, the staff at Leas Cross had been aware of their mother’s condition, had monitored her closely and adhered to written procedures. However, the report acknowledged that Ms Black had developed her pressure sores while in Leas Cross and that, while appropriate equipment had been used, there was no formal assessment of pressure sores in operation to establish levels of deterioration.

The review group also found that a large number of residents had been admitted to Leas Cross from St Ita’s at or around the same time as Dorothy Black, which had placed added strain on staffing resources. The review group concluded that there had been an improvement in staffing in the weeks following their investigation and that the Public Health Nursing Service would provide support and direction to the home in future.

In a written submission to the Commission, Nursing Home Inspector H has stated:

“The outcome for the complaint was inconclusive due to lack of documentation available to uphold the complaint. The home agreed to look at their pressure sore prevention policy, from assessment to treatment and documentation. We offered support from our nurse specialist but it was not taken up at that time. Ms Conway agreed also to look at the RGN staffing levels in light of the findings of the previous inspection and outcome.”

In this case, it appears to the Commission that the Health Board acted quickly to deal with the complaint when it was made, by agreeing to transfer Dorothy Black to a different home. It also appears that the investigation was thorough and completed within a reasonable time. The real issue in this case related not to the complaint but the poor standard of care which led to the deterioration of the resident’s health. While
it has been pointed out to the Commission that there was a shortage of public health nurses and a number of shortcomings in the inspection system, the Commission nonetheless considers that this poor standard of care should have been identified by medical and nursing staff or Health Board inspectors much earlier. Instead, it was left to Ms Black’s daughters to seek her transfer to hospital, when she had already suffered serious pressure sores and weight loss. It is also noteworthy that Leas Cross did not take up the offer of assistance from the Health Board in reviewing its pressure sore prevention policy. The Commission considers that it would have been desirable for the Health Board to have taken a more hands-on approach on the issue, in light of the complaint.

Complaints in 2004

Catherine Mullins

The first complaint to the Health Board in 2004 was made on the 15th January by Mary Hegarty regarding the care of her mother, Catherine Mullins. Ms Mullins had been resident in Leas Cross since June, 2003, suffering from Alzheimer’s Disease. Following a number of complaints to the matron at Leas Cross relating to the failure of the staff to understand the needs of an Alzheimer’s patient, an incident occurred in January, 2006 which persuaded the family to move their mother elsewhere. Ms Hegarty visited the home to find her mother slumped on a couch in the foyer, in pain and wearing soiled clothes. She received little assistance from the staff in trying to help her mother and she also found that her mother’s medication had been left in her room. The family removed Ms Mullins from Leas Cross a few days later.

On the 15th January, 2004, Ms Hegarty wrote a detailed letter to the matron, a copy of which she sent to Nursing Home Inspector H. The letter recounted the events of the 6th January and set out a series of complaints including issues of personal care, staffing, and fluid intake. The letter was acknowledged by Nursing Home Inspector H on the 22nd January, 2004, stating that she had initiated a review.

On the 2nd March, 2004 Ms Hegarty wrote to Nursing Home Inspector H to inform her that her mother had died in February and seeking a report on the current status of the investigation. Nursing Home Inspector H replied on the 8th March stating that she was in the process of reviewing the complaint and that she expected a response from Leas Cross that week.

An investigation was carried out by Nursing Home Inspector H and a Senior Area Medical Officer. In a written submission to the Commission, Nursing Home Inspector H has acknowledged that there was a delay in investigating this complaint. She states that she could not investigate the complaint without the assistance of a doctor, because under the 1993 Regulations only a doctor may examine medical records. The Commission has been furnished with copies of correspondence from Nursing Home Inspector H to her General Manager, stating that no medical officer was available in the area. Ultimately, a Senior Area Medical Officer assisted with the investigation.

58 See further Chapter 13.
The investigation team visited Leas Cross on the 16th March, 2004 and obtained a written response to the complaint from the nursing home on the 25th March. On the 23rd May, 2004, Nursing Home Inspector H and the Manager of Services for Older Persons met Ms Hegarty and members of her family.

The team ultimately reported to the Head of Quality at the Department of Corporate Governance on the 13th July, 2004, setting out their conclusions and recommendations under a number of headings, namely staffing, health and safety, medication, nursing care and consultation with G.P. A detailed response to the complaint was sent to Ms Hegarty by the Head of Quality on the 22nd July, 2004, setting out what was contained in the report. He concluded that a number of issues required immediate attention at Leas Cross and stated that a process to address those issues was under way.

Ms Hegarty replied to the Head of Quality on the 18th August, 2004 asking what punitive measures, if any, would be taken against the proprietors of the home and what remedial measures were being taken. That letter was acknowledged the following day and a more detailed response followed on the 4th October, 2004, setting out various steps that had been taken, including an agreement to appoint an assistant director of nursing at the home, a review of policies and procedures at the home and the introduction of a dependency rating model to identify specific needs of patients.

The family subsequently met members of the review team, including Nursing Home Inspector H, to discuss their complaint. At that meeting, they asked whether other complaints had been received in relation to Leas Cross Nursing Home. The family say they were told that no other complaints had been made. The family have told the Commission that this influenced their decision at the time not to take their complaint any further. They may have taken a different approach had they been aware at the time that theirs was not the first complaint. However, Nursing Home Inspector H has denied that the family were told that no other complaints had been made. She stated to the Commission:

“As per normal procedure I informed the family that if there were complaints I would not be in a position to discuss any complaint with them other than their own individual complaint.”

On the 4th August, 2004, a meeting took place at Leas Cross between Nursing Home Inspector H, the Head of Quality at the Department of Corporate Governance, Ms Conway and Mr and Mrs Aherne. Nursing Home Inspector H explains the reason for this as follows in her submission to the Commission dated the 25th September, 2008:

“Although there was no concrete evidence of poor care or poor management, I had a general feeling of concern in relation to Leas Cross, although it certainly was not the worst nursing home I had seen by any means. Because of my general feeling of concern, I arranged a meeting to take place on the 4th August, 2004 ... The purpose of this meeting was to intervene early with a view to getting the home back on track. As outlined above, there were by that time indicators that the level of care could diminish – i.e. the high patient numbers and poor skill mix ratio, together with the outcome of complaints ...”
The issues outlined in the complaint concerning Catherine Mullins were used as the basis for the agenda of the meeting on the 4th August, 2004. In relation to staffing, the appointment of three additional nurses together with an assistant director of nursing was recommended. Ms Denise Cogley was appointed assistant director of nursing on the 8th November, 2004. Other issues discussed at the meeting included care planning, which the matron agreed to follow up, and G.P. cover for the large number of patients, which the matron and proprietor agreed to discuss with the current G.P.

Administration of medication was also discussed, arising from the fact that medication for Catherine Mullins had been left on her locker. In her written submission to the Commission, Nursing Home Inspector H says the following regarding this issue:

"Following the outcome of the complaint ... in which we identified poor practice in relation to the dispensing of medication, we discussed this matter at the meeting. My memory of discussing the case was that Mr Aherne was not happy with me when I questioned his PIC [i.e. person in charge, namely the matron], Ms Conway as to what had been done to follow up in relation to this issue. In my opinion, there is a clear obligation on the PIC to ensure that medication is dispensed safely and that staff are competent to do the job. An Bord Altranais has very clear guidelines in regard to the administration of medication. ...  

Although I hadn’t met the RGN [i.e. registered general nurse] involved, Ms Conway did not facilitate me with meeting the RGN who had been involved. Ms Conway agreed to supervise the RGN’s practice and update her education with reference to medication management. She also agreed to ensure that the nurse involved who had left medication on [the resident’s] locker would be given an update in training. There was some evidence that Ms Conway had commenced this process in that she had contacted the Head of Education in St Ita’s to source any updated training on medication management. However I understand that she did not follow through the process. On discussion some time later with [the Head of Quality at the Department of Corporate Governance], I found the RGN involved had moved to another nursing home. [The Head of Quality] and I had to meet with the other home, to where the RGN had moved, and we followed through with the process of updating her training in this area."

The Commission considers that the Health Board responded to this complaint effectively and carried out a thorough investigation. The delay in dealing with the complaint, while undesirable, was not inordinate, and has been explained by Nursing Home Inspector H. The Commission is also satisfied that the Health Board took steps to follow up on the significant issues arising from the complaint, in meeting the management and owners of Leas Cross and ensuring that the nurse involved received appropriate training.

John Walsh
The second complaint in 2004 was made by Elizabeth O’Shea regarding her uncle, John Walsh, who suffered two serious falls during his time at Leas Cross. The first fall occurred in January, 2004, when Mr Walsh was pushed by another resident, despite the matron having been told by family members on the preceding day that he required protection from this person. He suffered a broken hip as a result of the fall. The second fall occurred on the 26th June, 2004. Despite a number of requests, Mr Walsh was not seen by a doctor until three days after the incident and was given only paracetemol for his pain. He was sent for an x-ray the following day and was found to have a broken hip, which required surgery. Ms O’Shea states that the doctor looking after her uncle in Beaumont Hospital found that he was under-nourished. Ms O’Shea obtained accident report forms from Leas Cross in respect of both incidents.

A written complaint was sent to Nursing Home Inspector H on the 30th August, 2004, a month after Mr Walsh had died. An investigation was carried out by Nursing Home Inspector H and a Senior Area Medical Officer. They visited Leas Cross and spoke to the matron. They reported their findings to the Head of the Nursing Home Inspectorate on the 22nd October, 2004. The matron had acknowledged that there had been a breakdown in procedure in Mr Walsh’s care and had prepared a new policy to ensure that similar problems would not recur. The investigation team had reviewed the new policy and intended to review its implementation and effectiveness regularly. The report also stated that the home had “allocated an extra nurse to the area”. The Head of the Nursing Home Inspectorate wrote to the complainant on the 25th November, 2004, setting out these findings.

It does appear to the Commission that the complaint was fully investigated within a reasonable time.

Resident J.B.

The third complaint in 2004 related to a sewage leak at Leas Cross. The complainant has requested anonymity in the Commission’s report. During a visit on the 29th August, 2004 to a friend who was resident at the nursing home, the complainant found sewage coming through a pipe into his friend’s bathroom and was informed that it had been there for some days. He spoke to the matron and had his friend moved to another room.

The following day, the complainant notified the CEO of the NAHB, of the incident by fax. The CEO acknowledged the complaint on the same day and undertook to arrange for the matter to be followed up. Nursing Home Inspector H and a Senior Area Medical Officer visited Leas Cross in response to the complaint and obtained a written response from the matron. The matron explained how the incident occurred and stated that the sewerage system was maintained by an independent contractor.

The investigators reported their findings to the Head of the Nursing Home Inspectorate on the 25th October, 2004. They concluded that the incident had been isolated and stated in their report that they had no concerns from a medical and nursing perspective. They also referred the matter to the Principal Environmental Health Officer. A Senior Environmental Health Officer visited the home and found that the problem had been satisfactorily resolved.
Michael Walsh, Chief Officer at the HSE, formally responded to the complaint by letter of the 14th April, 2005. His letter starts by apologising for the delay in sending the response “which seems to have been lost in transit”.

Although there was a significant delay in responding to the complainant in this instance, the Commission is satisfied that this complaint was investigated effectively.

Resident E.F.

The final complaint in 2004 was made on the 1st October by the husband of a resident suffering from Parkinson’s Disease, who developed a serious bed-sore while in Leas Cross. The family of the resident in question have asked to remain anonymous. The nursing home had been informed at the time the complainant’s wife was admitted that she was susceptible to pressure sores. A serious sore developed on her sacrum, which was treated in the Mater on three occasions in 2004 and recurred despite treatment. A wound specialist at the Mater Hospital asked for better cleaning of the wound by nursing home staff. The complainant ascribes the repeated development of the sore to the fact that his wife was allowed to spend long periods sitting in her wheelchair.

On the 1st October, 2004, the complainant wrote to the Nursing Home Section Manager to complain about the medical care provided to his wife at Leas Cross. She acknowledged his complaint and forwarded his letter to Nursing Home Inspector H on the 8th October, asking her to investigate. Again, there was a delay in processing the complaint, owing to the fact that there was initially no medical officer available to join the investigation team. A review of the complaint was ultimately carried out by Nursing Home Inspector H and an Area Medical Officer, who reported their findings to the Head of the Nursing Home Inspectorate on the 29th December, 2004. Their review consisted of an interview with the matron at Leas Cross, an examination of the nursing and medical notes and a meeting with the resident in question.

The report of the review team focussed on four areas: immobility, pressure sores, weight loss and standards of care. In relation to the pressure sore, the investigators found that the resident received “appropriate treatment in the main following identification of the pressure sore” but that “there [was] inadequate documentation of preventive measures”. They concluded that “much improved documentation and implementation of preventive measures” were required, together with the development of individual care plans and supervision of progress within care plans by senior nursing staff.

The complainant did not receive a reply to his complaint until the 18th February, 2005, by which time his wife had died. On that date, the Head of the Nursing Home Inspectorate sent him a detailed report, containing the findings of the investigation team. The complainant replied on the 30th March, 2005, setting out a detailed response to the report and raising a number of queries. He concluded:

“It is not a consolation to [the resident’s] family that the result of the Home’s negligence is an admonishment from the Health Board to keep better notes and follow their own preventative procedures more closely. What I seek from
The Head of the Nursing Home Inspectorate met the complainant on the 13th April, 2005 and, following a telephone call from him on the 17th June, 2005, again wrote to him stating that the matter had been referred to the Area Medical Officer, who was prepared to meet the complainant to discuss his concerns. On the 29th June, 2005, the complainant wrote to the Head of the Nursing Home Inspectorate to express his disappointment that nothing had resulted from their meeting and again seeking a statement that Leas Cross had been negligent. On the same date, he wrote to the Area Medical Officer seeking a list of dates on which his wife had been seen by the G.P. at Leas Cross and the reason for each such attendance. On the 12th July, 2005, a Senior Area Medical Officer, wrote to the Head of the Nursing Home Inspectorate stating that the Area Medical Officer would not be in a position to respond to the complainant’s request. She stated:

“it is inappropriate for her to comment on a colleague’s practice. If [the complainant] has any issue with the medical care his wife received whilst in Leas Cross he should deal directly with the said doctor and or the Medical Council, that is if he has any issues with the fitness to practice of the said doctor.”

On the 21st June and the 6th July, 2005, the complainant wrote to Michael Walsh stating that the queries raised in his letter of the 30th March remained outstanding. Mr Walsh responded to the first of these letters. While he did not address the substantive details of the complaint, Mr Walsh stated that he would ask the review team established by the H.S.E.N.A. to meet the complainant. He also referred to the fact that Prof. O’Neill would be reviewing deaths at Leas Cross Nursing Home and he offered to arrange counselling for the complainant.

In a written submission to the Commission, the complainant has registered his dissatisfaction with the manner in which his complaint was handled:

“I do not feel that [the Head of the Nursing Home Inspectorate’s] report adequately addressed my concerns. I had a follow-up meeting with [him] which led nowhere. His report was strangely complacent in the light of the national outcry that erupted a short time later following a report on national television about Leas Cross and treatment of patients’ ailments there, including pressure sores.”

In his letter of the 30th March, 2005, the complainant acknowledged to the Head of the Nursing Home Inspectorate that the investigation team “seems to have done a painstaking job”. The Commission considers that there was a thorough response from the Health Board to this complaint. While the complainant’s desire for a finding of negligence is entirely understandable, the Commission considers that it was open to the investigation team – consisting of a Director of Public Health Nursing and an Area Medical Officer – to reach the conclusions which they did. It would not have been appropriate for the Head of the Nursing Home Inspectorate, who did not personally
investigate the complaint, to have revised those findings. However, the Commission also considers that this could have been communicated to the complainant more clearly and speedily.

**Complaint in 2005**

**Margaret Leeper**

There was one complaint to the Health Board in 2005 prior to the broadcast of the *Prime Time* programme. The complaint was made by the family of Margaret Leeper, who was transferred to Leas Cross from St Ita’s in 2003. In April, 2005, Ms Leeper was admitted to Beaumont Hospital, where she was found to be suffering from an acute urinary tract infection, was severely dehydrated and required resuscitation.

On the 13th April, the family wrote to a consultant psychiatrist attached to the Psychiatry of Old Age CCA8 (referred to elsewhere in this report as ‘Consultant Psychiatrist A’) and to General Manager A in the NAHB to complain about their mother’s care at Leas Cross. A response was sent by Consultant Psychiatrist A on the 22nd April, in which she stated that patients suffering from advanced dementia, such as Ms Leeper, can develop urinary tract infections quite quickly and that there was nothing in the resident’s nursing notes from Leas Cross to indicate that she had been in any way different to usual in the weeks and days prior to her admission to Beaumont. However, at the family’s request, Consultant Psychiatrist A stated that she had arranged for a transfer of funding so that Ms Leeper could move to a different nursing home. Ms Leeper died in Beaumont before she could be moved elsewhere.

In a handwritten note on the letter of complaint, General Manager A has noted that she spoke to Consultant Psychiatrist A about the matter on the 15th April, 2005 and was aware that Consultant Psychiatrist A would be responding to the complaint with an offer of alternative accommodation. She also noted that the complaint was to be forwarded to the Head of the Nursing Home Inspectorate and the Nursing Home Section Manager. The complaint was ultimately forwarded to Nursing Home Inspector J, who sent it to Nursing Home Inspector H on the 21st April, 2005, with a suggestion that she should liaise with Consultant Psychiatrist A.

Nursing Home Inspector H and an Area Medical Officer investigated the complaint on behalf of the NAHB. They visited Leas Cross on the 7th June, 2005. Their report, dated the 12th January, 2006, identified a lack of documents such as care plans, weights, and nursing notes describing care given. They concluded that “given the very poor documentation in this case it is difficult to satisfy ourselves as to whether [the resident] received adequate nursing care”. They stated that they were unable to reach a conclusion on the implementation of policies for dealing with acute changes in residents’ conditions without further staff interviews, which apparently did not take place.

In a written submission to the Commission, Nursing Home Inspector H has explained why the investigation was not completed at the time:
“...the complaint could not be fully investigated following the Prime Time programme. We were advised from the CEO’s office to cease all work with relation to Leas Cross as an independent inquiry was being organised.

... our investigation was incomplete. We needed to interview staff, visit the home which at that point had closed ...”

On the 18th January, 2007, Ms Leeper’s family received a letter from the Regional Manager of the Nursing Home Inspectorate, who had been appointed to that position after the closure of Leas Cross, referring to the complaint. She stated that her records showed that Consultant Psychiatrist A had responded at the time. In relation to the investigation, she stated as follows:

“The inspectorate investigation has since been concluded and your complaint has been upheld.

The Nursing Home has not been requested to take specific action in relation to your concerns as the nursing home in question has closed.”

Ms Leeper’s family have informed the Commission in a written submission that the letter of the 18th January, 2007 is the first time they were informed that an investigation had taken place. The Regional Manager of the Nursing Home Inspectorate has informed the Commission that, on her appointment in 2006, she carried out a review of complaints, including complaints regarding Leas Cross Nursing Home. In the course of that review, it became apparent that no response had been sent to Ms Leeper’s family. Accordingly, she replied to the family to inform them of the outcome of the complaint.

The Commission notes that Consultant Psychiatrist A responded promptly to the complaint when it was first made, and also that an investigation was initiated by the Nursing Home Section of the NAHB. However, Ms Leeper’s family were not adequately notified of the NAHB investigation and a year elapsed before they were informed of the outcome.

Complaints made after the Prime Time documentary

The HSE received a number of complaints from the families of Leas Cross residents following the broadcast of the Prime Time programme. A Complaints Review Group was established to respond to the complaints.

In her written submission to the Commission, Nursing Home Inspector H, a member of the review group, has explained this process as follows:

“On the 25th October, 2005, I wrote to [the Local Health Manager] of Area 7, for clarity regarding the complaints... my own LHM, advised me to do so. I had concerns as I had not been contacted regarding the complaints and a number of them were outstanding, including [this one]. I was advised then to go ahead and complete the complaints. ... a three person team including
myself reviewed the remaining 13 complaints. Individual outcomes were provided to the families and a composite report was written. All complaints had been receipted following the Prime Time programme. With reference to the review, some files were missing and it was not possible to investigate some complaints. It was a limited review, as we did not have access to interview and staff members despite contacting both Ms Grainne Conway and Ms Denise Cogley. The home had closed so we could not review the environment either. A full summary of what was available to us is documented in the composite report.”

In response to this, Ms Cogley has informed the Commission that she was prepared to cooperate with an investigation of these matters and indicated to Nursing Home Inspector H her willingness to attend for an interview, but that no interview was held.

Twelve complaints were made between May, 2005 and February, 2006. The HSE has furnished the Commission with files relating to these complaints. The complaints related to the following residents of Leas Cross Nursing Home:

- Joseph Farrelly
- Mary Keogh
- Edward Mason
- John Brown
- Desmond Finnegans
- Richard Walsh
- Oliver Morris
- Joseph Ward
- Matilda Darcy
- Edward and Frances Clarke
- Eileen O’Rourke
- Mary McCarron

It appears that a standard-form letter was sent out following investigation of each complaint. Each such letter set out the normal complaints procedure and then contained the following paragraph:

“With respect to your individual complaint we were unable to complete the above procedure due to the closure of the home on the 1st August 2005. Consequently, we were unable to interview relevant staff despite our efforts to do so. We were unable to visit the home but did review their documentation in respect of [the resident in question].”

The letters then set out whatever findings had been made on the limited review carried out by the investigation team. Families were offered an opportunity to meet the investigators if they wished to discuss the findings.

The review team ultimately compiled a report on complaints received by the HSE in 2005 and 2006 relation to Leas Cross Nursing Home. That report was completed in November, 2006. It summarises the issues raised in the complaints as follows:
Twelve families complained about the standard of care their family member received during their stay in Leas Cross Nursing Home.
Nine families cited the lack of supervision as an issue of concern.
Eight families were seriously concerned regarding access to medical care.
Six families stated their family member had serious pressure sores while in the nursing home.
Four family members recorded concerns regarding the lack of communication between staff and families.
Four family members raised concerns regarding the lack of monitoring of their relatives’ weight and nutritional intake.
Three family members cited concerns regarding medication management in the nursing home.
Two family members put in writing their concerns regarding health and safety issues.
Two family members wrote regarding the lack of physiotherapy available to their relatives.

The report sets out findings made in respect of common themes emerging from the complaints and those made in respect of specific issues arising. The review team concluded that care delivered to the residents in question was “inadequate”, having regard to the requirements of the 1993 regulations. This conclusion was reached on the basis of the documentation reviewed from the home, in which the team found a lack of evidence to confirm that adequate care was delivered.

The Commission notes that the team was unable to visit the home or interview staff or residents owing to the closure of the home and the fact that the residents were all deceased. Accordingly, the Commission considers that the conclusions reached by the review team should be viewed with a degree of circumspection. However, it is also to be noted that the findings tend to corroborate concerns raised by residents and their families both before and after the closure of Leas Cross.

The review team went on to set out a number of recommendations “to prevent similar situations emerging in other nursing homes”. The recommendations included the following:

- Specialist professional services (e.g. physiotherapy and occupational therapy) should be available in all nursing homes.
- G.P.s providing medical cover to nursing home residents should have adequate specialist qualifications. A qualification such as the Diploma in Medicine for the Elderly from the Royal College of Physicians of Ireland should be considered a minimum requirement.
- All nursing home residents should have prompt access to the opinion of a consultant geriatrician, on an on-site basis if necessary.
- All nursing homes should undergo a structured multidisciplinary review every three months, including a medication review, a nursing assessment and paramedical evaluation.
• A central registry should be developed to collate data from the nursing home inspectorate and to identify poorly functioning nursing homes.

• Persons in charge of nursing homes should receive adequate specialised education, including a third level managerial qualification and a Higher Diploma in Gerontological Nursing.

• Minimum staffing levels should be one director of nursing, one assistant director of nursing, two clinical nurse managers, six registered general nurses and eight care assistants per 50 residents over 24 hours. This recommendation must reflect patient needs.

• Residents should receive “person centred care”, which actively encompasses respect for individual values, beliefs and personal relationships.

• “Care pathways” should be implemented for residents regarding specific pathologies, such as impaired tissue viability, nutritional deficits and weight loss, dehydration and incontinence.

• Nursing documentation is an integral part of clinical practice and should support patient care, continuity of care and evidence based clinical practice.

• All nursing homes should devise and implement a policy on the administration of medication, to be based on the guidelines of An Bord Altranais.

• All nursing homes should have designated senior staff responsible for risk management.

• There should be in place a process to audit and monitor practice to achieve and sustain best practice.

• There needs to be clear evidence in the service level agreement that the nursing home can provide adequate care for residents with conditions such as dementia.

Four further complaints were received after the completion of the November 2006 report into complaints. Each of these complaints sought a review of all nursing documentation in relation to the resident in question while at Leas Cross. Three of the complaints in question had been amongst those reviewed by Professor O’Neill for his report, ‘A review of the deaths at Leas Cross Nursing Home 2002-2005’. The residents in question were Teresa Smith, Clare Lawlor and Sean Colgan. A member of the complaints review team replied stating that the relevant files had been reviewed by Prof. O’Neill and that the HSE would not be conducting a further review.

In relation to the fourth complaint, made by Anne Bissett regarding her aunt, Kathleen Reilly, efforts were made by the HSE to obtain the resident’s files from John Aherne. A letter was sent to Mr Aherne seeking the files and legal advice was sought by the HSE as to its entitlement to require production of the files. On the 8th April, 2008, the Regional Manager of the Nursing Home Inspectorate wrote to the complainant stating that the HSE had been unsuccessful in obtaining the files:
“Mr Aherne has not provided us with the records and unfortunately there is no existing relationship between the Health Service Executive and Mr John Aherne in relation to our legal retrieval of records.”

Conclusions regarding the investigation of complaints

The Commission finds that the Health Board generally responded efficiently to formal complaints regarding Leas Cross Nursing Home. Investigations were usually carried out within a reasonable time and the findings were communicated to the complainants. However, it appears that, in most cases, complaints were considered to have been dealt with once the complainants had been notified of the outcome: rarely was there adequate follow up to ensure that similar problems did not recur.

Martin Hynes commented on the Health Board’s response to complaints in his Review of Nursing Home Inspections Carried out for the Purpose of Registration (June, 2005), stating:

“The investigation of complaints seems to have adopted a sympathetic approach to Leas Cross. What is striking about the complaints, recorded on the files, is that they were eloquently made and were serious. An audit of complaints would have revealed the cumulative nature of the complaints. There is no evidence that any analysis of the complaints was carried out. Each complaint appears to have been dealt with in isolation.”

The Commission agrees with Mr Hynes’s comment regarding the failure to take account of the cumulative nature of complaints. Indeed, the approach of the Health Board to nursing homes generally does not appear to have been coherent. Cumulatively, arising from applications for registration, routine inspections and complaints, the Health Board had access to a considerable volume of documentation regarding Leas Cross, as it must do in relation to every nursing home. In the opinion of the Commission, there was ample evidence within that body of information to alert the HSE to problems at Leas Cross before the situation was publicised by RTE.

For no obviously good reason, the information in the possession of the Health Board / H.S.E. was divided between a number of locations so that no single office or individual within the Health Board had full knowledge of all available information regarding the nursing home. The H.S.E. cannot rely on its administrative arrangements to excuse this failing. Patently, all relevant information relating to a nursing home should at all times be available to anybody inspecting, investigating or making a decision in respect of that home. As appears from the chapters in this report on inspections and registration of Leas Cross, it seems that no senior management in the Health Board took responsibility to satisfy themselves that all relevant information was considered before signing off on applications to register or re-register the nursing home.

The Commission notes that nursing home inspector Nursing Home Inspector H took the initiative to meet the matron and proprietors of Leas Cross in August, 2004,
following the investigation of a serious complaint, because she “had a general feeling of concern in relation to Leas Cross”. She describes the purpose of the meeting as having been “to intervene early with a view to getting the home back on track”. While Nursing Home Inspector H’s evident commitment to her role is commendable, it appears that her efforts came too late to divert Leas Cross from the course that led ultimately to its closure. It is the firm view of the Commission that a system of nursing home supervision which left it to chance that somebody, such as Nursing Home Inspector H, might spot a pattern of deficiencies in a nursing home and take initiative to address the problem, was inadequate and unacceptable and contributed in no small measure to the fate of Leas Cross and its residents.
CHAPTER 16

TRANSFER OF RESIDENTS FROM ST MICHAEL’S HOUSE

St Michael’s House is a voluntary, non-statutory organisation established in 1955, which provides services and support to persons with intellectual disabilities. These services include both respite and residential care. Residential services are provided in the main via ‘community houses’ located in residential areas. St Michael’s House also runs a small number of specialised units which provide residential care to patients with challenging behaviour or significant medical needs.

Most of the funding for St Michael’s House services comes from public sector finances.

St Michael’s House is governed by an independent Board of Directors. The Board has fifteen members, of which at least one third must be direct relatives of clients in service.

Background

In 1993 St Michael’s House submitted a seven-year strategic plan to the Department of Health. The plan highlighted both the growing demand for residential care services and the inability of St Michael’s House to meet that demand without a significant increase in funding. In a written submission to the Commission St Michael’s House stated:

“The Government response to the residential crisis between 1993 and 1999 was totally inadequate. The level of funding for residential beds over this period was completely inadequate to address the levels of demand for residential services. Waiting lists grew and the agency came under increasing pressure from desperate families.”

Between 1993 and 2000, ten clients of St Michael’s House were diagnosed with Alzheimer’s:

“Initially, the organisation tried to maintain clients with Alzheimer’s in existing services as long as possible. As their Alzheimer’s developed this put a huge strain on services as the majority of St Michael’s House staff had no nursing or medical qualifications...The agency was left to generate whatever alternatives it could to support people with late stage Alzheimer’s.”

Up until 1997, some clients were placed in Highfield, a private psychiatric hospital. Highfield Hospital has informed the Commission that these clients stayed for respite periods only and did not have Alzheimer’s. St Michael’s House stated to the Commission that in 1997, Highfield Hospital told them that they were no longer
prepared to accommodate clients with learning disability from St Michael’s House. Highfield Hospital has told the Commission that this was “a mutual decision”.

During 1998-1999, St Michael’s House continued to look for State funding to expand its residential care capabilities. The organisation also submitted a proposal to build and staff its own Alzheimer’s unit. Pending the provision of such facilities, St Michael’s House decided to use placements at Leas Cross and one other nursing home in an effort to ameliorate the ongoing crisis in residential care, as the following statement makes clear:

“St Michael’s House established a practice of placing clients it could not accommodate in Nursing Homes for long stays or respite breaks. The established practice was that these clients would then return to St Michael’s House services when the agency had an appropriate place available. A number of clients were initially placed in Nursing Homes and then came into St Michael’s House service when a place was available during this period.”

In 1999 the Department of Health commissioned a review of services to people with learning disabilities in the Eastern Health Board region. The resulting report (known as the Harmon Wolfe Report) recommended that funding be provided to St Michael’s House for an extra 100 residential beds “as a matter of extreme urgency”; and stated that an additional 85.8 frontline staff were needed. The report also supported the proposal by St Michael’s House to develop a dedicated Alzheimer’s unit.

The Harmon Wolfe Report produced an active response from the Government. During 2000 and 2001 St Michael’s House was allocated funding for an additional 140 residential places. Funding was also given to build a new Alzheimer’s unit, which opened in 2001. The provision of these new facilities allowed St Michael’s House to phase out the use of nursing homes. From November 2000, no new nursing home placements were made.

**Placement policy**

As indicated above, the use of nursing home placements by St Michael’s House was in response to a critical lack of residential care facilities for its clients. The vast majority of placements were for short periods of respite care, with only two clients placed in Leas Cross on a long-term basis. Even then, St Michael’s House states that it never planned to leave clients in nursing homes permanently. The intention was that those clients would return to full-time care with St Michael’s House as and when suitable residential places became available.

Clients who were staying at nursing homes continued to attend day services at St Michael’s House unless too ill to do so. The day service staff, though they may not have had medical or nursing qualifications, were nonetheless in a position to observe and report any problems with hygiene, personal care, general unhappiness or other obvious signs of neglect.
Staff from the relevant day units also made visits to their clients in the nursing homes. For the majority of people placed in nursing homes, it was their social worker who visited. According to St Michael’s House, the practice at the time was that clients in nursing homes were visited twice a month on average by St Michael’s House staff. Clients were also visited from time to time by off-duty staff.59

Responsibility for monitoring the care received by clients of St Michael’s House in nursing homes rested in the main with the Social Work Department.

**Contact with Leas Cross Nursing Home**

Leas Cross Nursing Home was first considered by St Michael’s House as a potential placement for clients in 1998. A senior social worker in the organisation was approached by the mother of a client, referred to as “client (K)” by St Michael’s House in their submission to the Commission. In a written statement to the Commission by St Michael’s House, the senior social worker states:

“This parent was associated with the organisation for a long period of time, and was highly respected. She had very high standards for her son who was severely intellectually and physically disabled. She said she had visited [Leas Cross] and was very impressed. In the summer of that year she requested a [respite] break which St Michael’s House was unable to provide. She insisted that part of it be provided in Leas Cross but funded by St Michael’s House. St Michael’s house agreed with proviso and I wrote to her confirming this situation ...

Client (K)’s mother was very happy with the care he received and client (K) had a number of breaks subsequently.

In the following year, the social workers in the department booked occasional breaks in Leas Cross to help St Michael’s House respond to family crises.”

According to St Michael’s House, the respite placements at Leas Cross from July 1998 until July 1999 were booked and monitored by the social worker assigned to the relevant client. Feedback on the placement was given by the individual social worker to a senior social worker. This system changed in July 1999, according to the senior social worker who first dealt with Leas Cross:

*As this practice [of using Leas Cross] increased, [the] Head Social Worker and I made a decision that I would become the contact person for Leas Cross.”*

Following her appointment as liaison person with Leas Cross, the senior social worker visited the nursing home in July 1999. It is not clear from her statement whether she

59 Submission of St Michael’s House to the non-statutory inquiry into the transfer of Peter McKenna to Leas Cross nursing home, February 2008.
had visited the home prior to this. On this occasion, she met the matron of Leas Cross, Mary Chance:

“She showed me around the house – she showed me occupied bedrooms (with residents’ agreement) and an empty bedroom. She showed me living areas, dining areas, bathrooms. She explained the OT [occupational therapy] programme and the GP support. The home had 25-30 residents at that time. She talked through staffing levels... I made arrangements with her for bookings.”

The senior social worker visited Leas Cross again the following month, and met with a new matron, Grainne Conway. Thereafter, the senior social worker made contact with Ms Conway on a monthly basis:

“I made bookings with her, discussed service users’ breaks and worked to resolve any issues.”

Respite care at Leas Cross

Sixteen different clients of St Michael’s House availed of a respite break in Leas Cross over a two-year period, from July 1998 to October 2000. The majority of these stays were for short respite periods, ranging from a few days to a few weeks.

Between July 1998 and July 1999, five clients of St Michael’s House were given a total of thirteen respite breaks at Leas Cross, for periods ranging from two to seven nights.

In August 1999, St Michael’s House reserved two beds at Leas Cross for respite use and one further bed for a long-term client, I.M. In September 1999 one of the two respite beds was given over to a client who, owing to a family break-up, ended up staying at Leas Cross until June 2000. Between August 1999 and March 2000, the remaining respite bed was shared among a total of fifteen clients for breaks ranging from two to 23 nights. According to the submission of St Michael’s House to the Commission:

“The respite bed was used to support a small number of clients over the autumn of 1999 and spring of 2000 who [were] effectively homeless at that time.”

St Michael’s House also told the Commission:

“Certain clients referred for a respite break exceeded the capacity of Leas Cross or did not fit well in the setting.”

For that reason, respite breaks were discontinued for two particular clients. In response to a request by the Commission for further information on this issue, St Michael’s House stated:
“Both of the clients in question were active and ambulant. Leas Cross raised issues in relation to their noise levels and a concern in relation to the impact of the appearance of one of the clients on other residents in the home.

Leas Cross was a setting for frail, elderly people and the matron felt that these clients... were not suitable for their setting.

The opinion of the social work department was that Leas Cross was more suitable for clients who required nursing care.”

The use of Leas Cross by St Michael’s House for respite placements was ended completely in November 2000.

**Long-term care at Leas Cross**

**Client I.M.**

Client I.M. had Down’s Syndrome. She had been living in one of the community houses run by St Michael’s House, but as she entered the later stages of Alzheimer’s disease it was decided that she required 24-hour nursing care of a kind which could not be provided in the community house. Client I.M. was transferred to Leas Cross in July 1999 and remained there until her death in August 2000.

The family of this client did not object to her transfer to Leas Cross, and made no complaint concerning her treatment at the nursing home. In a letter to the C.E.O. of St Michael’s House dated October 2005, the client’s brother praised the staff of St Michael’s House and Leas Cross for the care shown to his sister and stated that, prior to the allegations arising from the *Prime Time* programme and subsequent media coverage, he would have recommended Leas Cross “with enthusiasm and without reservation”.

In addition to praising the staff and management of Leas Cross for their care of his sister, the client’s brother also wrote that staff from the community house at which she had formerly resided visited her “constantly” at Leas Cross, “thus providing a constant monitor of affairs there”. According to St Michael’s House, there are 22 recorded visits of St Michael’s House staff to this client over the twelve months that she resided in Leas Cross.60

**Peter McKenna**

Peter McKenna was the second client of St Michael’s House to be transferred to Leas Cross with the intention that he would remain on a long-term basis. He was admitted

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60 Submission of St Michael’s House to the non-statutory inquiry into the transfer of Peter McKenna to Leas Cross nursing home, February 2008.
to the nursing home on the 10th October 2000. On the 22nd October 2000 he was admitted to Beaumont Hospital, where he died that same day.

The circumstances in which Mr McKenna came to be admitted to Leas Cross, his treatment at the nursing home, and the follow-up care provided by St Michael’s House after his arrival at the nursing home, have been the subject of several investigations, including an internal inquiry by the Eastern Regional Health Authority and an independent inquiry by Mr Martin Hynes, carried out at the request of the E.R.H.A. Mr McKenna’s treatment at Leas Cross was also featured in the Prime Time documentary about Leas Cross, broadcast on the 30th May 2005.

In addition to being investigated by this Commission, the transfer of Mr McKenna to Leas Cross is currently the subject of a further non-statutory inquiry chaired by Mr Conor Dignam B.L.

Because of the complex and controversial nature of the claims surrounding Mr McKenna’s transfer and treatment at Leas Cross, his case has been considered under a separate heading in this chapter.

**Nursing Home Inspections**

Between July 1998 and November 2000, a total of nine inspections were carried out by the Northern Area Health Board at Leas Cross. Only one of these, which took place on the 15th February 2000, resulted in any written reference to clients of St Michael’s House at the nursing home. The report of that inspection includes the following comment:

“Discussed respite care of residents attending St Michael’s House sharing rooms with older residents.”

Handwritten notes taken by the inspectors during the inspection mention a patient of St Michael’s House who was staying at Leas Cross for a short respite period, and who was sharing a room with an 80 year-old resident. There is no mention of any complaint having been made.

The inspection report does not say whether this discussion was prompted by any specific complaints or concerns; nor does it say what the results of this discussion were, if any.

**Complaints to St Michael’s House regarding Leas Cross**

Aside from the case of Peter McKenna, the submission of St Michael’s House to the Commission refers to four instances in which complaints or concerns were voiced to St Michael’s House regarding Leas Cross. All four complaints arose in 1999.
Client (J)

In March, 1999 client (J) had a fall while on a respite break in Leas Cross. The client had a history of falls both at home and while attending her day-care service with St Michael’s House. The client had stayed on a number of previous occasions at Leas Cross without any reported incidents.

According to the client’s social worker, the client was sent to hospital following her fall at Leas Cross, but the client’s mother was not informed of this. A senior social worker for St Michael’s House telephoned the matron of Leas Cross, Grainne Conway, who said that she herself had telephoned the client’s mother to inform her of the incident. The senior social worker subsequently made an appointment to see Grainne Conway about the matter:

“I reviewed the record of the nursing notes and discussed other issues which had arisen (i.e. missing items not returned home). Client (J) did not use Leas Cross again but lived in a second Nursing Home for a period of time.”

Client (K)

In August, 1999 client (K), described by a senior social worker in St Michael’s House as “very disabled”, had a week-long respite break in Leas Cross. He was visited over the weekend by his sister, who made two separate complaints:

- on Saturday, her brother had food on his face and was unshaven; and

- on Sunday, she found her brother on his own upstairs, with one of the two brakes on his wheelchair disengaged.

A senior social worker from St Michael’s House raised these complaints with matron Grainne Conway by telephone and at a subsequent meeting. However, the family remained unhappy – “both with [the] quality of care during the break and with the Social Work Department’s response to their concerns”.

Client (L)

In October, 1999 client (L) was offered a respite break in Leas Cross, but the client’s family turned it down. According to the submission of St Michael’s House to the Commission, “they felt Client (L) was not happy there but could not specify why.”

Client (D)

Finally, in November, 1999 client (D), who was wheelchair-bound and required a tube for feeding, used Leas Cross for several respite breaks. After one such break, the client was returned to his mother with his feeding tube broken. According to the submission of St Michael’s House to the Commission:
“Client (D)’s mother followed up with Leas Cross and spoke to the Matron who told her that these things happen. Client (D)’s mother spoke to the Dietician in St Michael’s House and she reported that the Dietician told her that the feeding tube should be long-lasting. Client (D)’s mother also raised unhappiness that Leas Cross did not wash Client (D)’s clothes while he was there but sent them home to her. She said to her social worker that she did not want to use Leas Cross again, but would take breaks in a different Nursing Home.”

The senior social worker liaising with Leas Cross discussed these issues at a meeting with the matron, Grainne Conway:

“[Ms Conway] said that it was her opinion that tubes could break, that it could also have happened on transport and that she had no record of the tube being broken.

We discussed the issues of clothes – she said that night staff in Leas Cross did not do washing. She also said that the Nursing Home would not be involved in the cleaning of wheelchairs.”

**Peter McKenna – his transfer and treatment**

Mr McKenna, who had Down’s Syndrome, was made a Ward of Court in 1967. In 1974 he became a client of St Michael’s House, attending on a day care basis. He became a residential client of St. Michael’s House in 1994 - initially in a community house in Castleknock before being moved to another community house in Warrenhouse Road, Baldoyle.

**Care at St Michael’s House**

Mr McKenna’s family have told the Commission that his care in the community houses at Castleknock and Baldoyle was exemplary:

“We must emphasise that the care given to Peter in St. Michael’s House was absolutely wonderful – there was always full communication between St. Michael’s House and Peter’s family up to September 2000. Peter received great care from Saint Michael’s House frontline staff in Warrenhouse Road and these staff were attentive and sympathetic to him when he went into Alzheimer’s.”

Mr McKenna was diagnosed with Alzheimer’s disease in November 1999. On the 31st January 2000 his family were called to a meeting at St Michael’s House to discuss his care needs. According to Mr McKenna’s family, they were told that as his Alzheimer’s condition progressed, he would need more nursing care, and that this might necessitate a move to ‘the Beeches’, a residential unit belonging to St Michael’s House which had full-time nursing facilities.
As the months passed, Mr McKenna’s condition deteriorated. In July he began attending the Beeches for day service, three days a week. He could not be moved into the Beeches full-time as all of the residential places were then occupied.

Towards the end of August, clinical staff from St Michael’s House visited Peter McKenna at Warrenhouse Road and advised the residential manager that staff at the house were no longer able to care for his needs.

On the 1st September 2000, Mr McKenna was moved to the Beeches. St Michael’s House maintain that the move was temporary. He was given the bed of a client who had gone home for the weekend, but it was intended that Mr McKenna would be transferred to a nursing home the following week. A booking was made on the 4th September for a bed in Leas Cross, and the nursing home charged St Michael’s House from that date.

Transfer to Leas Cross nursing home

The day before Peter McKenna was moved to the Beeches, his family received a telephone call from a doctor at St Michael’s House, informing them that Mr McKenna would shortly be transferred to Leas Cross Nursing Home. In their submission to the Commission the family stated:

“We were very surprised at this development. We said that we would inspect Leas Cross and report back to St Michael’s House. We were informed that there was an urgency about this matter and were asked to give our approval quickly.

We visited Leas Cross the day after we received the news that St Michael’s House intended to move Peter there. We were very concerned at the apparent levels of supervision of patients and we were not satisfied that this nursing home would be suitable for Peter’s needs as he would be isolated in a single room and Peter needed constant supervision in an open ward environment where staff would be passing in and out. Our big fear was that Peter would end up in a room on his own and would be isolated and unable to call for assistance. Peter was wheelchair bound and in the last vestiges of recognition and it was therefore important that he would be familiar with his surroundings.

We had a meeting with St. Michael’s House on 4th September 2000 during which we were advised that arrangements had been made with Leas Cross Nursing Home to take Peter into one of their nursing beds...We expressed our grave concerns about Leas Cross nursing home during this meeting but St Michael’s House gave a glowing report of Leas Cross and denied any difficulties. St Michael’s House were adamant that that they could no longer care for Peter and that he would have to go to an outside agency for nursing care as they had no facility for caring for Alzheimer’s clients.”

In a letter to the Divisional Manager of Residential Services at St Michael’s House dated the 8th September 2000, Mr McKenna’s family reaffirmed “...our clear wish that Peter should remain within the care of the St Michael’s House team”. The letter
also referred to the fact that Mr McKenna was a Ward of Court, and that “any material change to his lifestyle or circumstances would require the High Court’s prior approval”. According to the submission of St Michael’s House to the Commission, staff at St Michael’s House had “…no previous experience of a Ward of Court situation in this context”.

Solicitors for St Michael’s House made an application to the Wards of Court Office on the 16th September 2000. They were advised that the President of the High Court would decide on the application.

Peter McKenna’s family were not informed of the application by St Michael’s House, but were contacted by the Registrar for the Wards of Court Office who requested their views on the proposed transfer of Mr McKenna to Leas Cross. The family’s solicitors wrote to St Michael’s House and to the Registrar of the Office of the Wards of Court on the 18th and 19th September respectively, setting out the family’s concerns and requesting a copy of all relevant documentation in order to consider the matter fully.

The Wards of Court Office replied by letter dated the 19th September 2000 and stated inter alia that they would arrange for the court’s medical visitor to examine Mr McKenna and to provide a report for the court.

During this period, Peter McKenna continued to reside at the Beeches. As all the beds were fully occupied, he was kept in a bed in the sitting room. This was problematic for a number of reasons, outlined by St Michael’s House as follows:

“The house had a mixture of 10 clients, some of whom were highly dependent and others who presented with extreme challenging behaviour. Managing this mix of clients posed huge challenges to the staff. The staff at the time experienced high levels of stress. The addition of an 11th client in the sitting room exacerbated this situation.

... This sitting room was constantly used by some of the most difficult clients for ‘quiet time’ to calm them down and was also used by clients who were in extreme behaviour [with] outbursts / tantrums.

Peter McKenna required palliative care nursing, which was not compatible with the house where there were very high levels of noise and challenging behaviour.

The management of this diverse group of clients required an active programme of activities.

The addition of an 11th client needing palliative care restricted this programme. The group became more housebound which exacerbated difficult behaviours.”

The High Court appointed a consultant psychiatrist to act as medical visitor in this case. The consultant visited Peter McKenna at the Beeches on the 20th September and subsequently produced a written report which summarised his health situation as follows:
“He has, however, now developed Alzheimer’s Disease with mental deterioration and increasing dependency, incontinence of excretions, and inability to look after his basic physical needs of dressing and eating. He is now unable to walk unaided, cannot manage stairs and has to sleep in a living room of Beech House, which is a unit for temporary placement of mentally handicapped people for respite or crisis care, usually due to social problems.”

The report continued:

“Peter McKenna needs 24 hour nursing care and supervision, and will need this indefinitely. St Michael’s House Services do not, at present, have a long-stay facility suitable for his needs, and it is proposed that Peter be placed in a Nursing Home where his nursing needs can be met. I understand a place may be available in Leas Cross Nursing Home. I have visited there on several occasions, and I think Peter’s placement there would be satisfactory.”

On the 22nd September the Wards of Court Office wrote to the solicitors for Peter McKenna’s family confirming that the President of the High Court was prepared to make an order appointing Dan Moore, Mr McKenna’s half-brother as Mr McKenna’s committee (of estate and person). The letter also confirmed the opinion of the medical visitor that Peter McKenna should be moved to a nursing home facility and stated that the committee should consider suggestions for such a suitable establishment.

In the meantime, Mr McKenna’s family had contact on several occasions with the C.E.O. of St Michael’s House. Dan Moore told the Commission:

“…we met with the CEO of Saint Michael’s House on the 20th and 27th September 2000. I also spoke with the CEO by telephone on the 18th September 2000. On this occasion the CEO told me that he has people inspecting Leas Cross regularly and he’s getting good reports. In our meeting on the 20th September 2000, the CEO told me that Saint Michael’s House would care and be responsible for Peter ‘to the end, within or outside Saint Michael’s House’. During the meeting on the 27th September 2000, we asked Saint Michael’s House to help us to find an alternative nursing home for Peter. We were told that it was not possible for Saint Michael’s House to provide clinical back up in an alternative nursing home. We were also told that Saint Michael’s House ‘will not and cannot take responsibility for the standard and quality of care provided by a nursing home selected by the family’. We were also told that as Saint Michael’s House had contracted the bed in Leas Cross there would be no additional payment available if another venue was chosen by family.”

At the meeting of the 27th September it was agreed by St Michael’s House and Mr McKenna’s family that he would be kept in the Beeches for one further week while the family looked for a nursing home for him. If the family had not found a suitable placement for him by the end of that week, Mr McKenna would be moved to Leas Cross until such time as the family could find an alternative nursing home. St Michael’s House confirmed their unwillingness to be involved in the selection of an
alternative nursing home in a letter from their solicitors to the family’s solicitors dated the 29th September 2000.

The family of Peter McKenna made extensive efforts to secure an alternative nursing home placement for him. They were offered a bed in another County Dublin nursing home, which they considered to be much more suitable for his needs. However, two days before the High Court was to hear the application to move Mr McKenna, the family were told that his place at this alternative nursing home had been withdrawn, on the basis that he had been under the care of a health board which was outside the catchment area for that nursing home.

The President of the High Court heard the application to transfer Peter McKenna on the 6th October 2000. It appears that, during the course of the hearing, no mention was made of any previous complaints involving clients of St Michael’s House at Leas Cross. In a submission to the Commission dated the 25th March 2009, St Michael’s House stated:

“None of the parties who gave evidence and were directly examined and cross-examined, nor the Senior Medical Officer who was in the court, recollect any specific examination or cross-examination on the issue of whether or not there had been complaints from clients of St Michael’s House in relation to Leas Cross.”

The solicitors for St Michael’s House have no record of any questions being raised in relation to previous complaints about Leas Cross. A note of the hearing taken on behalf of the family also makes not mention of previous complaints having been raised as an issue.

At the conclusion of the hearing, the court decided that Peter McKenna should be moved to Leas Cross as a matter of urgency.

According to the submission of St Michael’s House to the Commission, the matron of Leas Cross, Grainne Conway, visited Mr McKenna in the Beeches prior to his transfer. She also met with the nurse in charge of the Beeches during her visit.

On the 9th October 2000 Mr McKenna was admitted to Beaumont Hospital from the Beeches. He was diagnosed with chronic retention of urine. A catheter was fitted and he was discharged back to the Beeches. A further appointment was arranged for him to see an urologist in Beaumont on the 12th October.

**Care at Leas Cross Nursing Home**

On the 10th October, Peter McKenna was transferred from the Beeches to Leas Cross nursing home. He was accompanied by two nurses from St Michael’s House. Earlier in the morning, one of the nurses had telephoned Grainne Conway to check that Leas Cross was still willing to accept Mr McKenna now that he had a catheter. She also told Ms Conway about his forthcoming appointment at Beaumont Hospital on the 12th October. As Leas Cross could not spare any nursing staff to accompany Mr McKenna
to Beaumont on that date, it was agreed that a nurse from St Michael’s House would do so.

Mr McKenna was seen by the G.P. attending Leas Cross, Doctor A, on the 11th October. An entry from Doctor A in the Leas Cross patient records for that date states:

“Could be difficult to manage in this establishment as he requires full time medical and nursing care.”

On the 12th October Mr McKenna was brought for his appointment at Beaumont Hospital. Following this, a further appointment was made for the 16th October. The entry for the 12th October in the nursing records at Leas Cross states:

“Went to Beaumont @ 11am… Returned @ 2pm… acc. To carer – consultant not concerned re haematuria, encourage fluids if possible. For outpatients on Monday (16th) for removal of catheter. To stay in all day for observation. Awaiting on Dr C— to contact Leas Cross with appt time. Will need escort & transport for Monday.”

Mr McKenna did not in fact attend at Beaumont on the 16th October. The reasons for this are not entirely clear, but it seems that Leas Cross was awaiting confirmation of (i) a time for the appointment and (ii) the availability of a day bed at Beaumont Hospital for him. An entry in Leas Cross records for the 16th October reads:

“Beaumont contacted re appt. Sec. will ring when appt is available.”

There is no record of any further response from Beaumont regarding the appointment. Nor is there any record of Leas Cross making any efforts to arrange an alternative appointment to have the catheter removed.

Over the night and morning of the 21st / 22nd October, Peter McKenna’s condition deteriorated. Nursing notes from Leas Cross for the 22nd October state:


According to a summary of the Beaumont Hospital Accident & Emergency records, prepared for Mr McKenna’s family by Beaumont Hospital in May 2001, Mr McKenna arrived at approximately 3.50 p.m. The summary states:

“Examination revealed him to be unwell looking. He was breathing at a rate of 18 breaths per minute. Oxygen saturation read 53%. It was difficult to feel his peripheral pulses. His temperature was noted to be 37.5%. His heart rate was 120 beats per minute. He was clinically dehydrated… It was noted that he had a urinary catheter in situ. The urine bag contained infected looking urine. There was a pustular discharge from his penile tip. The clinical diagnosis of sepsis secondary to primary infection was made. The most likely source was
thought to be a urinary tract infection. It is documented that Mr McKenna’s level of hygiene was poor.”

Peter McKenna was admitted to the hospital under the care of a medical team and a consultant physician. He died at 9.30 p.m. that night.

The medical certificate of the cause of death was signed, with the acquiescence of the coroner, by the St Michael’s House Senior Medical Officer. In a written submission to the Commission, St Michael’s House summarised the sequence of events as follows:

“St Michael’s House Senior Medical Officer was contacted by the Casualty Department in Beaumont Hospital on Monday 23rd October 2000 and obtained a full account of Peter McKenna’s condition on arrival in Casualty and during his time there to his death.

The Senior Medical Officer requested and subsequently received all the laboratory results from the Casualty Department. She was satisfied that Peter’s death was caused by one of the well recognised complications of advanced Alzheimer’s disease in people with Downs syndrome.

The Senior Medical Officer advised St Michael’s House that the hospital reports on Peter McKenna’s death raised no cause for concern and were entirely consistent with the nature of his condition of late stage Alzheimer’s...

The Senior Medical Officer only agreed to sign the Death Certificate following full discussion with the Casualty Department Beaumont Hospital, receipt of the laboratory reports and full discussion with the Coroner’s office.”

Amongst the material provided to the Commission by St Michael’s House is a report by an Associate Professor and Director of Research at the School of Nursing and Midwifery, Trinity College Dublin. The report, entitled ‘Supporting Persons with Down Syndrome and Advanced Dementia: Challenges and Care Concerns’, contains the following passage regarding nursing care issues and causes of death in patients with dementia or Alzheimer’s disease:

“There is a need for skilled and competent nursing care and support and the importance of medical surveillance among people with Down syndrome cannot be overemphasised. Supporting persons with advanced dementia demands a high level of skills and intuitive ability. Due to difficulties in communication and an inability to self-report symptoms and an atypical presentation many infections may be at an advanced stage before any diagnosis is made. It is well recognised that infections such as pneumonia, urinary tract infections and septicemia are not uncommon in late stages of dementia and are the most frequent causes of death in the terminal stages of the disease (Mitchell et al 2004; Morrison & Siu 2000).”

In the case of Peter McKenna, the medical certificate of the cause of death signed by the Senior Medical Officer for St Michael’s House cited the following causes of his death:
Complaints to St Michael’s House

The Commission has spoken with a senior clinical psychologist who worked at St Michael’s House until 2003. The psychologist told the Commission that he raised the issue of nursing home placements, and the case of Peter McKenna in particular, at several meetings with the Chief Executive Officer of St Michael’s House during 2001, but that he received no satisfactory response.

In September 2001 the psychologist wrote to the board of St Michael’s House with his complaints. The first of these related to what he described as “a culture of workplace bullying” at St Michael’s House. The second complaint referred to the placement of Peter McKenna at Leas Cross. The psychologist in question did not have any direct input into Peter McKenna’s care at the time of the client’s transfer to Leas Cross, but had learned of the matter from Mr McKenna’s family.

In response to this letter, the psychologist was invited to follow the in-house procedures for dealing with complaints. Having initially agreed to do this, the psychologist subsequently withdrew from the process, saying that two of the three people appointed to investigate his complaints had been involved in the alleged workplace bullying of which he had complained. The psychologist subsequently brought a claim for constructive dismissal based on the aforementioned allegations, which was dismissed by the Employment Appeals Tribunal in January 2007, following an 11-day hearing in 2005/2006.

In October 2001 the family of Peter McKenna wrote to St Michael’s House concerning the treatment of Peter at Leas Cross in October 2000. In their submission to the Commission the family stated:

“We were obviously extremely upset at the manner of our brother’s death. However we decided not to take any action for twelve months after Peter’s death as we were sure that we would hear from St. Michael’s House and/or the HSE. When this did not happen, we then wrote to all board members of St. Michael’s House. Not one member of the board met with us after receiving this letter.”

St Michael’s House state that they have no record of any letter from Mr McKenna’s family being received by its board members in October 2001.

The chairperson of the board of St Michael’s House did receive a copy of a letter sent by the family to the Minister for Health on 22nd October 2001. Receipt of this was acknowledged by letter dated the 5th November 2001. In a submission to the Commission St Michael’s House stated:
“As this letter was a complaint about St Michael’s House to the highest authority in the Health Service, it would have been inappropriate for St Michael’s House to initiate any further investigation until such time as the Department contacted them. The responsibility of St Michael’s House was to wait and to fully co-operate with any investigation initiated by the Department of Health, which it did.”

Complaints to the health services

Review by the E.R.H.A.

On the 22nd October 2001 – the first anniversary of Peter McKenna’s death – Mr McKenna’s half-brother Dan Moore wrote to the Department of Health, stating:

“Not hav[ing] heard directly or indirectly from St Michael’s House Management or indeed Leas Cross owners since Peter’s death, I am now requesting that you would arrange an independent inquiry into Peter’s death and the events surrounding it.”

Copies of the letter were also sent to the Eastern Regional Health Authority, the Northern Area Health Board, Beaumont Hospital, Leas Cross Nursing Home and the chairperson of the St Michael’s House Board.

The Department of Health requested a report on Peter McKenna from the E.R.H.A. A Medical Officer at the E.R.H.A.’s Department of Public Health was given the task of reviewing the health care management of Peter McKenna.

The Medical Officer obtained reports from the C.E.O. of St Michael’s House, from the Accident & Emergency consultant at Beaumont Hospital and from the consultant urologist at Beaumont, who had seen Mr McKenna on the 12th October 2000. She attempted to access Mr McKenna’s hospital records but was refused, on the basis that he was a ward of court.

The Medical Officer did not make contact with Leas Cross, following the advice of the Monitoring and Evaluation Department of the E.R.H.A.

On the 2nd August 2002 the Medical Officer reported to the Evaluation Manager, E.R.H.A. She summarised the information gathered by her before concluding:

“After discussion with the Director of Public Health... as I am unable to gain access to any further information at this point I am referring this representation back to the Directorate of Evaluation and Monitoring.”

The Department of Health wrote to the E.R.H.A. on the 20th November 2002 requesting an update. The E.R.H.A. responded by email on the 6th January 2003 to say that legal advice was being sought on accessing Peter McKenna’s hospital records.

On the 17th June 2003 the senior psychologist who had complained to St Michael’s House about Peter McKenna and other matters in 2001 wrote to the Minister for
Health and Children, again raising Peter McKenna’s case. The Department of Health wrote to the E.R.H.A. looking for a further update on the 4th July 2003.

Review by Martin Hynes

In August 2003 Mr Martin Hynes was asked by the C.E.O. of the E.R.H.A., Mr Michael Lyons, to carry out an independent assessment of the complaints made by the senior psychologist regarding St Michael’s House. As stated above, one aspect of these complaints related to the transfer of Peter McKenna to Leas Cross Nursing Home.

Mr Hynes met the psychologist, who asked him if he planned to meet with the family of Peter McKenna:

“I indicated that having considered the matter I would not be meeting with the family. I expressed the view that I was giving him [the psychologist] an opportunity to elaborate on his complaints and that the complaint regarding the client [Peter McKenna] was only part of this. My terms of reference were to investigate his [the psychologist’s] original complaints and to review the processes and inquiries undertaken by St Michael’s House to investigate those complaints.”

The psychologist refused to participate further in Mr Hynes’s review, saying that without input from the McKenna family, it would be unbalanced.

Mr Hynes completed his report in October 2003. By letter dated the 23rd February 2004, E.R.H.A. C.E.O. Michael Lyons wrote to Mr Hynes, accepting his report but stating:

“I am of the view that a number of additional steps are required to satisfy myself as regional Chief about the care issues including the following:

1. Meeting with Mr McKenna’s family to clarify their concerns regarding the placement in Leas Cross Nursing Home and any subsequent issues in this regard.

2. Meeting with relevant personnel in the Northern Area Health Board to clarify the inspection arrangements in relation to Leas Cross Nursing Home and any issues arising.”

Mr Hynes agreed to undertake these additional steps. He also obtained documentation from the family and from Leas Cross Nursing Home, and had further contact with the Chief Executive of St Michael’s House. On the 3rd June 2005 Mr Hynes submitted a further report to the E.R.H.A. Sections of this report were forwarded to relevant parties for their consideration. Their responses were considered by Mr Hynes, who elected to leave his report of June 2005 essentially unchanged, but to submit a sixteen-page addendum dealing with some of the issues raised by the relevant parties who had been consulted. This was done in August 2005.
The Commission notes that a period of almost two years elapsed between the time when the E.R.H.A. first received a complaint regarding Peter McKenna and the commencement of Mr Hynes’ inquiries in August 2003. It also appears that the complaints about Peter McKenna’s treatment were tangential to Mr Hynes’ initial inquiry, which focused in the main on complaints made by a senior psychologist about alleged bullying at St Michael’s House. In the circumstances, it is not surprising that the E.R.H.A. subsequently found it necessary to extend Mr Hynes’ terms of reference to specifically address the concerns of Peter McKenna’s family. In reality, it was not until Mr Hynes’ report of August 2005 that the family’s original complaint of October 2001 was fully addressed by the E.R.H.A. In the Commission’s view, a delay of such length is unacceptable.

Some observations regarding St Michael’s House and Leas Cross Nursing Home

The Commission accepts that the decision by St Michael’s House to place clients in nursing homes was driven by a lack of viable alternatives.

St Michael’s House used Leas Cross Nursing Home between July 1998 and November 2000. At this time Leas Cross was a relatively small nursing home, with a maximum capacity of 38 residents.

Complaints to St Michael’s House

In the first year of using Leas Cross, St Michael’s House placed a total of five clients there, all for respite breaks of less than a week. During that period, only one complaint was recorded by St Michael’s House: that complaint related to a fall by a client who, according to St Michael’s House, had a history of falls. There is no evidence that the fall occurred as a result of any want of care on the part of Leas Cross. In any event, the matter was followed up by a senior social worker from St Michael’s House.

Between August and November 1999 a further three complaints were recorded. Two of these complaints have generated contrasting views as to their significance. In the addendum to his report of June 2005, Martin Hynes states:

“Two of the four complaints made to SMH [St Michael’s House] related to levels of hygiene of those in respite care. A similar complaint arises in the case of Peter [McKenna]. In my opinion the nature of two of the complaints should have raised questions about [Leas Cross’] suitability to care for Peter. It would have been better if these complaints had been known to more senior personnel within SMH when they were deciding to transfer Peter to Leas Cross.”

St Michael’s House, on the other hand, maintains that the above complaints were minor in nature. St Michael’s House also point out that both complaints were discussed with the matron of Leas Cross by a senior social worker. As to whether
senior management at St Michael’s House should have been informed of the complaints, St Michael’s House stated in a letter to the Commission that “the substance of the ... complaints in relation to Leas Cross is such that it would not have caused either Senior Clinical or Senior Management staff to question the continued use of Leas Cross”.

The Commission is of the view that St Michael’s House responded appropriately to the complaints it received concerning Leas Cross in 1999. The complaints were specific in nature; they were brought to the attention of the matron at Leas Cross by St Michael’s House, and it was reasonable to believe that the nursing home would take matters from there.

In relation to the transfer of Peter McKenna to Leas Cross in October 2000, the Commission believes that those responsible for making the decision to move Mr McKenna should either have known or been made aware of the complaints made about Leas Cross in 1999. In particular, the Commission notes that the High Court was not informed by representatives of St Michaels House that there had been previous complaints from clients of St Michael’s House concerning Leas Cross. It should have been left open to the High Court to decide the seriousness and relevance of the complaints in the context of considering the transfer of Mr McKenna to Leas Cross.

The Commission notes that the complaints in question were followed up with the nursing home, and that the most recent complaint had occurred some nine months before the decision to move Mr McKenna was made. Nonetheless, the Commission considers that all relevant information should have been made available to the High Court and considered before a decision was made to move a frail, vulnerable client with heavy nursing care needs to Leas Cross.

Transfer of Peter McKenna

As Martin Hynes pointed out in his report of August 2005, “Peter’s care needs in September 2000 posed a particular challenge to the care system. There was, in effect, no ideal placement for him”.

In considering the decision to move Mr McKenna, it should be remembered that Leas Cross had successfully cared for client I.M., another St Michael’s House client with Down’s Syndrome and Alzheimer’s disease, for over a year until her death in August 2000. The key question, therefore, is whether Mr McKenna’s needs were of a different order to those of client I.M., such that St Michael’s House should not have agreed to transfer him to Leas Cross.

In July 2000, while Mr McKenna was resident in the community house at Warrenhouse Road, written guidelines were drawn up for staff in the house concerning Mr McKenna’s care management. The guidelines emphasised that Mr McKenna required “constant supervision”. Peter McKenna’s family have told the Commission that one of their main objections to Leas Cross was that “Peter needed constant supervision in an open ward environment where staff would be passing in
and out. Our big fear was that Peter would end up in a room on his own and would be isolated and unable to call for assistance”.

The Commission put this to St Michael’s House in correspondence and received a written response which said that the ‘constant supervision’ requirement related not to Mr McKenna’s nursing care but to safety issues arising from the fact that, at that time, he could still move around independently:

“It was fundamental to the continued placement of Peter in Warrenhouse Road that every staff member and relief staff member clearly understood that under no circumstances could he be left unattended for any period of time. He was ambulant and at risk – e.g. the stairs, kitchen or electrics ...

When Peter moved to Leas Cross he was non-ambulant, wheelchair-bound, unable to weight bear and totally dependent for all his needs...

The issue of ‘constant supervision’ as outlined in the guidelines written specifically for Warrenhouse Road in July 2000 were no longer applicable. Peter’s needs had changed.

He was no longer ambulant, was now completely dependent for all his needs, and required high dependency nursing care.”

Included in the submission of St Michael’s House to the non-statutory inquiry chaired by Mr Conor Dignam B.L. into Mr McKenna’s transfer to Leas Cross is a section entitled “Why could Warrenhouse Road not care for Peter McKenna”. It contains the following statement:

“It was inappropriate and potentially dangerous to continue with caring for Peter in the absence of 24-hour nurse cover.”

In correspondence the Commission asked St Michael’s House whether Leas Cross could have offered effective 24-hour nursing cover in October 2000, considering that the night shift had only one nurse catering for approximately 35 patients. St Michael’s House responded in writing as follows:

“In the opinion of [the] Senior Medical Officer:

‘Peter did not require one to one nursing on a 24 hours basis. However, he did require 24 hour access to nursing care at short notice.

In the Beeches where he stayed prior to his transfer to Leas Cross, on some nights a nurse was on sleep-over duty and not awake caring for patients throughout the night.’

In the Beeches on a night where the nurse was asleep the person awake on duty would be an unqualified care assistant, who could access the nurse at short notice if the need arose.
This is similar to the arrangement in Leas Cross. However, the nurse in Leas Cross was awake and on duty throughout the night.

If a vacancy had been available in the Beeches Peter McKenna would have been cared for there.”

Taking all of the above into account, the Commission considers that St Michael’s House were not unreasonable in holding the view that Leas Cross Nursing Home would be suitable for Peter McKenna’s nursing care needs.

**Follow-up care by St Michael’s House**

In a letter dated the 19th September to the solicitors representing Peter McKenna’s family, St Michael’s House stated in relation to follow-up care at Leas Cross:

“We have an ongoing relationship with the nursing home and maintain very close links in order to monitor the level of service provided to our service users who are using its facilities. In addition, we will provide clinical back-up.”

The precise nature of the clinical back-up to be provided was not specified in the letter.

The letter continued:

“I wish to assure you that Peter will remain as a service user of St Michael’s House and that we will be very much looking after his interest in ensuring that he receives the care appropriate to his needs in Leas Cross. Should he have other needs we will attend to them and do whatever we can to have those needs met also.”

The Commission is of the view that once Peter McKenna was transferred to Leas Cross, the primary responsibility for his medical and nursing care rested with the nursing home. This view is echoed by Martin Hynes in his report of August 2005. Addressing the missed appointment at Beaumont on the 16th October 2000, he stated:

“Leas Cross Nursing Home did not take adequate steps to ensure that Peter returned to the Urology clinic at Beaumont Hospital on 16th October, or seek an alternative appointment for the removal of the catheter... In my opinion the duty of care rested with Leas Cross and it was their responsibility to pursue this matter with Beaumont; to enlist the assistance of SMH if necessary, and to inform the family of the difficulty which had arisen.”

However, although the principal duty of care may have rested with Leas Cross, the fact remains that St Michael’s House had promised Mr McKenna’s family that they would monitor his care and provide “clinical backup”. From the information disclosed to the Commission it seems that no formal, clinical monitoring of Peter McKenna’s nursing care at Leas Cross was carried out by St Michael’s House during the twelve days he resided there.
In a submission to the Commission dated the 25th March 2009, St Michael’s House gave the following details of the following visits by on-duty personnel from St Michael’s House to Mr McKenna at Leas Cross:

10th October  Visit by the Manager of Residential and Respite Services (who was also a registered nurse).

12th October  A registered nurse brought Mr McKenna to Beaumont Hospital and back to Leas Cross; another registered nurse visited Mr McKenna that evening.

14th October  A social care worker from Mr McKenna’s former residence at Warrenhouse Road visited him in Leas Cross.

It appears that no further visits by on-duty personnel to Leas Cross took place after the 14th October, although St Michael’s House have stated to the Commission that one social care worker “visited Peter regularly while off duty,” and that another social care worker visited Mr McKenna in Beaumont Hospital on the 22nd October and stayed with him until his family arrived.

On either the 19th or 20th October 2000, a psychologist from St Michael’s House telephoned Leas Cross to advise them of their intention to visit the following week. Also on the 19th October, a consultant psychiatrist from St Michael’s House telephoned the GP attending Leas Cross to request permission to visit Mr McKenna. Mr McKenna was transferred to Beaumont before either visit had taken place.

**Response of St Michael’s House to complaints**

In 2001, senior management at St Michael’s House received complaints about the treatment of Peter McKenna from two sources: one was Peter McKenna’s family, and the other was a senior clinical psychologist within St Michael's House. The Commission has seen no evidence of any response by St Michael’s House to the concerns expressed by the family in their letter of October 2001.

Nor, it would appear, did the complaint of the psychologist result in any re-examination of Peter McKenna’s case by St Michael’s House. The psychologist was invited to avail of an internal grievance procedure, but the documentation disclosed to the Commission makes it clear that this procedure was intended to address complaints made by the psychologist in relation to workplace bullying at St Michael’s House, and was not intended as a response to his complaints regarding the treatment of Peter McKenna.

In light of this, the Commission considers that St Michael’s House did not respond appropriately to the complaints received concerning Peter McKenna in 2001.
CHAPTER 17

TRANSFER OF RESIDENTS FROM ST. ITA’S HOSPITAL

Background to the transfer of patients from St Ita’s Hospital

St Ita’s Hospital, Portrane was constructed between 1896 and 1900. It was designed as an asylum capable of accommodating 1,200 patients. A number of smaller buildings were added at various points during the 20th century. The original building remains intact and continues in partial use to this day.

Unlike most other psychiatric institutions, the number of long-stay patients at St Ita’s Hospital did not decline as expected over time. This was due in part to the transfer of long-stay patients from other units within the Health Board. Approximately 70 patients came to St Ita’s in 1986 when the ‘Lower House’ at St Brendan’s Hospital was closed. Further transfers occurred from St Brendan’s in 1997 and from Unit 10 of James Connolly Memorial Hospital, Blanchardstown in 2002.

In addition to this, a shortage of nursing home beds in the north Dublin area meant that patients admitted to St Ita’s on a temporary or respite basis often ended up staying there long-term.

Further difficulties were caused by the ongoing practice of admitting elderly patients with dementia but who were not mentally ill to the psychiatric wards at St Ita’s. While the continued admission of patients with dementia to St Ita’s lessened the pressure on the health services to create and fund geriatric services, the continued absence of such services in turn meant that there were very few alternatives for elderly patients with dementia to receive care.

Planned changes in residential psychiatric services

Attitudes towards the mentally ill and their treatment changed during the twentieth century. The wisdom of using large, isolated institutions such as St Ita’s was questioned and, as early as 1966, the report of a Commission of Inquiry on Mental Illness recommended a new policy of de-institutionalisation. However, while, in general, the number of persons residing in psychiatric hospitals decreased over the years, the age profile of residents did not change drastically. As of 2001, the percentage of elderly residents in psychiatric hospitals was close to 40%, just as it had been in 1984.

In 1984, the Department of Health published a report entitled ‘The Psychiatric Services – Planning for the future’, which promoted a gradual move away from long-term accommodation in psychiatric hospitals with “a planned progression to a community-oriented service”. The report criticised the use of long-term psychiatric facilities for dementia patients who were not mentally ill.
These recommendations were not acted upon at the time. They were echoed by the Inspector of Mental Hospitals seventeen years later in his 2001 report, where he noted that older people who were not mentally ill but who suffered from “organic damage, mainly Alzheimer’s disease” were still being admitted to St Ita’s. Instead of accommodating such persons in that hospital, the Inspector recommended the establishment of “…a comprehensive, integrated medical and social community-based service with institutional support ... working in conjunction with the medical services for older persons in Beaumont Hospital”. As part of this, the existing facilities at St Ita’s could be de-designated – as had been envisaged since Planning for the future in 1984.

The 1984 report had acknowledged the difficulties involved in moving long-term residents of psychiatric hospitals. It expressed a preference for leaving them in situ but, where their needs were primarily geriatric, treating them separately from patients with functional mental illness.

In the case of St Ita’s Hospital, however, there were problems with this approach: the enormous size of the complex in comparison to the number of patients to be housed, the ongoing deterioration of many of the buildings due to lack of investment and use, the isolated location of the hospital, and the stigma associated with its history as an asylum.

The alternative approach – moving the long-stay patients elsewhere – also presented problems, caused in the main by a lack of resources. When the Northern Area Health Board (N.A.H.B.) was established in 2000, there were only 480 public nursing home beds available to it, which was far fewer than the availability per capita elsewhere in the country.

The ultimate decision to phase out the use of St Ita’s for long-stay patients, together with the scarcity of public long-stay beds in the region, led the N.A.H.B. to rely heavily on arrangements with private nursing homes to provide both respite and long-term care for elderly patients.

**Psychiatry of Old Age Service**

Regional consultancy services in specific aspects of psychiatry, including the psychiatry of old age, were first established in the late 1980’s, in line with recommendations in the Department of Health’s 1984 report. In 2002, the Psychiatry of Old Age Service was extended to Community Care Area 8, with the appointment of a consultant psychiatrist, Consultant Psychiatrist A, and a support team.

Consultant Psychiatrist A’s remit included the assessment of long-stay patients at St Ita’s Hospital and attempting to rationalise the long-stay facilities there. As part of this task, Consultant Psychiatrist A was asked to reduce the long-stay population in the hospital by seeking suitable long-term placements elsewhere.

The Psychiatry of Old Age team was based initially at St Ita’s Hospital. The team was joined by a consultant psychiatrist attached to the Psychiatry of Old Age (referred to
elsewhere in this report as ‘Consultant Psychiatrist B’), a consultant psychiatrist attached to St Ita’s, who had previously served Community Care Area 8 alone. In line with Consultant Psychiatrist B’s pre-existing practice, the Psychiatry of Old Age team broadened its intended remit to include not only typical old age psychiatric patients but also dementia patients of all ages. The team also operated a consultancy service for nursing home residents, accepting referrals from in excess of 800 private nursing home beds in Area 8.

Consultant Psychiatrist A and Consultant Psychiatrist B were clinically independent of one another but evolved a close working relationship. Both reported to the Clinical Director of St Ita’s. In terms of service development and planning, Consultant Psychiatrist A had a lead role.

Consultant Psychiatrist B was due to retire in 2005. Following representations by Consultant Psychiatrist A, another full-time consultant psychiatrist’s post was created for the Psychiatry of Old Age team. Consultant Psychiatrist B remained in her post until the new appointee took up duty, eventually retiring in January, 2007.

**Developments at St Ita’s Hospital**

When Consultant Psychiatrist A took up her appointment to the Psychiatry of Old Age team in March, 2002, there were 136 beds in the long-stay wards at St Ita’s. This included four twenty-bed units (L, M, N and P) in a stand-alone complex known as Reilly’s Hill. Reilly’s Hill was one of the newer buildings on the St Ita’s estate, having been built in the 1940’s. In the main hospital itself there were twenty beds in Unit 1 Female, twenty beds in Unit 1 Male and sixteen beds in Unit 8. Unit 8 served as an infirmary and also accepted acute admissions of persons over 65 years from the community for acute psychiatric treatment. The other long-stay wards were also used on occasion for admissions and respite care.

In anticipation of Consultant Psychiatrist B’s eventual retirement, Consultant Psychiatrist A took over management of the long-stay wards at St Ita’s on a gradual basis, starting initially with Units 1 Male and 1 Female. Consultant Psychiatrist B retained responsibility for the patients in Reilly’s Hill until the complex was finally closed towards the end of 2003.

**Changes at Reilly’s Hill**

In 1998 the Eastern Health Board produced draft proposals for the future of St Ita’s Hospital. Those proposals included the removal of all residential patients from the original hospital building, which was “no longer considered suitable for its purpose”, together with “considerable upgrading and extensions” to the Reilly’s Hill complex.

Upgrading and refurbishment work was carried out on the complex during 1999 and 2000. Nonetheless, in 2002 Inspector of Mental Hospitals reported that conditions there were unacceptable and recommended the following:
The Psychiatry of Old Age team under Consultant Psychiatrist A were in full agreement with the Inspector’s assessment of Reilly’s Hill.

Shortly after her appointment to the Psychiatry of Old Age team in March, 2002, Consultant Psychiatrist A organised a survey of the long-stay wards at St Ita’s in order to assess the care needs and the management regime for each individual patient. Based on the results of this survey, Consultant Psychiatrist A attempted to re-organise the wards at St Ita’s, primarily with a view to separating patients with ongoing psychiatric illnesses from those with dementia as a primary diagnosis. Units 1 Male (1M) and 1 Female (1F) were designated as treatment units for patients exhibiting dementia with behaviour disturbance. This was intended as a temporary solution: in the longer term, the N.A.H.B. had promised to open a new 40-bed facility off the St Ita’s site for such patients.

In November, 2002, ten patients were transferred to beds at Lusk Community Unit. An informal follow-up arrangement was established, whereby the staff at Lusk could contact the staff at St Ita’s for advice. In a statement to the Commission, Consultant Psychiatrist A described this initiative as “extremely successful”. The “carefully planned” exercise provided experience of discharging patients which allowed the Psychiatry of Old Age team “to develop a template for further discharge planning”.

The transfers to Lusk enabled the closure of Unit 8 at St Ita’s, although the unit was later re-opened as a temporary acute admission unit for the Psychiatry of Old Age service.

Following the transfers to Lusk, the Psychiatry of Old Age team decided that the unit which required the most urgent attention was Unit L in Reilly’s Hill. This was a male ward containing twenty patients, most with long-term mental illness and challenging behaviours. A few of the patients had dementia, some with challenging behaviour, some without. Conditions in the ward were extremely cramped, with a very small living area.

Consultant Psychiatrist A proposed that sixteen patients with ongoing psychiatric illnesses be moved from Unit L to Unit 9. This process was completed by the 23rd July, 2003. The remaining patients in Unit L, who had a primary diagnosis of dementia, were either moved to ward 1M or discharged to nursing homes. One such patient was moved to Leas Cross on the 6th June, 2003.

The closure of Unit L left 60 long-stay patients in three units at Reilly’s Hill.

On the 17th July, 2003, Consultant Psychiatrist A met with the Clinical Director at St Ita’s, the Director of Nursing at St Ita’s and the Acting Area Manager to discuss bed management in the remaining units at Reilly’s Hill. A document which appears to be a memo of that meeting, albeit one unsigned by any of the participants, records the following:
“It was agreed that Unit P would be the first and most appropriate for bed reduction / closure as it was identified as been (sic) unsuitable for the accommodation of elderly patients, followed by the reduction / closure in beds M and N...”

A time frame of two months was given for the closure of Unit P, a female ward.

The proposal was conveyed to Michael Walsh, Assistant CEO, N.A.H.B. by the Director of Nursing at St Ita’s in a letter dated the 28th July, 2003. The letter highlighted the continuing practice of admitting elderly patients with dementia. It observed that the N.A.H.B., in its 2002 report on Services for Older People, “acknowledged that care can be provided in nursing homes or the Board’s elderly care units”.

The letter went on to state that 23 female patients at St Ita’s had been identified as being suitable for nursing home care:

“...50% of these patients have end state dementia and 50% are stable with ongoing psychiatric illnesses. These patients do not require continued inpatient psychiatric care and would be more appropriately placed in nursing home care.”

In her statement to the Commission, Consultant Psychiatrist A states that she approved of the initial decision to close Unit P:

“Overall, I saw the closure of one unit as an opportunity to help those families whose relatives were stranded at St Ita’s and as a way forward to stop inappropriate long-stay admissions to St Ita’s. It required just fourteen contract beds to close Unit P. This seemed a reasonable objective. From my preparatory work with patients and families I was satisfied that fourteen suitable patients could be identified with their own and their relatives’ consent for this transfer.”

The decision to close Reilly’s Hill completely

According to a report dated the 10th November, 2003 from Consultant Psychiatrist A to the Clinical Director at St Ita’s, the initial plan for Reilly’s Hill was to use it to provide palliative care for patients with dementia:

“However, an initial suggestion to close twenty beds in Reilly’s Hill in an attempt to comply with the Inspector’s report and suggestions received from the Dementia Services Information and Development Centre, as well as to free up staff to cover nursing vacancies, developed into a larger project to close the building completely. This latter proposal was made feasible by the moving of Unit L and its clients from Reilly’s Hill.”

Consultant Psychiatrist A told the Commission that she was not involved in the decision to close Reilly’s Hill completely, although she did write a letter to the Clinical Director of St Ita’s on the 18th August, 2003 in which she said:
“... it would seem that the gradual closure of Reilly’s Hill would be a realistic aim.”

At the request of the Director of Nursing at St Ita’s, a project team was set up in October, 2003, “to facilitate the smooth transfer of patients from Psychiatry of Old Age to nursing home accommodation in the coming weeks, and the subsequent closure of Units M and N”. The ten-member team, which included four assistant directors of nursing, met for the first time on the 14th October, 2003. According to the minutes of that meeting, Units M and N were scheduled to close by the end of November, 2003.

According to Consultant Psychiatrist A, the members of the project team did most of the work in relation to the sourcing of beds and the subsequent transfers of patients from Units M and N.

In oral evidence to the Commission, Consultant Psychiatrist A said that in her view the project team did “a very, very comprehensive job” and that the best interests of the patients were looked after. However, she also stated that she was “surprised” at the timescale that was imposed upon them to close Reilly’s Hill completely. When asked who set the timetable and for what reasons, Consultant Psychiatrist A replied:

“I am not exactly sure why that deadline was set. I know there was a tendency in the Health Board to usually stop contract bed moves by the 1st December of a certain year but I am not sure exactly why that happened. I know that it did make it a bit tight ... and that there was a lot of work to be done during that month of November.”

Legislative framework for the discharge of patients

Discharging patients

The transfers of patients from St Ita’s Hospital to Leas Cross Nursing Home, which took place between 2002 and 2005, were governed by the Mental Treatment Act 1945 (“the 1945 Act”).

Under the 1945 Act, persons could be admitted to a mental hospital as either “voluntary” or “temporary” patients. Voluntary patients were those who submitted themselves voluntarily “for treatment for illness of a mental or kindred nature”. Temporary patients could either be addicts requiring at least six months’ treatment, or persons “suffering from mental illness” who were believed to require less than six months’ treatment. Neither “mental illness” nor “illness of a ... kindred nature” were defined by the 1945 Act.

61 The sections of the 1945 Act dealing with the discharge of patients were repealed by Mental Health Act 2001. However, the relevant sections of the 2001 Act were not brought into effect until the 1st November, 2006 (S.I. no.411 of 2006). The Health (Mental Services) Act 1981 also contains sections on the discharge of patients, but no part of this Act was ever brought into effect.
Patients at a mental hospital could be discharged under the 1945 Act if they were deemed to have “recovered”. The Act did not define what constituted “recovery” in this context.

Section 218(1) of the 1945 Act provided:

“Where the person in charge of a district mental hospital or other institution maintained by a mental hospital authority is satisfied that a person detained therein as a chargeable patient has recovered, he shall give notice to that effect to such relative (if aware of any) of the person detained as he thinks proper, and the notice shall contain an intimation that, unless the person detained is removed before a specified date not earlier than seven days after the date on which the notice is given, he will be discharged.”

If the person in charge was not aware of any relative to whom notice may be given under s.218, the patient should be discharged without such notice under s.219.

The above sections applied to a “chargeable patient”, defined by the 1945 Act as:

“…a patient who is receiving mental hospital assistance and who (with the persons, if any, liable to maintain him) is unable to provide the whole of the cost of such assistance.”

The discharge of private patients was governed by s.215(1), which provides:

“A person detained in a mental institution as a private patient shall be discharged on the written direction of the person by whom the last payment on account of the person detained was made…”

In the case of the patients who were sent from St Ita’s to Leas Cross, all were deemed either not to have been mentally ill in the first place, or to have recovered from mental illness to the extent that full-time residential psychiatric care was not required.

**Duty of care**

Under the Mental Treatment Act 1945, a discharged patient was simply released from the custody of the institution concerned. The Act did not impose any express responsibilities on the institution to find an appropriate residence and / or further care for a discharged patient.

Irrespective of the legislative provisions in force at the time, the Commission is satisfied that St Ita’s Hospital and the N.A.H.B. owed a duty of care to patients in transferring them from the hospital to nursing homes. These transfers differed from a simple discharge from hospital. As set out below, the hospital and the Health Board actively sought out nursing home places for many of the patients. Having taken on that responsibility, they were bound to ensure that the patients were moved to institutions capable of providing adequate care for them. This was acknowledged by Consultant Psychiatrist A in a letter to the Director of Nursing at St Ita’s, where she
stated that “we have to stand over the quality of the accommodation offered and we must monitor the situation in the new facilities very carefully”.

The Commission also notes that the Mental Health Act 2001 now provides that, in making a decision under the Act concerning the care or treatment of a person, “the best interests of the person shall be the principal consideration”.

Once the patients were transferred, the Commission considers that the main duty of care rested with the nursing homes, which became the primary carers for the new residents. However, given the high level of dependency of many of those residents and their particular psychiatric needs, St Ita’s quite rightly maintained some level of contact with its former patients, in the form of regular visits by Consultant Psychiatrist B and other members of the Psychiatry of Old Age team.

Guidelines on good practice

In 1998 the Inspector of Mental Hospitals issued a document entitled ‘Guidelines on Good Practice and Quality Assurance in Mental Health Services’.

Paragraph 4.8 of the Guidelines referred to the importance of good discharge planning and provision of appropriate aftercare. The following recommendations were made:

1. **Discharge plan**

   “A clear discharge plan designed for the safe discharge of the patient should be in place. This will include documentation and a pre-discharge checklist to ensure all appropriate information is given and all appropriate services are arranged prior to the patient’s actual discharge.”

2. **Discharge summary**

   “Immediately following discharge, a discharge summary should be sent to the general practitioner and to the members of the psychiatric services providing aftercare, setting out the principal details of the patient’s management and treatment while in hospital, including medication on discharge and whether and for how long it is to be continued.”

3. **Patient information form**

   “The patient too should be supplied with a standard information form giving information on the drugs prescribed, the name of his or her general practitioner and the telephone number of the mental health centre or service where staff can be contacted ...”

4. **Aftercare plan**
“An aftercare plan for the patient should be recorded in detail in the patient’s care file and available to each member of the professional team responsible for the patient. The discharge plan should be drawn up by the patient’s treating consultant psychiatrist and should fully consider and provide for the immediate and long-term needs of the patient and include an assessment of the risk of the patient harming himself and others. Aftercare should be properly co-ordinated and supervised under the general direction of the patient’s treating consultant psychiatrist.”

Consultant Psychiatrist A has pointed out to the Commission that the above guidelines were concerned primarily with the discharge of patients to their own homes rather than to nursing homes. Nonetheless, Consultant Psychiatrist A is of the view that the discharge and follow-up of patients conducted by St Ita’s Hospital and the Psychiatry of Old Age team fulfilled all of the recommendations in the above guidelines.

Consultant Psychiatrist A also informed the Commission that, as a matter of practice, the Psychiatry of Old Age Service took guidance from research carried out by the Royal College of Psychiatrists, who had published papers dealing specifically with the discharge of patients into private nursing homes.

**Transfer of patients to Leas Cross Nursing Home**

**Initial transfers, 2002-2003**

Prior to the decision to close Reilly’s Hill, a small number of individual patients were moved from St Ita’s to Leas Cross nursing home. One patient was transferred in November, 2002. In April, 2003 another patient was transferred but was discharged from Leas Cross within a week.

Three more patients were transferred from St Ita’s in May and June, 2003 respectively. One had been admitted to St Ita’s on a short-term basis for treatment of depression; the other two were long-term patients with advanced dementia. Consultant Psychiatrist A and Consultant Psychiatrist B were of the view that the care these patients received in Leas Cross was satisfactory – at least up until September, 2003, when the first of the transfers arising from the closure of Reilly’s Hill took place.

**Transfers from Reilly’s Hill, 2003**

In July, 2003 it was decided to close Unit P, a female ward in the Reilly’s Hill complex. A number of patients’ families were contacted to see if they would consent to a nursing home transfer. According to Consultant Psychiatrist A, in a statement to the Commission, some of those families had previously requested that their relative be looked after in a nursing home rather than in St Ita’s. A list of those patients whose
relatives agreed to a nursing home transfer was compiled by Consultant Psychiatrist B. Of the patients on that list, four died before they could be transferred.

On the 18th August, 2003 Leas Cross was visited by Consultant Psychiatrist A, the Director of Nursing at St Ita’s and the Area Manager. They met the proprietor of the nursing home, John Aherne and the matron, Grainne Conway to discuss in general terms whether Leas Cross would be a suitable place to transfer a group of patients from St Ita’s Hospital. No contemporary note of the meeting has been disclosed to the Commission.

Consultant Psychiatrist A recalls being shown some of the day areas, bedrooms and bathrooms at Leas Cross during this visit. She and Consultant Psychiatrist B were already somewhat familiar with Leas Cross, having visited a number of patients admitted from Beaumont Hospital for long-term care during 2003. Consultant Psychiatrist A told the Commission:

“Their care was satisfactory in my opinion. I was also satisfied with the care of a gentleman who had been with us in St Ita’s Hospital for short-term treatment of depression ... Furthermore, earlier in 2003, we had transferred two patients there from St Ita’s ... Both had quite advanced dementia and the care was satisfactory. I had noted nothing untoward in any of these visits but I would not have had any role in ‘inspecting’ the premises. We were not aware of any issues ... with Leas Cross...”

At some point following the visit of the 18th August 2003, a decision was made to place a significant number of patients (23 or more) in Leas Cross. It is likely that bed capacity was the principal factor in this decision: the recent completion of a 73-bed extension meant that Leas Cross had the room to accommodate a large number of new residents. Geographical location was another significant factor: the fact that Leas Cross was near to St Ita’s Hospital would facilitate follow-up visits by the Psychiatry of Old Age team.

Other nursing homes were chosen for the placement of smaller groups.

Negotiations regarding price were conducted on behalf of the N.A.H.B. by General Manager A. Leas Cross ultimately agreed to supply fourteen beds for one year for the price of twelve. According to a letter from Grainne Conway to the N.A.H.B. dated 26th August 2003, this equated to a price of €663 per bed. Documents disclosed to the Commission indicate that prices paid by the N.A.H.B. for beds in seven other nursing homes around this time ranged from €615 to €738, although the nursing homes at the higher end of the price scale took in only one to four patients, much fewer than the number of patients accepted by Leas Cross.

The documentation disclosed to the Commission does not include contracts of care for any of the patients transferred from the Reilly’s Hill complex at St Ita’s to Leas Cross. Grainne Conway, who was matron of Leas Cross at the relevant time, has stated to the Commission that the families of patients in contract beds were “totally unwilling to sign contracts of care for fear they may have to pay for the service”.

236
Ms Conway visited St Ita’s Hospital on the 10th September, 2003 to assess and discuss a group of female patients who were listed for transfer. According to a note by a member of the Psychiatry of Old Age team:

“She [Ms Conway] spoke with all of them and was very happy with the selection of patients.”

The note continued:

“Grainne would like the transfer to take place as soon as possible.”

Ms Conway has told the Commission that this was to limit the possibility of any deterioration in the patients’ condition between the time of her assessment and the date of their admission.

It was suggested by the Psychiatry of Old Age team that the patients would be transferred in three groups composed of five or six patients each, once arrangements with the patients’ relatives had been finalised.

On the 17th September, 2003, four patients from Unit P were transferred to Leas Cross. They were followed on the 19th September by four patients from Unit N. From the 23rd to the 27th September, a further seven patients were transferred from Unit 1F. The patients from St Ita’s were amongst the first residents of the new building at Leas Cross.

Transfers arising from the closure of Reilly’s Hill resumed during November, 2003, when a total of eleven patients were moved to Leas Cross in three groups. Eight of these were long-stay patients at St Ita’s, with three others coming from the acute ward. In December 2003 one respite patient was admitted to Leas Cross from the casualty department at Beaumont Hospital. He subsequently became a long-stay patient at the nursing home.

Further transfers, 2004-2005

A further five patients were moved from St Ita’s to Leas Cross during 2004, in February, June, July, November and December respectively. One of these patients was sent for a period of temporary respite care and was duly discharged after two months. Another patient was sent for several short periods of respite care during November and December, 2004. In January, 2005, she was again admitted to Leas Cross and this time remained there until the nursing home closed in August, 2005.

Two more patients were moved to Leas Cross in March, 2005. Records disclosed to the Commission state that one of those patients was intended to be there for only two weeks’ respite care, but in fact remained at Leas Cross until July, 2005.
Suitability of Leas Cross for transfers

The Commission has not been able to establish who made the final decision to use Leas Cross for the St Ita’s discharge initiative, and on what basis. According to a letter of December, 2005 from the Director of Nursing at St Ita’s, the visit of Consultant Psychiatrist A, the Director of Nursing and the Area Manager to Leas Cross on the 18th August 2003 did not result in an immediate decision to use Leas Cross in the discharge initiative:

“The visit by the team was a preliminary visit and involved discussions on the availability of beds, number of staff and facilities. The visit did not include an inspection of facilities and no decision was made at this point to place patients from St Ita’s in Leas Cross.”

In oral evidence before the Commission, Consultant Psychiatrist A confirmed that the Psychiatry of Old Age team were not in receipt of any nursing home inspection reports concerning Leas Cross. She told the Commission that the team relied on advice as to the suitability of Leas Cross from the Northern Area Health Board management, to whom she assumed the nursing home inspectors reported:

“They would have been the central people involved in nursing homes and they would have been negotiating with the management of St Ita’s… about this. It was from there that the decision to use Leas Cross was made.

So, as a St Ita’s team we were trusting that they were satisfied that Leas Cross was up to scratch at the time … we believed when they recommended Leas Cross or asked us to look at Leas Cross that they were happy that it was up to scratch.”

Consultant Psychiatrist A added:

“I suppose we also took the assurances of the matron, based on our experience of a visiting team up to then, that it would be okay.”

In a submission to the Commission dated 24th March 2009 Mr Michael Walsh denies that N.A.H.B. management were responsible for choosing Leas Cross as a potential placement for patients from St Ita’s:

“Other similar initiatives took place to private nursing homes between September 2003 and January 2005... All of these facilities were selected and accessed by the clinical teams, as appropriate... Neither I nor my administrative staff had any involvement in the selection or on advising on the suitability of any home; nor were we qualified to do so.”

St Ita’s Director of Nursing, in a submission to the Commission dated 16th March 2009, also takes issue with Consultant Psychiatrist A’s view on this issue, stating:

“This account is an erroneous interpretation as it relates to negotiating arrangements between Northern Area Health Board personnel and the St Ita’s Management Team. Many meetings took place between the NAHB and the
management team of St Ita’s which consisted of [the Clinical Director of St Ita’s], [the Area Manager] and [St Ita’s Director of Nursing] to discuss management and service issues. [Consultant Psychiatrist A] attended and participated at those meetings as they pertained to her area of responsibility… Mr Michael Walsh or any of his team did not meet or contact [the Director of Nursing] outside the management meetings relating to the discussions on Leas Cross. It is also incorrect of [Consultant Psychiatrist A] to state that ‘it was from there that the decision to use Leas Cross was made.’ This is categorically rejected.”

From the above statements, it appears that no one is willing to accept ultimate responsibility for the decision to use Leas Cross for the discharge of a large group of patients from St Ita’s. The documentation made available to the Commission is equally inconclusive on this issue.

A 2006 report on the St Ita’s discharge initiative states that during the summer of 2003 “a number of nursing homes” were visited by Consultant Psychiatrist A, Director of Nursing and the Area Manager. However, in his submission to the Commission the Director of Nursing states that only two visits were undertaken by that group – the first being to Leas Cross on the 18th August 2003. According to the Director of Nursing, they visited another nursing home on the 28th August 2003. The Director of Nursing states:

“I can recall that the nursing home was unilaterally and immediately rejected by [Consultant Psychiatrist A], prior to us departing the nursing home, on the basis that the nursing home’s arrangement in respect of patient mix was not appropriate.”

Consultant Psychiatrist A herself recalls rejecting this other nursing home as a suitable place to discharge patients, “on the grounds that its physical conditions were no better than Reilly’s Hill.” In oral evidence she told the Commission that did not recall making visits to assess any other nursing homes for the discharge initiative at that time.

**Communication with patients / relatives**

According to a letter dated the 7th October, 2004 from Consultant Psychiatrist A to the Medical Superintendent at St Ita’s Hospital, the families involved in the patient transfers arising from the closure of Unit P were contacted directly by the Psychiatry of Old Age team regarding the proposed transfers. However, a different approach was taken for the closure of Units M and N.

In a submission to the Commission, Consultant Psychiatrist A drew a distinction between this transfer and the earlier closure of Unit P:

“This involved the transfer of a much larger group of patients. Whereas the first initiative was managed by seeking out families who had requested transfer and by approaching others for their opinions, the second phase involved more definite decision making from our Bed Committee, which
consisted of 3 Assistant Directors of Nursing and the two Consultant Psychiatrists in the Psychiatry of Old Age. We sent a letter to the relatives of persons we deemed were suitable for transfer to nursing homes giving them an opportunity to discuss the issue with us.”

She continued:

“In all cases for both discharge initiatives the families were invited to see the nursing home proposed and the person in charge of the nursing home would have visited to assess the needs of patients to see could they be adequately catered for.”

In her submission to the Commission, Consultant Psychiatrist A has explained that it was the short deadline imposed for the closure of Reilly’s Hill which led to patients’ families being informed by letter rather than in person of the proposed transfer of their relative to a nursing home.

The standard form letter which was sent to relatives was drawn up by the Psychiatry of Old Age team. According to Consultant Psychiatrist A, it was sent to the N.A.H.B. headquarters for approval before being sent to the families. The letter took the following form:

“We are writing to tell you, as you may have seen in the press, that St Ita’s Hospital will be closing in the near future. The first phase of this will be the closure of most of the long stay beds under Psychiatry of Old Age with the transfer of clients to suitable nursing home accommodation. Your [name of family member] has been assessed for [his / her] current level of need and we feel it would be more appropriate for [him / her] to be placed in a suitable nursing home. We have accessed beds within the general area of St Ita’s Hospital which will enable our team to provide regular follow-up for our patients.

We feel that [name of family member] is suitable for transfer to [name and address of nursing home].

We would encourage you to visit or call there within the next week as the transfers are to take place shortly. Please contact the Assistant Director of Nursing, Psychiatry of Old Age ... if you have any queries.”

Regarding the statement that the entire hospital would shortly be closing, Consultant Psychiatrist A has informed the Commission:

“[This] reflected the stated position regarding St Ita’s Hospital at the time. A site plan had just been revealed to the St Ita’s Hospital staff. This involved the disposal of most of the land at St Ita’s Hospital and transfer of the psychiatric services elsewhere.”

Objections to transfers
According to Consultant Psychiatrist A,

“Opportunity was afforded to all to object to the transfers and anyone who was reluctant was not moved. The senior nursing staff liaised with patients, families, wards and nursing homes.”

In a number of cases patients or their families did make objections to the proposed transfer to a nursing home. This was explained by Consultant Psychiatrist A in a letter to the Medical Superintendent of St Ita’s in October, 2004:

“The approach taken by families to the discharge of their relatives was very varied. In some cases families were delighted, a few had actively sought transfer prior to the discharge initiative... Other relatives were vehemently opposed to the transfer and in one case...a complaint was issued against the process and the care of the patient over many years was questioned. Some other relatives approached us requesting that patients not be transferred and indeed some patients themselves asked not to be sent. In all eleven patients were not transferred following requests by themselves or their family. No patient was transferred against the wishes of himself / herself or his or her family.”

Consultant Psychiatrist A has told the Commission that she does not recall any specific objections being raised by patients or their families to Leas Cross as a nursing home; rather, the patients concerned simply wanted to stay at St Ita’s.

**Patients returned to St Ita’s Hospital**

On the 23rd October, 2003, a male patient was transferred from Unit 9, St Ita’s to Leas Cross. According to Consultant Psychiatrist A, the transfer took place at his wife’s request. The patient, who suffered from chronic paranoid schizophrenia, was described in the patient summary which accompanied his transfer to Leas Cross as:

“... relatively stable at present. He has ideas of deliberate self-harm at times, e.g. cutting himself.”

Records disclosed to the Commission indicate that this man was returned to St Ita’s Hospital in March, 2004 after five months in Leas Cross.

On the 14th November, 2003, another male patient with a history of schizophrenia was moved from Unit M, Reilly’s Hill to Leas Cross. According to Consultant Psychiatrist A, the patient himself had requested the transfer. After one month the patient was discharged from Leas Cross and returned to St Ita’s Hospital “due to aggressive / disturbed behaviour”.

In the case of both the above-mentioned patients, Consultant Psychiatrist A states that they were returned to St Ita’s, “because they failed to settle and relapsed mentally needing care in a psychiatric hospital.” Four more male patients with similar problems were later returned from two other nursing homes. In her submission to the Commission Consultant Psychiatrist A stated:
“All those male patients had functional illness, schizophrenia or bipolar affective disorder and the nursing homes could not manage their symptoms or associated behaviours. No female patient developed a mental health relapse equivalent to the male patients. If a female patient had relapsed mentally readmission to St Ita’s Hospital would have been arranged.”

In a published response to the report of Professor O’Neill on deaths at Leas Cross Nursing Home, the Chief Officer of the H.S.E. Northern Area made the following statement concerning the possibility of patients being readmitted to St Ita’s:

“Our Board’s policy has always been that where patients who were discharged from St Ita’s to either our own community residences or to private nursing homes and who did not settle in or were unable to be managed in their new residence, have always been readmitted back into St Ita’s without difficulty. At no time have barriers ever been placed on consultants at St Ita’s relating to this readmission policy and I am concerned that if such were the consultants’ concerns about the care provided at Leas Cross that they did not readmit the patients back to St Ita’s without question as has always been the norm.”

However, Consultant Psychiatrist A has confirmed to the Commission that, in reality, the closure of Reilly’s Hill meant that there was no space to readmit more than one or two patients to St Ita’s. Readmissions were therefore confined to patients who suffered a mental relapse and needed a return to full-time psychiatric care.

Wards of Court Office

Documents disclosed to the Commission by the H.S.E. indicate that four of the patients transferred from St Ita’s Hospital to Leas Cross were wards of court at the time of their transfer. Three other patients from St Ita’s were made wards of court subsequent to their arrival at Leas Cross.

Ward ‘A’ was amongst the first group to be transferred from Reilly’s Hill on the 17th September, 2003. The Wards of Court Office was not notified until the day of the transfer itself, when it received a letter from St Ita’s Hospital informing it of the transfer. When the Wards of Court Office made inquiries as to why it had not been notified earlier, it was told that the Eastern Regional Health Authority had not been aware that ward ‘A’ was a ward of court.

Ward ‘B’ was transferred to Leas Cross on the 19th September, 2003. The documentation disclosed to the Commission does not show whether the Wards of Court Office was informed of the transfer. Ward ‘B’ died one month later.

In the case of ward ‘C’, who arrived at Leas Cross on the 25th September, 2003, the Wards of Court Office was not informed of the transfer until a letter arrived on 26 September – the day after it had taken place.
Ward ‘D’ was moved from St Ita’s to Leas Cross on the 27th November, 2003. From records disclosed to the Commission, it would seem that the Wards of Court Office was not informed of this until approximately one year after the transfer had taken place. The sole reference in the relevant Wards of Court file consists of an undated, handwritten note which states:

“[Ward ‘D’] is gone from hospital to Leas Cross Nursing Home Swords area a year ago.”

Given that the wards of court system is intended to protect some of the State’s most vulnerable citizens, the Commission considers this pattern of inadequate communication between the health services and the Wards of Court Office to be totally unacceptable.

**Chronology of care for St Ita’s patients at Leas Cross Nursing Home**

**September – November 2003**

During the month of September, 2003, fifteen patients were moved from St Ita’s to Leas Cross.

In oral evidence to the Commission, Consultant Psychiatrist A recalled that, around the beginning of October, 2003 the matron of Leas Cross, Grainne Conway, telephoned to tell her that two former patients of St Ita’s had been admitted to Beaumont Hospital. Consultant Psychiatrist A told the Commission that the patients in question appeared to have had problems with swallowing and/or dehydration. She stated:

“No they were the type of problems that could have happened ... had they been in St Ita’s but I wasn’t sure and I didn’t want to take that chance.

It didn’t mean that I thought there were fatal flaws in the nursing care in Leas Cross at that time. But it meant that I felt they needed more help, they needed some guidance. And I set about getting that provided.”

On the 2nd October, 2003, Consultant Psychiatrist A wrote to the Director of Nursing at St Ita’s, regarding follow-up care for these and other proposed transfers:

“As you know we are proposing the transfer of some 50 patients from St Ita’s to nursing homes. These will require follow-up in the community. The Psychiatry of Old Age team would find it difficult to manage adequate follow-up with our present compliment of nursing staff. Given the numbers of staff that will be freed up by this move, would it be possible to assign someone to our team to help with the increasing workload ...”
Consultant Psychiatrist A wrote again to the Director of Nursing at St Ita’s on the 13th of October, 2003, repeating her concerns regarding follow-up care for patients transferred from St Ita’s, and this time referring specifically to Leas Cross:

“You will be aware that 3 of an initial group of 14 patients discharged to Leas Cross Nursing Home during the month of September have been referred into Beaumont Hospital and all have been quite seriously ill. Nursing care appears to have been the issue in all of these.”

Consultant Psychiatrist A then repeated her request for additional staff to be assigned to follow-up care:

“We are now in a stage of informing families that the hospital is closing and that their relatives will have to move to alternative accommodation. As such I feel we have to stand over the quality of the accommodation offered and we must monitor the situation in the new facilities very carefully. As such I want a named person from the hospital staff to be in charge of following-up nursing care issues in the nursing homes during the transition period, at least two months. Our own team can follow up on the patients with ongoing psychiatric illness but it would be inappropriate in my opinion for them to follow up those who have been receiving long term nursing care. This is due to an ever-increasing workload in the community and also their distance as a group from providing long term nursing care.”

Following receipt of this letter, the Director of Nursing at St Ita’s agreed to Consultant Psychiatrist A’s request and established a psychiatric nursing support service for all nursing homes that had accepted patients from St Ita’s. The nature of the support is described by Consultant Psychiatrist A as follows:

“…this was a service to help nurses and care assistants at Leas Cross and the other nursing homes to become familiar with the needs of the patients. This was a well-resourced service and assistant directors, clinical nurse managers and senior staff nurses who knew the patients took part in the visiting service.”

Follow-up care from St Ita’s was primarily directed at the mental health of transferred patients. Responsibility for their medical care was transferred to the general practitioner attending Leas Cross. Consultant Psychiatrist A states:

“Medical staff from the Psychiatry of Old Age team were not in a position to physically examine patients or to inspect standards of care. When we visited we did make general enquiries regarding issues such as food intake, hydration, skin integrity, bowel habit and weight but our active input and prescribing was mainly on issues of psychiatric symptoms. In persons with dementia the two issues, general health and behaviour, often interact.”

According to the St Ita’s Director of Nursing in his response to the O’Neill Report, the support service commenced on the 18th October, 2003. Between then and February, 2004 a total of nineteen visits were carried out, eleven of which were to Leas Cross nursing home.
Between the 18th and the 22nd October, 2003, three of the patients who had been moved from St Ita’s to Leas Cross in September died. On the 23rd October, 2003 Consultant Psychiatrist A wrote to inform the Clinical Director at St Ita’s Hospital of the deaths.

In a separate letter to the Clinical Director on the same date, Consultant Psychiatrist A asked for “…some involvement of the management team in the proposed discharges [to nursing homes] at this stage to ensure uniformity of approach from St Ita’s Hospital”. The Clinical Director assured Consultant Psychiatrist A in his response that the management of St Ita’s was fully supportive of the discharge initiative.

On the 17th November, 2003 another patient who had been transferred from St Ita’s in September died at Leas Cross.

Seven more patients were transferred to Leas Cross on the 27th and the 28th November, 2003.

December 2003 – January 2004

On the 3rd December, 2003 General Manager A, met with Ms Chris Green, the sister of two Leas Cross residents, Dymphna and May Monks, to hear Ms Green’s complaints regarding standards of care at Leas Cross.62 The Monks sisters were not former patients of St Ita’s, but had come to Leas Cross from Blanchardstown and Beaumont Hospitals in February and August, 2003, respectively. According to an unsigned memo of the meeting, Ms Green informed General Manager A that she

“...had noticed a deterioration in the care given since her sisters moved into the home – particularly since the Board transferred a number of patients from St Ita’s. In her view there did not appear to be a corresponding increase in staff.”

Following this, a meeting was called for the 9th December at N.A.H.B. headquarters to discuss issues which had arisen in relation to Leas Cross. Minutes of this meeting have not been disclosed to the Commission, but a handwritten note from N.A.H.B. records dated the 5th December, 2003 sets out the issues which were to be discussed as follows:

“(1) Verbal complaint re May Monks...

(2) [Consultant Psychiatrist A] / [Director of Nursing] (St Ita’s) have concerns re St Ita’s pts in Leas Cross e.g. loss of weight also. They seem to have a complaint from 1 family re – a pt in Leas Cross also.”

The Commission has not been able to establish whether the proposed meeting on the 9th December actually took place; or if it did take place, what was discussed and decided there.

62 See further Chapter 15.
On the 8th December, 2003 the Psychiatry of Old Age team met and discussed a recent visit by an Assistant Director of Nursing to Leas Cross. According to the minutes of that meeting,

“She [the Assistant DON] expressed some concern over some patients and their personal hygiene. There is a new G.P. working with the home now and it was decided that [s]he should be contacted. There is also concern about the number of patients nurses have to look after and the lack of nursing care.”

It was decided that Consultant Psychiatrist A and another doctor should visit Leas Cross to review all the patients transferred there from St Ita’s. This visit took place on the 10th December. A handwritten note of the visit, signed by Consultant Psychiatrist A, has been disclosed to the Commission. The note states:

“Matron / staff nurse did rounds. Very attentive.
Lots of care staff...
No bed sores on any current resident.
All pts had medical charts + cardexes – all correct from our records except they seemed to be unsigned.
No weights done – asked team at Leas X to weigh dependent ladies – told weights given.”

Consultant Psychiatrist A and her colleague observed the condition of residents at the nursing home but did not carry out any physical examinations. Consultant Psychiatrist A told the Commission:

“... my understanding of my role in the follow-up was that I was a psychiatrist, I was responsible for the mental health of my patients, but I had transferred the physical nursing care of my patients to the nursing home and their medical care to the G.P. ... I wouldn’t see it as my role to physically examine a patient outside of an emergency situation.”

Arising from her observations on the visit of the 10th December, Consultant Psychiatrist A recommended that a particular patient, Thomas Whelan, be seen by the G.P. attending Leas Cross: records from the nursing home indicate that the patient was seen by the G.P. on that same day.

Mr Whelan, who suffered from dementia and was acknowledged to have been frail at the time of his transfer to Leas Cross, was transferred to Beaumont Hospital two days after Consultant Psychiatrist A’s visit, on the 12th December, 2003. He died on the 25th December 2003. The cause of death was identified as respiratory insufficiency consequent upon bilateral pneumonia. An autopsy carried out at Beaumont Hospital found that the deceased had a large sacral pressure sore, approximately 10 x 10cm. However, it is not clear whether this pressure sore existed prior to Mr Whelan’s transfer to Beaumont Hospital. The summary report which accompanied Mr Whelan from Leas Cross indicated that his skin was intact at the time of transfer.

In oral evidence to the Commission, Consultant Psychiatrist A made a distinction between ‘general basic care’ and ‘critical basic care’. Issues associated with critical
basic care, in her explanation, include food and fluid intake, weight, and skin condition. In a written submission to the Commission she summarised the principal concerns of the Psychiatry of Old Age team arising from the deaths of former St Ita’s patients in 2003 and early 2004 as follows:

“These patients were frail and a certain death rate is expected in this group. Dementia reduces life expectancy and within dementia, increased age and decreased functional status at diagnosis shorten survival ... We had comparable death rates in St Ita’s over the same period so it could not be claimed by us that there was a statistically inflated death rate: rather it was the circumstances around the deaths, the type of patients and our perception of the skill mix [of staff] that caused the most concern. Also the presence of dehydration, aspiration pneumonia or bedsores can all be taken as indicators of the quality of nursing care. These were noted in some of those who had succumbed.

Dehydration and pneumonia are expected at the very end stages of dementia as the person loses his or her ability to swallow and intake reduces or ‘goes the wrong way’ but in well managed cases they occur over time and are anticipated in advance. After careful evaluation the care plan is altered, accepting that a palliative care management approach is appropriate. The focus of care then switches to relieving any distressing symptoms such as pain, dry mouth and breathlessness. Pressure sores should not occur on a wide scale in any institution in this day and age.”

On the 11th December Consultant Psychiatrist A wrote to a consultant surgeon at Beaumont Hospital concerning Dorothy Black – a former patient at St Ita’s who had been transferred to Leas Cross on the 17th September, 2003, and admitted to Beaumont on the 23rd November 2003 with decubitus ulcers (i.e. pressure sores). The letter stated:

“For the purposes of our records and follow-up of the development of the decubitus ulcers in this lady I would welcome a report from yourself or one of your team regarding the clinical status of this lady.”

The consultant surgeon responded by letter dated the 17th December 2003 in which he stated:

“This lady came in through casualty on November 23rd 2003 with pressure areas on both hips and a small one on the sacrum. They were deep and infected. Here general condition is poor... It seems unlikely that these sores will heal in view of her poor condition.”

Five days earlier, on the 12th December 2003, General Manager A received by fax a letter from the family of Dorothy Black.63 The letter, which highlighted the family’s concern regarding the treatment of Ms Black in Leas Cross, ended with a request for further action by the Northern Area Health Board:

63 See further Chapter 15.
“We would appreciate if you could give your urgent attention to the circumstances that led to our mother’s admission to Beaumont Hospital.”

As a result of this letter, the Head of Quality at the Department of Corporate Governance, N.A.H.B. was asked to co-ordinate an enquiry into the care of Dorothy Black at Leas Cross. He visited Leas Cross together with Nursing Home Inspector H on the 22nd December, 2003. An appointment was then made for a further visit, which took place on the 12th January, 2004. The Head of Quality was accompanied on that occasion by Nursing Home Inspector H and the Senior Area Medical Officer. According to Consultant Psychiatrist A, the Head of Quality kept in close telephone contact with the Psychiatry of Old Age team during the period he was inquiring into Dorothy Black’s treatment.

On the 26th December, a patient who had been transferred to Leas Cross from St Ita’s Hospital one month earlier, died in Beaumont Hospital.

On the 29th December, Consultant Psychiatrist A visited Leas Cross. She requested that the G.P. be asked to see a particular patient who had been described as “sickly” by the matron. Records from Leas Cross indicate that the G.P. did see this patient on the 30th and 31st December, 2003 and on the 1st January 2004. On the 2nd January, the patient died.

On the 9th January, 2004, Consultant Psychiatrist A wrote to the Head of Quality at the Department of Corporate Governance informing him that “since the first discharges to Leas Cross in September there have been 7 deaths of these patients”. The letter was copied to the Clinical Manager, the Director of Nursing and the Area Manager at St Ita’s Hospital. Consultant Psychiatrist A has told the Commission that the purpose of the letter was twofold: firstly, to provide information to assist the Head of Quality in co-ordinating the investigation of the Dorothy Black case, and secondly to act “as a marker” to the senior management in St Ita’s, “that this had happened and that they should know it happened”.

In her submission to the Commission, Consultant Psychiatrist A stated:

“Because of our concerns about the high level of deaths of frail patients by January 2004, we decided not to fill the vacancies [with] anyone who needed total nursing care and instead we used the beds for respite. What this means is that patients being cared for at home and known to our community team were admitted for short periods of respite to facilitate the patients and their carers.”

In oral evidence Consultant Psychiatrist A told the Commission that this decision by the Psychiatry of Old Age team was not conveyed to the management of Leas Cross:

“We operated that within our own team and we decided ourselves that we would be very careful as to who we would allow go to Leas Cross for long-term care after that time.”

On the 11th January, 2004, Dorothy Black died in Beaumont Hospital. The autopsy report stated:
“She was admitted to Beaumont Hospital ... with a number of pressure sores on her buttocks, legs and elbows... Her family gave a history of profound weight loss over the previous 8 weeks prior to admission. On examination in casualty she was found to be generally frail and cachetic and had pressure sores on her right and left buttocks and sacral region. The clinical impression was that of general poor health from malnutrition and sepsis from pressure sore ulcers...

I formed the opinion that death was due to probable sepsis due to extensive pressure sores on a background of severe Alzheimer’s disease.”

Following an inquest, the Dublin City Coroner recorded the following verdict:

“Dorothy Black was pronounced dead on the 14th January 2004 at Beaumont Hospital, Dublin 9 from sepsis complicating multiple pressure sores ...

Death by medical misadventure.”

March – April 2004

In March, 2004, a patient who had been moved to Leas Cross in October, 2003 was returned to St Ita’s Hospital owing to “deterioration and behavioural problems.”

From the 1st March, 2004 there are entries at more-or-less weekly intervals in the Leas Cross matron’s diary marked “St Ita’s”, which suggests that a system of regular visits from St Ita’s personnel was instituted early in 2004.

Minutes of a Psychiatry of Old Age team meeting on the 30th March, 2004 indicate that the son of a former St Ita’s patient, Margaret (‘Peggy’) Leeper, had expressed “some unease about Leas Cross but nothing specific” in a conversation with Consultant Psychiatrist A, who visited the patient on the following day.

Margaret Leeper had arrived in Leas Cross from St Ita’s Hospital on the 23rd September, 2003. The subject of the Leeper family’s concerns about Leas Cross was raised by the Commission at an oral hearing with Consultant Psychiatrist A, who responded:

“I would say that I had an extremely cordial and friendly relationship with the Leepers and we would have spoken on the phone many a time and I would say that [the family] were uneasy from the start as they would have noticed the same type of things that I did... They would have noticed general basic things and we would have too. In any conversations I had with Bryan [Mrs Leeper’s son] what I would have said to him was, ‘Your mum appears to be okay, her nursing care appears adequate, there is no evidence of anything critical.’”

Consultant Psychiatrist A went on to acknowledge that there were matters about which Mrs Leeper’s family were right to feel uneasy, including the suitability of the
room in which Mrs Leeper was placed, and the apparent lack of supervision. However, Consultant Psychiatrist A went on to state:

“But I would have felt very powerless in that situation because they weren’t issues that you could do an awful lot about, other than assure him that I would do my best for his mother’s medical care.”

In the first week of April, 2004 a mental health nurse from the psychiatric nursing support team visited Leas Cross. He noted that there was no water beside one particular patient (who was in bed, apparently with the winter vomiting bug) and advised staff at the nursing home that the patient could be dehydrated.

On the 29th April, the Psychiatry of Old Age team received a phone call from Leas Cross concerning a patient whose condition had deteriorated. This patient was not in a contract bed and, according to Consultant Psychiatrist A, should have been visited by the G.P. rather than Psychiatry, as the deterioration was likely to be physical rather than mental. Nonetheless, Consultant Psychiatrist B agreed to review the patient on the 1st May 2004 and asked for a urine test to be carried out in the meantime. This request was noted in the Leas Cross nursing care notes for the patient, but the test had not been carried out by the time Consultant Psychiatrist B visited two days later. This was noted in the minutes of Psychiatry of Old Age team meeting on the 6th May, 2004. Consultant Psychiatrist B repeated her request and the test was subsequently carried out.

May – June 2004

As would be expected in the ordinary course of events, some elderly occupants of contract beds at Leas Cross concerning a patient whose condition had deteriorated. This patient was not in a contract bed and, according to Consultant Psychiatrist A, should have been visited by the G.P. rather than Psychiatry, as the deterioration was likely to be physical rather than mental. Nonetheless, Consultant Psychiatrist B agreed to review the patient on the 1st May 2004 and asked for a urine test to be carried out in the meantime. This request was noted in the Leas Cross nursing care notes for the patient, but the test had not been carried out by the time Consultant Psychiatrist B visited two days later. This was noted in the minutes of Psychiatry of Old Age team meeting on the 6th May, 2004. Consultant Psychiatrist B repeated her request and the test was subsequently carried out.

At a Psychiatry of Old Age team meeting on the 15th June, 2004, reference was made to a resident of Leas Cross who had had a pressure sore on his bottom for fifteen months: “It has not cleared up in fact it is much worse.” The resident, who suffered from dementia, had come to Leas Cross from James Connolly Memorial Hospital in April, 2003.

At the same meeting, reference was made to a recent meeting between Consultant Psychiatrist A and the family of a patient (Thomas Whelan) who was admitted to Beaumont Hospital from Leas Cross on the 10th December, 2003. The patient had contracted aspiration pneumonia and was also found to have a bed sore: he was hospitalised on the 12th December and died on the 25th December, 2003. The minutes of the meeting record the following:

“The purpose of the meeting was to discuss the sequence of events leading up to [the patient’s] death... The family criticised the ethics, atmosphere and the care the staff in the nursing home showed towards the patients there. In
general they had many complaints regarding Leas Cross... His family went back to Leas Cross to get some clothes for him and they found mouse droppings in the wardrobe. They feel the nursing home was not suitable. Generally this is just a feeling there is nothing concrete. [The patient] got sick very quickly. He aspirated and became infected very quickly.”

July – August 2004

It seems that the Psychiatry of Old Age team continued to have concerns regarding the standard of care at Leas Cross. Amongst the documents disclosed to the Commission is a draft letter dated the 15th July, 2004 from the St Ita’s Bed Management Committee to Nursing Home Inspector H which is headed “Re Leas Cross Nursing Home”. The draft letter states:

“On our previous and recent review visits to Leas Cross, the ambience and décor of the building was pleasant. On interviewing our patients, a percentage of them complained re the inappropriate use of incontinence pads. Another ambulant patient’s shoes were missing for two days. His relatives who were visiting at the time expressed their concerns to us. Four of our patients were sitting in wheelchairs and others in old buxton chairs. General personal hygiene was poor with evidence clearly visible. Their clothes were grubby in appearance and a few patients had a strong odour of incontinence. The heating in the sitting room in the older part of the building was stifling with a large radiator extremely hot.

The staffing appeared inadequate with only one qualified staff nurse and nine care staff caring for sixty five residents in one area, and one qualified staff nurse and four attendants caring for approximately forty residents in another area.

We would like to raise these issues as causes for concern. Many of these issues could be resolved with adequate staffing levels and examination of standards ...

The draft letter concludes with more general remarks concerning the policy of transferring patients to nursing homes:

“Staffing levels, skill mix, policies and procedures, staff training for nursing and non-nursing grades are pertinent areas of inquiry. The scope of Nursing Home regulations and the remit of the current Inspectorate need reviewing.”

A handwritten note on the face of the document indicates that the draft letter was not sent, but that the issues contained in it were discussed with both the St Ita’s Director of Nursing and Nursing Home Inspector H. However, both of them have informed the Commission that no such discussion took place. In a submission dated the 6th May 2009 Nursing Home Inspector H wrote:

“I wish to state that neither the letter nor the contents were ever received or discussed with me then or at any other time... I and all the other inspectors
were completely unaware of the plans to transfer patients from St Ita’s to Leas Cross Home. We were not informed regarding the decision, consulted regarding its suitability or requested to make any extra visits in light of the number of patients being transferred to Leas Cross…”

Another handwritten note on the document states that the relevant issues were also discussed with the matron of Leas Cross, Grainne Conway, during follow-up visits to Leas Cross in July, 2004 by Consultant Psychiatrist A and another member of the Psychiatry of Old Age team.

At a meeting of the Psychiatry of Old Age Bed Management Committee on the 31st August, 2004, it was decided to formalise nursing and medical reviews of long-stay patients discharged to nursing homes as follows:

“Medical review of medication every 6 months.
Nursing review every 6 weeks – 3 monthly or more frequently if necessary – notification letter sent to Nursing Homes.”

Consultant Psychiatrist B and Consultant Psychiatrist A then divided responsibility for the various nursing homes between them: Consultant Psychiatrist B was given responsibility for Leas Cross at that time.

December 2004 – April 2005

On the 10th January and the 30th March 2005 two more patients were transferred from St Ita’s to Leas Cross, taking places vacated by three residents who had died in December, 2004 and January, 2005. The families of two of the deceased residents mentioned above have made complaints to the Commission about the care of their relatives at Leas Cross, but it appears that neither the H.S.E. nor the Psychiatry of Old Age team were made aware of the families’ concerns until some time after the Prime Time programme was broadcast on the 30th May 2005.

A handwritten note on the minutes of a Psychiatry of Old Age Bed Committee Meeting from the 1st March, 2005 states:

“Recently on inspection by the N. Home Inspectorate, [Leas Cross was] closed for admissions until further notice. Regular respites known to Leas Cross may continue, but no new cases.”

On the 2nd April, 2005, another former patient of St Ita’s, who had been discharged to Leas Cross in December 2004, died at Beaumont Hospital.

On the 13th April, 2005, another former patient of St Ita’s, Mary Keogh, who had arrived in Leas Cross in November 2003 died at Beaumont Hospital.

64 See further Chapter 13.
On the same date, the family of Margaret (‘Peggy’) Leeper, wrote to Consultant Psychiatrist A “…to express our outrage over the level of care received by our mother Margaret Leeper in Leas Cross Nursing Home.” The letter continued:

“Our mother was admitted into Beaumont Hospital on 11th April suffering from severe dehydration, a urinary tract infection and severe anaemia. We understand from the hospital that she was in a very poor state of health upon arrival from Leas Cross (flat was the term used). When we got there, she looked gravely ill and on numerous occasions the staff at Beaumont asked us had she been eating and drinking recently as it appeared to them that she had not...”

Following receipt of this letter Consultant Psychiatrist A visited Leas Cross and spoke to the acting matron, Denise Cogley. With her permission, Consultant Psychiatrist A examined the nursing care notes for Mrs Leeper. She also spoke to a doctor in Beaumont Hospital. On the 22nd April, 2005, Consultant Psychiatrist A wrote to General Manager A enclosing her response to the Leeper family and stating:

“It would appear from both sources that it is likely that Peggy got sick suddenly and that there was no delay in having her seen to with this illness. The family, however, had been unhappy with Peggy’s care in Leas Cross for some time and had telephoned me on a few occasions to check everything was going all right.”

Permission was obtained by Consultant Psychiatrist A to transfer Mrs Leeper’s contract bed to another nursing home, but Mrs Leeper died in hospital on the 3rd May, 2005, before the transfer could take place.65

On the 29th April, 2005, the sister of the recently deceased Mary Keogh wrote to inform the Director of Nursing at St Ita’s Hospital of her “serious concerns with regard to Mary’s care” at Leas Cross. Mary Keogh had been admitted to Beaumont Hospital from Leas Cross with severe abdominal pain and septicemia. Mary’s sister expressed the view that “her suffering was acute, and I believe, unnecessary, had her condition / physical health been monitored more closely at the nursing home”.

**Psychiatry of Old Age, bed management and the N.A.H.B.**

As mentioned earlier, a decision was taken by the Psychiatry of Old Age team in January, 2004 not to use Leas Cross for long-stay placements of frail patients.

On the 14th April, 2004 Consultant Psychiatrist A wrote to the Clinical Director of St Ita’s Hospital to inform him that the Psychiatry of Old Age team had set up a Bed Committee to manage the long-stay beds available to them. It was envisaged that the committee would meet on a monthly basis. The letter continued:

65 See further Chapter 15.
“The beds will be managed essentially in 2 groups. The in-patients wards of Unit 1 Male, Unit 1 Female, Unit 9 and 35 out of our new nursing home stock will be managed as St Ita’s Hospital beds. Our 10 beds in Lusk and 20 nursing home beds will be managed on the basis as need for Psychiatry of Old Age from the community.

As the Commission understands it, the reference to managing nursing home beds as “St Ita’s Hospital beds” simply means that those beds would be used for patients living in the community and under the care of the Psychiatry of Old Age team. It does not mean that St Ita’s Hospital were assuming responsibility for the nursing care of those patients once transferred to nursing homes.

In a letter dated the 19th April, 2004 to the Executive Officer, N.A.H.B., Consultant Psychiatrist A expressed concern regarding inadequate subvention funding for nursing home placements and the effect this might have on standards of care:

“You are probably aware that two of the nursing homes used by St Ita’s on the[Reilly’s Hill] discharge initiative have had complaints issued about the care and are under review. If nursing homes are being left short of money as a result of the new system of enhanced subvention rather than contract beds, this cannot be good for patient care. Nursing homes are in a competitive market and we know from Health Board negotiations recently that prices were reduced on negotiation. Staff costs and overheads continue to rise.”

Three days earlier, the matron of Leas Cross had written to the families of those occupying N.A.H.B.-funded contract beds in the nursing home, informing them of a new €40 charge to be imposed by Leas Cross, ostensibly because of the inadequacy of N.A.H.B. funding for those beds. After one month, the proposed €40 charge was abolished following protests by some families.

The Psychiatry of Old Age Bed Committee met again on the 27th April, 2004. Amongst other matters, the Committee discussed the kinds of patients who would be most appropriate for the various places in which Psychiatry of Old Age had beds. From the minutes of this meeting, it appears to have been agreed that Leas Cross would be used for patients who met the following description: “mobile, functional illness, mild to moderate cognitive impairment.”

On the same day, Consultant Psychiatrist A wrote to General Manager A concerning the problems in ensuring quality of care for Psychiatry of Old Age patients in nursing homes, stating:

“... you are of course aware that we have had some problems from our discharge initiative. There were a number of deaths in the frail dementia group and a lot of these occurred in one nursing home...We tried very hard to follow up our patients following discharge and we would have had twice weekly visits by senior nursing staff and regular medical visits... I would feel that we needed to look at the nursing home regulations in terms of inspection, process and powers of Inspectors, staff levels and skill mix and in particular number of qualified staff nurses, and staff training.”
The letter continued:

“I have spoken with [Nursing Home Inspector H], and she shares my concerns. We have met regarding the nursing homes on a number of occasions.”

Consultant Psychiatrist A concluded by informing General Manager A of a proposed meeting between Nursing Home Inspector H, Consultant Psychiatrist A and their respective teams, to take place late in May, at which these concerns would be discussed.

On the 30th April, 2004 Consultant Psychiatrist A wrote to Michael Walsh, Assistant C.E.O., N.A.H.B. concerning long-term care generally under the N.A.H.B. In reference to the need to place patients appropriately, Consultant Psychiatrist A commented:

“As clinicians we are aware of patient need and we have a responsibility not to discharge patients to inappropriate environments. My recent experience of discharging patients to nursing homes has been very mixed in terms of my own feelings regarding appropriate provision of care, our ability to monitor that care and the outcome for one particular patient group, the frail with end-stage dementia.”

Consultant Psychiatrist A has confirmed to the Commission that these comments referred to Leas Cross and one other nursing home in Area 8, both of which had been coming under increased scrutiny.

Concerning the letters written by her to senior N.A.H.B. figures in April, 2004, Consultant Psychiatrist A described her intention to the Commission as follows:

“... the point I was really trying to raise ... was to have them know that there were frail patients coming from the Mater, from Beaumont, from James Connolly, from home – it was really to have an awareness for those other patients ... I wasn’t particularly worried about my own patients when I wrote [those letters] in April 2004.”

As we have seen, the Psychiatry of Old Age team had addressed their concerns for former St Ita’s patients at Leas Cross by deciding in January 2004 not to place any more frail patients there on a long-stay basis, and by increasing their visits to the home. However, it is clear that Consultant Psychiatrist A remained concerned that other hospitals were discharging frail patients into Leas Cross, notwithstanding the problems that had arisen in relation to the care of patients transferred from St Ita’s towards the end of 2003.

On the 1st June, 2004 the Psychiatry of Old Age team met with Michael Walsh. According to Mr Walsh, the purpose of the meeting was to discuss the content of the letters written by Consultant Psychiatrist A to Mr Walsh and other members of the N.A.H.B. management in April 2004. Amongst the matters discussed were the bed management system, the nursing home inspection process and monitoring of quality of care in nursing homes. According to General Manager A, no issues relating
specifically to Leas Cross were raised at the meeting on the 1st June. Michael Walsh also states:

“I am absolutely certain that [Consultant Psychiatrist A] never raised any issue in relation to the admission of frail patients from acute hospitals at the meeting of June 1st.”

On the same day, Leas Cross was approved for re-registration for the period 2004-2007.

Although it is true that Leas Cross was not mentioned by name in the letters written by Consultant Psychiatrist A in April 2004, she clearly believed the recipients of those letters were aware, or should have been aware, that the problems experienced at Leas Cross were central to many of the concerns being expressed by her.

The Commission cannot understand how a high-level N.A.H.B. meeting, called to discuss the concerns expressed by Consultant Psychiatrist A, could take place without any specific reference to Leas Cross. In the passage quoted above from Consultant Psychiatrist A’s letter to General Manager A, it is clear that the matters which Consultant Psychiatrist A wanted to discuss flowed directly out of the problems experienced during the St Ita’s discharge initiative, and in particular the “deaths in the frail dementia group” which occurred in Leas Cross following the discharge initiative. The Commission also finds it hard to understand why the decision to re-register Leas Cross Nursing Home, which was taken by General Manager A on the same day as the N.A.H.B. meeting with Consultant Psychiatrist A, was not discussed or even mentioned at that meeting.

Michael Walsh, in a response to Professor O’Neill’s report, stated that Consultant Psychiatrist A “commented verbally to me that Leas Cross could not provide the appropriate level of care to high dependent patients referred by her and as a consequence she reverted to referring low dependent patients, as well as patients on respite care.” Consultant Psychiatrist A believes that her comment to Mr Walsh was made after one of a series of meetings held between Mr Walsh, consultant geriatricians and psychiatrists regarding service development issues in 2004 / 2005.

The Bed Management Committee met again in September, 2004. The meeting was also attended by General Manager A who, according to the minutes of the meeting, “clarified issues relating to Nursing Homes”. Amongst other matters, General Manager A stated (a) that “nursing home places subvented by the Health Board are public beds in private nursing homes”, and (b) that such beds “are not set in stone and may be moved if Psychiatry of Old Age Team encounter difficulties regarding patient needs or care.”

At the same meeting, it was noted that the Hospital School of Nursing had offered four places for a five-week course of general nurse training to nursing homes in the Northern Area. It was decided to offer two of these places to Leas Cross, and two to another nursing home. The Commission is unaware whether that offer was taken up by the nursing home.

66 See further Chapter 8.
Consultant Psychiatrist A was not at the meeting in September, 2004. In oral evidence to the Commission, she took issue with General Manager A’s statement that subvented beds in private nursing homes could be regarded as public beds:

“[That] would imply that you had some sort of control over the nursing, which wasn’t really so ... it was clear that ... the Director of Nursing at St Ita’s, didn’t feel that there were public beds in private nursing homes ... he clearly felt ... that the nursing care of these patients was the responsibility of the nursing home, with their oversight by the Nursing Home Inspectorate.”

Consultant Psychiatrist A pointed out that, even in circumstances where the cost of a bed is being met, in full or in part, by the health services, the contract of care in each case was between the nursing home and the occupant of the bed.

On the 7th October, 2004, Consultant Psychiatrist A wrote to the Medical Superintendent, St Ita’s Hospital to inform him of “… our experiences during the discharge initiative of September to December 2003 when Reilly’s Hill was closed”.

Having given a brief history of the discharge process, Consultant Psychiatrist A observed:

“In retrospect any difficulties we encountered with respect to the care of our patients in nursing homes would have related to the numbers of qualified nursing staff on the ground in the nursing homes. In some cases the nursing ratios were very low with just one nurse and a number of care attendants looking after perhaps forty or fifty patients ... 

Nursing issues would appear to be the most important factor in discharge planning and the assessment of dependency levels is crucial.”

The letter concluded by summarising the current situation as regards follow-up care:

“At this stage we still have fifty-five contract nursing home beds. A psychiatric review is carried out by one of the senior members of the team every six months to look at medication levels. In addition nursing staff pay regular visits to the nursing homes and the nursing home in which we have most beds (23 of our own beds plus numerous patients from the community) is visited every week by [Consultant Psychiatrist B].”

On the 21st April 2005, the Psychiatry of Old Age team wrote to General Manager A requesting permission to transfer funding for six respite beds from Leas Cross to other nursing homes. The beds had become available for use because of patients who had died at Leas Cross, “...and we decided the best use of those beds in Leas Cross was to use them as respite rather than filling them permanently.” The letter continued:

“Since January 2005 we have had approximately forty patients in for respite for one or two weeks at a time. Now because of investigations into the running and standard of care in Leas Cross we (on consultation with Michael Walsh...
by [Consultant Psychiatrist A]) can only use these respite beds for patients who have already availed of respite there before.”67

General Manager A responded by letter dated the 26th April, 2005, stating:

“I support the request, which is without prejudice to Leas Cross Nursing Home. Leas Cross Nursing Home are currently pro-actively engaged in a service review with the Northern Area Inspection Team.”

On the 30th April 2005, the Prime Time programme on Leas Cross was broadcast and, the following day, a team was assigned by the H.S.E. to take over the operation of the nursing home. The events that followed are documented elsewhere in this report.68

Some observations on the transfer of residents from St Ita’s Hospital

Between the 17th September and the 28th November, 2003, some 23 patients of St Ita’s Hospital were discharged to contract beds in Leas Cross Nursing Home. There is an accumulation of evidence – from families of residents, from nursing home inspectors and from the Psychiatry of Old Age team who co-ordinated the discharge process – which leads to a conclusion that this intake of patients coincided with a significant deterioration in standards of care in the nursing home.

The family of Dympna and May Monks raised this issue specifically with General Manager A at a meeting on the 3rd December, 2003. Other families, whilst they may not have made this complaint at the time, have made similar observations to the Commission, as the following quotes taken from their written statements indicate:

“My mother... was a resident at Leas Cross Nursing Home for six months from the 18th September, 2003 until her death on the 22nd April, 2004... During my mother’s stay at Leas Cross, a large number of patients were transferred from St Ita’s psychiatric hospital. It was clear that Leas Cross was not equipped to deal with these patients, most of whom seemed to have a very high level of dependency. Their arrival changed the nature of Leas Cross. It distressed the existing Leas Cross patients and resulted in a lower standard of care for everybody in the nursing home...”

“My mother was transferred to Leas Cross on 27 November 2002... In my view, a particularly dramatic change in standards of care took place when some 20 or more patients from St Ita’s Hospital, Portrane were taken into Leas Cross. The arrival of such a large group of patients, with high care needs, in a relatively short space of time meant that the existing residents in the home did not get the same level of care that they had previously enjoyed...”

“My mother... was a resident at Leas Cross Nursing Home for seven months from the 23rd June, 2003 until the 6th January, 2004... The level of care

67 See further Chapter 13.
68 See Chapters 21 and 22.
deteriorated significantly when there was a large intake of patients. I now know that these patients, who had high dependency needs, were transferred to the home from St Ita’s Hospital. I noticed that there was a complete change in the atmosphere of the nursing home. It was now noisy and congested when before it was quiet. Staff presence at the nursing station was minimal and it became increasingly difficult to establish a relationship with staff regarding my mother’s needs…”

In the Commission’s view, the questions that need to be answered are as follows:

1. Was it necessary to discharge these patients from St Ita’s Hospital?

2. Why were so many patients moved from St Ita’s in such a relatively short period of time?

3. Who decided that Leas Cross was a suitable place to discharge 23 patients from St Ita’s, and what was the basis for that decision?

4. How should Leas Cross Nursing Home have responded to these placements?

5. How should the Northern Area Health Board have responded to these placements?

6. How should the Psychiatry of Old Age team have responded to these placements?

1. Was it necessary to discharge these patients from St Ita’s Hospital?

The Commission is of the view that, in the long term, keeping these patients at St Ita’s was not an appropriate option. There are a number of reasons for this, which are set out in detail in the early paragraphs of this chapter.

In summary, the Department of Health had decided, as early as 1984, as a matter of policy that it was no longer appropriate to house psychiatric patients in institutions like St Ita’s and that a community based approach was required. Partly as a result of this, and despite efforts at refurbishment, St Ita’s had been allowed to fall into disrepair. This was recognised by the Inspector of Mental Hospitals and the Psychiatry of Old Age team, both of whom considered that the Reilly’s Hill complex no longer offered acceptable accommodation.

In addition to the infrastructural problems at St Ita’s, there was a relatively large number of patients who, whilst they may have had significant nursing care needs, did not require the kind of psychiatric care which St Ita’s was intended to provide. This was either because their mental illnesses had stabilised or because they suffered from dementia or Alzheimer’s and, as such, had never been appropriate patients for St Ita’s.

It is important to note that none of this is a criticism of the care provided by staff at St Ita’s. On the contrary, the Commission has received only praise from the families of former St Ita’s patients concerning the quality of care provided by St Ita’s staff.
2. Why were so many patients moved from St Ita’s in such a relatively short period of time?

Whilst the Commission accepts that there were good reasons to transfer a large number of patients out of St Ita’s Hospital the Commission questions whether it was necessary for so many of those transfers to take place within just a few months.

The central factor here is the decision (apparently taken in July or August, 2003) to close the remaining units in the Reilly’s Hill complex by the 1st December, 2003. The Commission has been unable to establish why or by whom this deadline was chosen. The effect of the December 1st deadline, in the Commission’s view, was to put unnecessary pressure on the project team managing the discharge process. Contact with patients’ families, which had been face-to-face in earlier discharges, was reduced to a standard form letter notifying them of the impending discharge. The nearness of the deadline also reduced the time available to inspect and evaluate the various nursing homes in which patients could be placed.

Most importantly, the imposition of the December 1st deadline left little time to monitor the response of Leas Cross Nursing Home to the arrival of the first group of patients in September, 2003. Fifteen patients were discharged to Leas Cross between the 19th and the 27th September. By early October, three of those patients had been hospitalised with issues relating to nursing care – difficulty in swallowing and dehydration. At Consultant Psychiatrist A’s insistence, a nursing support service was then put in place by St Ita’s to assist Leas Cross in coping with the newly arrived patients.

As noted elsewhere in this report⁶⁹, Nursing Home Inspector H has told the Commission that she informally requested the matron, Grainne Conway, to “suspend / slow down admissions” in March or April, 2004 while the inspectors looked at the increase in resident numbers, staff numbers and the skill mix of staff. The information available to the Commission suggests that this informal request had little or no effect on admissions to the nursing home.

The Commission accepts the view of Nursing Home Inspector H that a limit on admissions was necessary but considers it would have been more appropriate for the Health Board management to have imposed a formal condition under the nursing home legislation, to ensure compliance. In the Commission’s view, the most appropriate time to impose such a condition would have been in October or November 2003, after the initial group of 15 patients had been transferred from St Ita’s. to give the psychiatric support team and the nursing home inspectors time to assess the impact of the transfers on the standards of care at the nursing home. Instead, a further twelve patients were transferred from St Ita’s in October and November, 2003. Records disclosed to the Commission by Leas Cross indicate that during the same period, a further eight patients were admitted on a long-stay basis from other hospitals.

⁶⁹ See chapter 13.
3. Who decided that Leas Cross was a suitable place to discharge 23 patients from St Ita’s, and what was the basis for that decision?

As outlined earlier in this chapter, the Commission has been unable to establish who made the final decision to use Leas Cross for the discharge initiative.

Nor is it clear on what basis it was decided that Leas Cross could handle the admission of 23 elderly patients from St Ita’s, many of whom were high dependency. The nursing home was visited in August, 2003 by Consultant Psychiatrist A, St Ita’s Director of Nursing and the Area Manager, but, according to the Director of Nursing, this was just a preliminary visit, involving general discussion but no inspection of facilities.

The 111-bed Leas Cross Nursing Home was approved for registration on the 22nd November, 2002. The first inspection of the newly expanded home took place on the 9th July, 2003. On that day there were 60 residents, 26 of whom were either wheelchair bound or bedfast. There were three nurses and five care attendants on duty. The inspection form contained no conclusions regarding the state of the home or the wellbeing of the residents, and the inspection itself was not completed owing to the unavailability of certain information. The inspectors followed up certain matters in correspondence with the matron, but did not visit Leas Cross again until the 17th November, 2003.70

In the Commission’s view, the information provided by the inspectors to the N.A.H.B was not an adequate basis on which to make a decision to transfer 23 patients from St Ita’s Hospital. If anything, the information that almost half the existing residents at Leas Cross were not ambulatory in July, 2003 should have led the N.A.H.B. to question whether the nursing home could cope with a further 23 residents, many of whom were high dependency.

At the next routine inspection on the 17th November, 2003, Nursing Home Inspector H commented to the matron Grainne Conway concerning the rapid growth in resident numbers. According to Nursing Home Inspector H, the matron then explained to her that “some of the residents had been transferred from St Ita’s since our last inspection”. This implies that Nursing Home Inspector H had not been informed by the N.A.H.B. that these transfers were to take place. In a written submission to the Commission, Nursing Home Inspector H has confirmed that she was not informed of the transfers prior to this inspection.

The Commission considers that the N.A.H.B. did not make sufficient efforts to determine the suitability of Leas Cross to accommodate and care for the St Ita’s patients, insofar as reliance was placed on the one incomplete inspection carried out since the expansion of the nursing home to 111 beds, together with an informal, “preliminary visit” by Consultant Psychiatrist A, the Area Manager and St Ita’s Director of Nursing in August, 2003.

In the opinion of the Commission, the N.A.H.B. should have arranged for a detailed inspection of Leas Cross to be carried out, with a view to deciding on the specific question of its suitability to care for a large group of patients from St Ita’s Hospital.

70 See chapter 13.
That inspection should have been carried out with the assistance of a representative from St Ita’s, who could advise the inspectors on the particular needs of the patients.

It may be that the failure to carry out such a detailed inspection was linked to the decision to close wards at Reilly’s Hill within a very short space of time. However, as noted above, the Commission can find no justification for that urgency and considers that it does not excuse the N.A.H.B.’s failure to make a informed assessment of the suitability of Leas Cross or to give sufficient thought to the implications of the proposed transfer.

4. How should Leas Cross Nursing Home have responded to these placements?

In July, 2003 Leas Cross was operating with less than half of its beds occupied. It is easy to see how a proposal to transfer 23 or more patients from St Ita’s would have been welcomed in principle by the management of the nursing home.

It should be said that Leas Cross did not enter blindly into this agreement with the N.A.H.B. In addition to the preliminary meeting in August, 2003 referred to above, the matron Grainne Conway visited St Ita’s in September, 2003 to assess the patients listed for transfer. Ms Conway informed the Commission in correspondence that her assessment of the patients’ suitability for transfer to Leas Cross was based on a consideration of the following factors: (i) degree of mobility, (ii) state of confusion, (iii) nursing needs and (iv) history of aggression.

In considering the needs of the patients arriving from St Ita’s, Ms Conway decided that it was sufficient to increase the number of care attendants at the nursing home. In oral evidence Ms Conway informed the Commission that there was no formal procedure at Leas Cross for assessing staff levels: she would discuss the matter informally with her nursing staff and would then decide herself on what the appropriate staff level should be. Ms Conway also stated that an additional nurse was rostered for duty in or around this time, although that appears to have been in response to the general increase in resident numbers rather than to cater specifically for the needs of St Ita’s patients.

It is clear that the transfer of patients from St Ita’s had a significant impact on Leas Cross Nursing Home. The influx of a relatively large number of elderly, highly dependent dementia and Alzheimer’s sufferers placed a great burden on the staff of the nursing home, which, according to a number of families, resulted in a diminution in the standard of care for all of the residents. The Commission has set out its general findings regarding staffing at Leas Cross elsewhere, but particular emphasis must be placed on the failure to cater adequately for the arrival of patients from St Ita’s. The dependency profile and nursing requirements of those patients were such that staff numbers should have been increased and consideration should have been given to engaging some specialist nurses to care for them.

Responsibility for the decision to move so many patients from St Ita’s to Leas Cross cannot be ascribed solely to the nursing home. However, although members of the Psychiatry of Old Age team paid regular visits to the home, the management and staff

71 See Chapter 11.
of Leas Cross bear primary responsibility for the manner in which those residents were cared for once they had arrived. Insofar as adjustments were made by Leas Cross to reflect the complex needs of the St Ita’s patients, those adjustments were inadequate.

5. How should the Northern Area Health Board have responded to these placements?

The N.A.H.B. sanctioned the discharge of 23 or more patients, most of whom were high dependency, from St Ita’s Hospital to Leas Cross in 2003. At the same time, the nursing home continued to accept admissions of patients from Beaumont, the Mater and other acute hospitals. The Commission has already criticised the decision to sanction the transfers without adequate consideration. However, accepting that the transfers were being made, the Commission is also of the view that the N.A.H.B. should have taken steps to ensure that an acceptable standard of care was maintained at Leas Cross for all residents, including the new arrivals from St Ita’s.

As stated elsewhere in this report\(^\text{72}\), the Commission is of the view that the N.A.H.B. could and should have attached conditions to the registration of the newly expanded Leas Cross Nursing Home in 2002. By either limiting dependency levels, restricting the number of high dependency residents, restricting the rate of growth in resident numbers or by setting minimum staff ratios, the Health Board could have avoided the problems which beset Leas Cross in the ensuing years. This was not done, and does not seem to have been considered at the time of registration.

In July, 2003 there were 60 residents in Leas Cross, almost half of whom were not ambulatory. Over the next six months the N.A.H.B. contracted beds for a further 23 patients from St Ita’s Hospital. Leas Cross had never had this many residents before. In those circumstances, the Commission believes it would have been prudent for the N.A.H.B. to instruct the nursing home inspectors to make Leas Cross a priority – increasing the frequency of inspections until they were satisfied that the nursing home could cope with this many residents. This did not happen.

6. How should the Psychiatry of Old Age team have responded to these placements?

Once the patients from St Ita’s had been discharged to Leas Cross, the Psychiatry of Old Age team were not responsible for their nursing care. The role of the Psychiatry of Old Age team was to monitor the mental health of the patients concerned, and they did this. The Commission notes that two male patients who experienced a relapse into mental illness were both returned to St Ita’s by the Psychiatry of Old Age team.

To their credit, whenever Consultant Psychiatrist A and her team were made aware of possible nursing care problems at Leas Cross, they sought to bring those problems to

\(^{72}\) See chapter 8.
the attention of the appropriate person or persons within the health service. For example:

- In October, 2003 Consultant Psychiatrist A made repeated requests for a psychiatric nursing support team to be put in place, to assist staff at Leas Cross in addressing the particular needs of former St Ita’s patients. A support team was eventually established.

- In December, 2003 Consultant Psychiatrist A and other members of the Psychiatry of Old Age team visited Leas Cross on several occasions and recommended that certain residents be seen by the G.P.

- In January, 2004 Consultant Psychiatrist A wrote to the Head of Quality at the Department of Corporate Governance, N.A.H.B., who was investigating the treatment of Dorothy Black, to inform him of the deaths of other former St Ita’s patients at Leas Cross.

- In April, 2004 Consultant Psychiatrist A wrote separately to the clinical director at St Ita’s, General Manager A, the N.A.H.B. Assistant Chief Executive and the Chief Executive of the N.A.H.B., raising a number of concerns in relation to the discharge of public patients to private nursing homes and the ability of the health services to monitor care in private nursing homes.

In addition to alerting others within the health service to the apparent problems at Leas Cross, the Psychiatry of Old Age team also took action on its own behalf, choosing from January, 2004 onwards to use the contract beds at Leas Cross for respite rather than long-stay patients. From March, 2004 (and possibly earlier), visits from Psychiatry of Old Age personnel were increased to once a week.

When specific complaints were received by the Psychiatry of Old Age team from the families of former patients, those complaints were responded to quickly and thoroughly.
CHAPTER 18

TRANSFER OF PATIENTS FROM BEAUMONT HOSPITAL

There are two distinct aspects to the relationship between Beaumont Hospital and Leas Cross Nursing Home. In the first place, a significant number of persons admitted to Leas Cross went there following treatment at Beaumont Hospital or assessment by a consultant geriatrician attached to the hospital.

Secondly, and perhaps more importantly, Leas Cross was within the catchment area for Beaumont Hospital, which meant that most of the residents who required hospital treatment were admitted to Beaumont. Staff at the hospital were therefore in a position to observe first-hand the health and physical condition of a number of the residents at Leas Cross over a period of time, and perhaps to draw conclusions regarding the standard of medical care being applied to those residents at the nursing home.

Background

During the period which concerns the Commission, Beaumont Hospital had a catchment population of approximately 250,000. Whilst the hospital did have some access to beds in public nursing homes for rehabilitation and long-term care of their patients, that access was not sufficient to meet the needs of the hospital in discharging patients. A submission from the hospital to the Commission dated 3rd February 2009 states that there was “no regular delivery or availability of long-term care beds through the public system or from the Health Board…”

Consultant Geriatrician A arrived in Beaumont Hospital in 2000. From the time of his arrival until the end of 2004 he was the only geriatrician at the hospital. In addition, Consultant Geriatrician A worked sessions as a geriatrician at James Connolly Memorial Hospital, and was included in the general medical on-call rota at Beaumont. He told the Commission:

“When I arrived in Beaumont Hospital in 2000, the issue with regard to getting beds for long term care was an acute management issue at the hospital and has remained at the top of the hospital agenda even to this day. As a single-handed geriatrician in the years 2000-2004… the pressures relating to bed management in Beaumont Hospital were substantial. There were significant pressures to discharge older people from the hospital and there were regular meetings and contacts between the hospital senior management and the health board regarding the need for long term care beds.”
Discharge policy

Assessment for discharge

In general, a decision by a patient or his or her family to seek a nursing home placement is based on a medical opinion that such a placement would be appropriate – whether for short-term respite, convalescence, palliative or long-stay care. In most instances, the recommendation comes following assessment of the patient by a multi-disciplinary team. In the case of Beaumont Hospital, the process was led by Consultant Geriatrician A.

The assessment process was described in a letter to the Commission signed by Consultant Geriatrician A and two former heads of the Social Work Department. The letter states:

“As a specialist in the care of older people, part of [Consultant Geriatrician A’s] role is to advise and assess older people in need of long term care. This is a process which may take some time and involves nursing, medical, physiotherapy, occupational therapy, dietician and social work input and reviews. To make any recommendation regarding long term care, it is his normal practice to review all of the patient’s medical notes, and the input and opinions of all of these healthcare professionals. He is always aware of family’s and relatives’ opinions also.

In making a recommendation about long term care, it is his practice to recommend getting an appropriate environment for the current and future care for that patient, so that when they are discharged from the hospital that this new environment will be their new home and that they will not have to move out of there without a very good reason. Thus, it is important, in his view, that when patients are transferred to appropriate long term care that they do not have to return to the hospital unnecessarily.”

In a separate statement to the Commission, Consultant Geriatrician A identified the key elements in assessing patients for discharge as follows:

“When assessing patients for long term care, I needed to have details of their medical conditions, their social and home care circumstances, their current care needs, whether they had improved with rehabilitation and what had been discussed regarding their current and future care plans. This information was provided by the medical teams, the nursing staff, the occupational therapists, the physiotherapists, the dieticians and the social workers.”

Social Work Department
The Social Work Department of the hospital can provide advice and support to any patient seeking a nursing home placement. However, the department retains records only for those who use the service.

In response to a request from the Commission, the Social Work Department of Beaumont Hospital reviewed its records for patients whose placements at Leas Cross were subsidised by the health services. The department found and reviewed files relating to 40 patients who entered Leas Cross on a long-stay basis between 2000 and 2004. In a letter to the Commission, the head of the Social Work Department stated:

“Having reviewed the 40 patient transfers it is evident that:

1. Each of the patients had multiple medical problems.
2. There was a very definite process to transfer the patient to a long term care placement which is documented primarily in the medical chart.
3. There was multidisciplinary agreement that the person could not return home.
4. There is evidence of involvement and documentation of meetings between health care professionals and the patient’s families regarding the transfers. The ultimate decision to transfer someone into publicly funded long term care was a medical one.
5. A large cohort of patients (or their families) made the decision themselves that they wanted to go into long term care in Leas Cross.”

Choice of nursing home

The Commission has received submissions from the families of some former Beaumont patients who state that Consultant Geriatrician A had recommended Leas Cross Nursing Home for their relative. However, this is denied in the letter to the Commission from Consultant Geriatrician A and two former heads of the Social Work Department, which states:

“The process of recommending Leas Cross, in a personal sense, did not occur. It was not our practice to recommend any particular nursing homes but to try to match the care needs of individual patients to the available nursing home beds. As indicated, this process was taking place in the context of acute bed pressures and many patients waiting on trolleys in the Emergency Department.”

In a written submission to the Commission, Consultant Geriatrician A states:

“It is not my practice, and has never been my practice, to recommend patients and their families for any particular nursing home. However, it is usually my practice to advise that patients’ current and future care needs most likely would be met in a nursing home.”

His statement continues:
“For that reason I have always recommended that the hospital would liaise with the nursing home before any patient is transferred there. This liaison usually involves the director of nursing or a senior nurse from the nursing home coming to the hospital ward to meet the nursing staff and medical staff there when making their own assessment of a particular patient. This process has been part of my practice in Beaumont Hospital since 2000. As part of this process patients and their families could get advice on what nursing homes might be able to cater for particular care needs; this information would be based on knowledge about previous patients that had gone to the nursing home, feedback from nursing homes and collective information about nursing homes which the multidisciplinary team had accumulated over a period of time.”

In response to a question from the Commission as to whether a decision had ever been made not to recommend Leas Cross for a particular patient, the head of the Social Work Department stated in writing:

“I am not aware of any specific case where Leas Cross was not recommended.”

Discharge and follow-up care

According to Consultant Geriatrician A, primary responsibility for patients admitted to Beaumont Hospital is with the admitting clinician and remains with the admitting clinician for their discharge and follow up.

In June 2005, the operation of Leas Cross was taken over by the H.S.E. Consultant Geriatrician A was asked by Michael Walsh, Chief Officer for the H.S.E. Northern Area if he could provide a medical assessment of patients in the nursing home. Consultant Geriatrician A visited the nursing home on six occasions during June and July, 2005. He described his role as being “to give advice and opinions about patient care, which was being requested by the senior nursing staff”.

In a written submission to the Commission, Consultant Geriatrician A had the following to say regarding follow-up care by referring hospitals:

“For all of the patients that I was asked to see (about 50 referrals) it was clear to me that very few of the patients had ongoing contacts with the hospitals who had referred them to the nursing home in the first place with no follow-up appointments. All or most of the care was left in the hands of the nursing home and the associated staff. It was clear to me from my visits and patients assessments at this time that this approach was not adequate for the ongoing care of frail older patients with complex care needs and multiple medical problems.”
Transfers to Leas Cross from Beaumont Hospital

Health Board-funded transfers

From records kept by Leas Cross nursing home between July 1998 and May 2005, the Commission has identified 136 patients who stayed at Leas Cross following treatment at Beaumont Hospital. 82 of those were admitted to the nursing home on a long-stay basis; the remaining 54 were admitted for periods of respite care ranging from one to three weeks.

From information supplied by the Social Work Department at Beaumont Hospital to the Commission, it seems that approximately half of the 82 long-stay placements were funded, partly or fully, by the health services. The following written summary of the funded placements was provided to the Commission by the head of the Social Work Department:

“- 4 patients were placed in hospital funded beds. This means that the full cost of care was subsidised by Beaumont Hospital, at no cost to the patient or their family. In this case the patients and their families were asked to identify their preferred long term care placement and this was funded for them. 4 patients choose Leas Cross and as that was a registered nursing home Beaumont Hospital agreed to fund those placements.

- 21 patients aged over 65 years were placed in fully publicly funded beds by the ERHA allocated to Beaumont Hospital. These were known as contract beds. The procedure was that the Nursing Home Section [of the ERHA] allocated beds in named nursing homes. Beaumont Hospital would have been allocated 21 placements in Leas Cross for patients who required long term care.

- 13 patients and their families chose Leas Cross themselves, applied for subvention were successful and then were granted enhanced subvention by the nursing home section of the ERHA.

- 2 patients aged under 65 yr old were placed in contract beds in Leas Cross. These patients required high dependency care and were allocated two placements by the nursing home section in Leas Cross for those patients.”

Regarding the decision by the E.R.H.A. to allocate 21 contract bed placements in Leas Cross to Beaumont Hospital, the head of the Social Work Department stated:

“We had no input to the decision, and the choice of nursing home beds were never discussed in advance of offering them.”

The families of two former patients of Beaumont Hospital have told the Commission in written submissions that they felt pressurised by staff at the hospital to accept a placement in Leas Cross. The daughter of one patient simply stated:

“When my father was in Beaumont [in March 2004], the hospital was pushing for him to be discharged as they needed the bed.”
The daughter of the second patient had a more detailed complaint:

“In late May 2003, I was contacted by a social worker attached to Beaumont Hospital and told that a bed had become available in Leas Cross and we had 24 hours to make a decision as to whether this was suitable as a full time care facility for my father. If we decided not to take the place my father’s name would be put to the bottom of the waiting list for beds and it was unknown when he would be offered another bed. The social worker stated it could be 4 to 5 years before he would be offered another place. My father was 80 years of age at the time. We were put under extreme pressure to make a decision.”

The Commission put these complaints to the head of the Social Work Department, and received the following written response:

“Most families were aware of the acute pressures for beds in the hospital, particularly as there were frequent media reports about the Accident & Emergency crises and the numbers of patients waiting on trolleys to be admitted to the hospital. Our approach was to be professional and to be clear imparting information but also to be sensitive to the needs of individual patients and their families. In discussions, [Consultant Geriatrician A] feels that it may have arisen that they were informed that there were significant pressures for us running the clinical services and that moving patients to nursing homes was part of the process of running the hospital.”

The Commission understands the problems created by the shortage of beds in acute hospitals and appreciates that this places pressure on those hospitals to discharge patients as soon as they are ready. However, the Commission also realises that placing a relative in a nursing home is a difficult decision for any family. It is important for hospitals to deal as sensitively as possible with families in such circumstances, while at the same time endeavouring to make the most efficient and appropriate use of limited resources.

**Admissions to Beaumont Hospital from Leas Cross**

Using information provided by families in their submissions to the Commission, together with some documentation disclosed by the H.S.E. and by the former proprietors of Leas Cross Nursing Home, the Commission has assembled the following information concerning residents from Leas Cross who were admitted to Beaumont Hospital with problems which were, or may have been, care-related.

**October 2000**

Peter McKenna, a client of St Michael’s House who was moved to Leas Cross on the 10th October 2000 was admitted to Beaumont twelve days later, on the 22nd October. His family told the Commission:
“The doctor there told us that Peter was in an appalling state and asked us who was responsible for his “appalling medical condition”. The doctors were unable to take blood from Peter as he hadn’t been hydrated in three or four days. His catheter was ‘grimy’ and he was suffering from a bladder and/or kidney infection.”

Peter McKenna died at Beaumont Hospital that same day. The medical certificate of the cause of death recorded the causes of death as being:

“
I. (a) septicaemia
   (b) chronic urinary retention
   (c) Alzheimer’s disease
II. Downs syndrome.”

In May 2001, Peter McKenna’s family obtained a report from Beaumont Hospital, which was based on the records kept by the A & E department. The report confirms that that Peter was clinically dehydrated on his arrival at the hospital; that his urine bag contained infected looking urine and that his level of hygiene was poor.

February - May 2002

On the 7th February 2002 Kathleen Reilly, a resident of Leas Cross since July 1999, was admitted to Beaumont Hospital with a fractured left hip. She was found to be dehydrated on admission, having been nauseous and vomiting. Ms Reilly was discharged from Beaumont on the 4th March 2002, having had a long-term catheter inserted. On the 31st March she was admitted to Beaumont once more, this time with acute renal failure secondary to dehydration. Following treatment she was discharged on the 5th April.

On the 28th April, Kathleen Reilly was again admitted to Beaumont with dehydration and chronic renal impairment. Medical records from Beaumont Hospital contain the following note dated the 1st May 2002:

“Admitted from Leas Cross NH with acute Renal Failure-pre-renal 2. 0 Dehydration... Need to contact NH re second admission with dehydration in past 1/12.”

On the 2nd May the nursing care records note that Ms Reilly’s niece, Anne Bissett had phoned the hospital to express her concern that the care at Leas Cross was not adequate to meet Kathleen’s needs.

A further note on the patient file dated the 2nd May requested the opinion of Consultant Geriatrician A concerning the fact that Ms Reilly had been admitted twice in one month with dehydration. On the 7th May Consultant Geriatrician A wrote the following note in the patient file:

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73 For further information see chapter 16.
“I agree it is surprising to have second admission in one month. I will ring N/Home. She has significant medical problems …..and this may reflect her deterioration.”

This is followed by further note from Consultant Geriatrician A which states:

“I have rang Nursing Home – Mrs Reilly has been deteriorating since…. operation . Since last discharge she was refusing to eat and drink despite best efforts of staff and family. She has been less mobile and it seems likely that there has been progress of her physical and mental problems. If there are concerns about nutrition and fluid I think PEG will need to be discussed. I think this ladies problems need to be discussed with family (Nursing Home and GP) and management plans agreed; repeated hospital referrals and admission are not necessarily in her best interests. Happy to discuss.”

Kathleen Reilly was returned to Leas Cross on the 13th May 2002. In June 2002 she was admitted to the hospital once more with a bout of pneumonia. In July 2002 she attended the hospital for a consultant review, and in August 2002 she was readmitted with a respiratory tract infection. Ms Reilly’s final admission to Beaumont came on the 26th September, and she died on the 10th October 2002.

The Commission provided Consultant Geriatrician A with a copy of the submission of Ms Reilly’s niece to the Commission and asked him to comment on the issues raised therein. Consultant Geriatrician A responded in writing as follows:

“The concerns should have been addressed, in my opinion, by senior clinicians involved in her case, including doctors, nurses and social workers. I was consulted about her case and gave my advice as outlined in the medical notes. I was not aware of any of the concerns of her family which are summarised in the notes supplied. Decisions about her ongoing care, including her discharge from the hospital, rest with the clinical team and clinicians responsible for her care during these admissions.”

August 2002

Oliver Morris, a resident of Leas Cross since May 2000, was admitted to Beaumont Hospital on the 22nd August 2002. In her submission to the Commission his daughter stated:

“When we arrived in Beaumont Hospital we were told that our father was in the casualty area and that he was badly dehydrated, had pressure sores and a severe chest infection. On the day after he was admitted, my sister ... was going into the ward where my father had been taken following his admittance when a nurse came over and asked ‘Who is supposed to be looking after this man?’ She [the nurse] stated he was severely dehydrated and it had been noted that he had two pressure sores. My sister explained that he was a patient in Leas Cross Nursing Home. The nurse expressed her disgust at the condition my father was in when he arrived into the hospital. I incorrectly assumed that, once the nurse made this comment to my sister about my
Although Mr Morris responded well at first to treatment at Beaumont, he subsequently contracted MRSA and died at the hospital on the 3\textsuperscript{rd} October 2002.

**June – November 2003**

Frank Beegan, an 80 year-old patient of Beaumont Hospital, moved to Leas Cross in June 2003. Mr Beegan had a catheter, which required him to return to Beaumont regularly for it to be checked. In a submission to the Commission his daughter stated:

“I brought my father every six weeks or so to Beaumont Hospital to have the catheter changed. On numerous occasions the nurses at Beaumont Hospital complained that his catheter was not being washed or the bag changed. One nurse even phoned the nurse on duty at Leas Cross to complain but to no avail. My father regularly had infections that were preventable if the basic level of care had been provided to him in Leas Cross. This was the opinion expressed to me on more than one occasion by staff in Beaumont Hospital.”

In August 2003 Mr Beegan’s daughter contacted a social worker at Beaumont and asked that her father be moved to another nursing home as he was unhappy in Leas Cross. According to her statement to the Commission, she was told that there was a six-month “settling in period” and that her father’s care would be assessed again in January 2004. Mr Beegan attended Beaumont on the 7\textsuperscript{th} November 2003 for a chest x-ray. He was returned to Leas Cross by taxi on the same day and died two days later on the 9\textsuperscript{th} November 2003.

In correspondence with Beaumont Hospital the Commission raised the Beegan family’s request that Mr Beegan not be returned to Leas Cross. The written response to the Commission on this issue stated:

“It is usual practice to discharge the patient back to their referring address with appropriate discharge letters etc… In terms of authorising a transfer to a different private nursing home, the HSE nursing home section govern all aspects of that as it is tied in with their funding and regulation of the nursing homes… In the case of a private nursing home bed being managed by the HSE nursing home section, we have no authority to engage in any transfers. All requests would be directed to the nursing home section in the relevant HSE administrative area.”

The documentation disclosed to the Commission by the H.S.E. shows no evidence of the Beegan family’s request being passed on to the Nursing Home Section from Beaumont Hospital.

On the 28\textsuperscript{th} September 2003, another resident of Leas Cross, Mrs Clare Lawlor was admitted to Beaumont with cyanosis and breathing difficulties. Medical records disclosed to the Commission indicate that she was dehydrated on her arrival at the hospital, and that it was necessary to administer fluids to her intravenously.
On the 12th October 2003 Clare Lawlor was readmitted to Beaumont with severe dehydration and pressure sores. According to a statement received by the Commission from both of her daughters,

“My mother never had bed sores before coming to Leas Cross. The staff at Beaumont Hospital seemed pretty annoyed about the condition my mother was in.”

While Mrs Lawlor was in Beaumont, her daughter voiced her concerns about Leas Cross with a junior doctor in the Accident & Emergency Department:

“The doctor said they would arrange for someone to talk to me. I then received a telephone call from the patient advocate, to whom I related my concerns. I am not aware that any further action was taken by Beaumont Hospital in relation my complaint. I feel that the hospital should have acted on this matter. I believe that a protocol should be in place for dealing with situations such as this, when an elderly patient presents on more than one occasion with symptoms of dehydration and neglect.”

On the 2nd October 2003 Theresa Smith was admitted to Beaumont from Leas Cross with dehydration, anorexia and urosepsis. She died on the day following her admission.

On the 23rd November 2003, Dorothy Black was admitted to Beaumont from Leas Cross with severe pressure sores. Dorothy’s family stated to the Commission:

“We were shocked by the severity of the sores – the real state of our mother’s health had never been made clear to us by the staff at Leas Cross. She was crying in pain from the pressure sores.”

On the 11th December Consultant Psychiatrist A of the Psychiatry of Old Age service wrote to a consultant surgeon at Beaumont seeking a report on Ms Black’s condition. The consultant surgeon responded by letter dated the 17th December 2003 in which he referred to the fact that Ms Black had “deep and infected” pressure sores on both hips and on the sacrum, and that her general condition was poor. Dorothy Black died at Beaumont Hospital on the 14th January 2004. A post-mortem was carried out, and the Dublin City Coroner was informed.74

**February 2004**

Mary Keogh, a resident of Leas Cross since November 2003, was admitted to Beaumont during February 2004 with severe dehydration. She was returned to Leas Cross following treatment.

74 For further information see chapter 17.
July 2004

Sean Colgan, who had moved to Leas Cross from Beaumont in March 2004, was readmitted to Beaumont on the 29th July with serious pressure sores.

Another resident, Ann Pierce, was admitted to Beaumont with a large pressure sore during the month of July. According to her family, a nurse in A&E “seemed annoyed at the condition of it”.

February 2005

Vincent Dowling was admitted to Beaumont from Leas Cross on the 12th February 2005 with urine infection and dehydration. Medical staff at the hospital told his family they were “shocked” at his condition.

April 2005

Mary Keogh was admitted to Beaumont on the 7th April 2005 with septicaemia, enlarged pressure sores, dehydration and chronic constipation. She died at the hospital on the 13th April.

On the 11th April 2005, Margaret Leeper was admitted to Beaumont with a urinary tract infection and severe dehydration. Staff at Beaumont told Mrs Leeper’s family that “[her] fluid intake did not appear to have been managed properly at Leas Cross”.

Ms Leeper’s family complained in writing to Consultant Psychiatrist A, Consultant in Psychiatry of Old Age. The letter was copied to a gastroenterologist at Beaumont. After speaking with the gastroenterologist and reviewing the patient file at Leas Cross, Consultant Psychiatrist A responded to the family by letter dated 22 April.  

Review of deaths at Beaumont Hospital

As part of his inquiry into deaths at Leas Cross Nursing Home, Professor O’Neill reviewed information from Beaumont Hospital concerning residents of Leas Cross who died at the hospital. In his report, Professor O’Neill summarised the information as follows:

“The hospital or A/E records of 46 of those who died in Beaumont were examined by me in the course of the review. Eight were brought in with cardio-respiratory arrest, and are recorded as dying in A/E, although the precise time of death cannot be established with certainty.”

75 See chapter 17.
Of the remaining 38, of the 24 who had renal profiles available for inspection, 20 had renal failure, often at very elevated levels, for which dehydration was likely [to] be a contributory factor, particularly given the lack of routine use of fluid charts in Leas Cross.

Pressure sores were noted in 12 patients and red skin (possible Grade 1 pressure sores) in 4, giving a total of somewhere between 32-42% prevalence of pressure sores. Six of thirty-eight were noted to have swallow disorders. Two patients, both fallers, were noted to have rib fractures on chest X-rays.”

**Reporting of concerns by staff at Beaumont Hospital**

In a letter to the Commission, the head of the Social Work Department stated:

“Since 2005 we have initiated a new system where we systematically highlight any patient who we have a concern about to the HSE nursing home inspectorate. The process involves a staff member (usually a nurse or doctor) in A & E or on the ward, who has a concern about a patient admitted from a nursing home to fill in a risk management form. That form is sent to the principal social worker who liaises with the admitting consultant and / or the geriatric team to check if there was a genuine reason that the symptoms were present... If following that consultation, we remain concerned a copy of the risk management occurrence form goes to our in-house risk management group and to the nursing home inspectorate.”

An example of the new system in operation can be seen in a letter dated the 13th July 2005 from the head of the Social Work Department at Beaumont to the Nursing Home Section of the H.S.E. Northern Area. The letter was written “...to highlight a concern that has been forwarded to me by staff from the Accident and Emergency Department in Beaumont Hospital”. The concern related to a Leas Cross resident who was admitted to Beaumont on the 29th June 2005 with pressure sores.

Prior to the introduction of this new system in 2005, it would seem that there were no formal procedures in place for processing concerns expressed by medical staff at Beaumont Hospital regarding patients admitted from nursing homes.

In the absence of such a formal system, the Commission has had to rely for the most part on information given to it by relatives of Leas Cross residents who say that concerns were voiced to them by Beaumont medical staff.

The Commission provided details of the concerns recorded by patients’ families to the head of the Social Work Department, who acted as the liaison officer between the Commission and Beaumont Hospital. In a written response the Commission was informed that
"There is no documentary evidence of complaints or concerns being passed on about those families by those who treated the patients. Whilst families may have expressed these concerns, there is no evidence of them being progressed."

Some observations regarding Beaumont Hospital and Leas Cross Nursing Home

The information provided to the Commission by patients’ families, together with the review of medical files conducted by Professor O’Neill, suggests that staff at Beaumont Hospital were witnessing a recurring pattern of residents being admitted from Leas Cross with problems which either were or could be indicators of poor care at the nursing home. These problems included pressure sores, dehydration and urinary tract infections.

In the previous chapter, the Commission outlined the concerns of Consultant Psychiatrist A and the Psychiatry of Old Age team, which arose from the admission of a number of former patients of St Ita’s Hospital to Beaumont with one or more of the above medical conditions. Consultant Psychiatrist A and her team were concerned in the first instance for the patients who had been transferred to Leas Cross from St Ita’s Hospital. However, as Consultant Psychiatrist A made clear to the Commission, her concerns subsequently spread beyond that to include frail patients who were being admitted to Leas Cross from Beaumont and other hospitals. From the information available to Professor O’Neill and to the Commission, it appears that these concerns were entirely justified.

The submissions received by the Commission from a number of residents’ families record concerns about care at Leas Cross, which the families say were expressed in Beaumont by nurses, doctors, and in one case (that of Kathleen Reilly), by Consultant Geriatrician A. Yet it seems that the staff at Beaumont did not convey any of their concerns about Leas Cross to the Health Board or to the H.S.E.

Furthermore, with the sole exception of Consultant Geriatrician A, there is no evidence of any member of Beaumont’s medical staff raising their concerns with the matron of Leas Cross. In the cases of Dorothy Black and Margaret Leeper (and possibly Kathleen Reilly also), any action that was taken resulted from complaints made by the patients’ relatives, not by staff at Beaumont Hospital.

The Commission notes the comment of Oliver Morris’ daughter to the effect that she expected that, once a nurse had expressed a concern about her father’s care at Leas Cross, “...a mechanism would be put in place by the hospital to report my father’s condition to the HSE or relevant authority”. In the Commission’s view, this was an entirely legitimate expectation.

There is no doubt that the absence of any formal procedure for recording and reporting such concerns within the hospital contributed to the failure to identify and respond to the emerging pattern of care problems at Leas Cross. However, the fact that there was no formal procedure does not, in the Commission’s opinion, absolve
the hospital’s medical staff from fulfilling their duty of care to their patients. In the Commission’s view, such duty of care must include a duty to report, and if necessary to follow up on, any concerns which they have regarding the care afforded to patients in the nursing home from which those patients have been admitted.

The Commission reiterates the point, made in chapter 15, that article 26 of the Nursing Homes (Care and Welfare) Regulations 1993 allows a formal complaint to be made to the Health Board / H.S.E. by any person acting on behalf of a nursing home resident. The Commission has received submissions from Beaumont Hospital which claim that as a matter of practice, the Health Board / H.S.E. has refused to accept complaints from the hospital’s Social Work Department unless they are made with the express consent of the patient concerned or their family. However, the key issue here is not that the complaints of Beaumont staff about Leas Cross were rejected, but that, prior to the introduction of a formal reporting system in 2005 there is no evidence of such complaints being made in the first place.

Finally, the Commission notes the view expressed by Consultant Geriatrician A to the Commission that the level of follow-up for patients who were discharged from general hospitals to nursing homes “was not adequate for the ongoing care of frail older patients with complex care needs and multiple medical problems”. Consultant Geriatrician A’s view echoes the concern expressed by Consultant Psychiatrist A in a letter of the 30th April 2004 to then Assistant Chief Officer of the N.A.H.B. Michael Walsh, where she stated:

“My recent experience of discharging patients to nursing homes has been very mixed in terms of my own feelings regarding appropriate provision of care, our ability to monitor that care and the outcome for one particular patient group, the frail with end-stage dementia.”

The Commission considers that the question of the extent to which hospitals can and should follow-up on frail, elderly patients discharged to nursing homes is one that warrants further consideration by the hospitals themselves and by the H.S.E.
CHAPTER 19

TRANSFER OF PATIENTS FROM THE MATER HOSPITAL

Discharge policy

The standard procedure of the Mater Hospital for the discharge of patients to long-term residential care involves a multi-disciplinary assessment under the direction of the admitting consultant physicians. Once the assessments are completed the patient is referred to the consultants in the Department of Medicine for the Elderly. The final decision on the patient’s need for long-term care rests with the consultants in that department.

The Commission has been provided with a document from the Department of Medical Social Work at the Mater Hospital. The document, which is dated the 1st December 2001, sets out that department’s policy regarding the placement of patients in alternative care environments. According to the Mater Hospital, “the Social Work Department’s policy and procedure as outlined is only one part of the discharge process and is designed to guide best Social Work practice.”

The following general principles are applied by the Social Work Department:

1) Where possible, patients should be discharged back to their home. Only in circumstances where all home care options are exhausted should an alternative care placement be sought.

2) Decisions on placement are made following a consultative process involving the patient, family members and the relevant members of the multi-disciplinary team concerned with the care of the patient while in the Mater Hospital.

3) Any specific requests from patients in regard to placement should be taken into account far as possible.

The policy document sets out the following procedure for placing patients in alternative care facilities:

1. Social worker assesses patient’s need for placement taking into account the patient’s age, ethnic background, religious preference, mental health and physical ability. Patient and family to be encouraged and actively assisted to seek placement of choice in as far as possible.

2. Social worker documents their professional judgment as to the patient’s placement needs. In situations where mental capacity is in doubt, social worker recommends the patient be assessed by Geriatrician and / or psychiatry of old age / psychiatry as appropriate to establish whether the patient has sufficient mental capacity or not. Where they have capacity, decisions can normally only be taken with the patient’s consent.
3. Social worker reports result of assessment to multi-disciplinary team and continues to co-ordinate with patient, family and multi-disciplinary team.

4. Once placement recommended, ensure patient and family are informed of this by the medical team and in the context of a family meeting where possible.

5. Patient’s transition to long-term care:
   - Client, next of kin and family are empowered with concrete information re specific placement.
   - Pre-placement visits to be encouraged where possible to minimise disruption and to facilitate and promote continuity of care for patient. In the absence of family members or next of kin, MSW [Medical Social work Department] to consider appropriateness of carrying out pre-placement visit with patient. MSW shares information with matron, nursing home on a need to know basis and in the best interests of the patient. MSW forwards written information via contact sheet to the Matron of the nursing home. In certain situations, it may be appropriate to request the nursing home matron to assess patient’s suitability for placement whilst an inpatient in the hospital.
   - Post placement visits may be carried out where necessary to facilitate and support patient in adjusting to alternative care. If the social worker is informed of concerns regarding the patient’s suitability or adjustment to identified placement once the transition is made, the social worker will establish concerns and inform and discuss with HMSW [Head Medical Social Worker] if deemed appropriate.
   - Social worker may need to liaise with medical consultant, geriatrician, relevant health board, matron, family and patient where appropriate in establishing concerns; sharing information and identifying key personnel responsible in addressing and responding to concerns. In certain situations it may be deemed appropriate to adopt an active role in responding to concerns.

**Communication with patients / families**

Amongst the documentation produced by the Mater Hospital to the Commission is a document which summarises the involvement of the hospital’s Social Work Department in the case of each patient discharged to Leas Cross.

According to this document, the Social Work Department adhered to the stated policies of informing patients and their families, allowing them a choice of nursing homes where possible, and encouraging pre-placement visits to the chosen home.
Complaints

The Commission received a submission from the family of one former Leas Cross resident which stated:

“Our family was put under extreme pressure by the Mater Hospital to find a place in a nursing home for our mother – every time we went to visit her we were asked by a member of the nursing or social work team whether we had found a place for her. We were then told that if we didn’t find a nursing home bed as quickly as possible, that we would come in one day and find that our mother had been transferred to St Mary’s Hospital in the Phoenix Park...

When we told the staff in the Mater Hospital that we were thinking of sending our mother to Leas Cross, they responded very positively. However, we feel that this was as much a reaction to getting our mother placed in a nursing home as specific approval of Leas Cross.”

The Commission put this account to the C.E.O. of the Mater Hospital, who responded by letter dated the 26th February 2009, stating that “the hospital is unable to comment, as the staff referred to are not identified by the [patient’s] family.”

Concerns regarding Leas Cross

Information provided to the Commission by the Social Work Department of the Mater Hospital includes references to a patient who was assessed as requiring long-term care in March 2004 and was awarded an enhanced subvention. Her family considered a number of nursing homes. On the 26th March, the patient’s son contacted a social worker at the hospital to say that he had viewed Leas Cross and was very satisfied with it. According to the Social Work Department records, “The medical social worker stated that this nursing home was under investigation by the Health Services Executive”. The family decided nonetheless to proceed with the transfer, and the patient was duly admitted to Leas Cross on that same day.

By letter dated the 15th December 2008 the Commission asked the Mater Hospital:

i) who informed the social worker in this case that Leas Cross was under investigation;

ii) whether the Social Work Department as a whole had been informed that Leas Cross was under investigation, and if so by whom; and

iii) whether social workers and / or medical personnel at the Mater Hospital were made aware of the outcome of any investigations into Leas Cross in 2004.

The Hospital responded to these questions in writing as follows:
“There is no documented evidence to indicate who informed the social worker that Leas Cross Nursing Home was under investigation. The social worker referred to is no longer employed in the Hospital.

...the Social Work Department as a whole was not informed that Leas Cross was under investigation.

...the Mater Hospital (including Medical and Social Work personnel) was never advised of the outcome of any investigation into Leas Cross in 2004.”

Transfer of patients to Leas Cross

From documents provided to the Commission by the Mater Hospital and by Leas Cross Nursing Home, it appears that approximately 75-80 patients were discharged from the Mater to Leas Cross between October 1998 and February 2005. There are discrepancies between the hospital and nursing home records which prevent the exact number being identified.

Of these, 31 patients were admitted to Leas Cross on a long-stay basis; the rest were admitted for periods of respite care, usually one or two weeks in duration.

In response to a question from the Commission as to when and on what basis Leas Cross was selected as a suitable nursing home for the discharge of patients, the Chief Executive Officer of the Mater Hospital wrote:

“Leas Cross Nursing Home was on a list compiled by the then Northern Area Health Board (NAHB)... When patients were being discharged from the hospital they were assessed by the Multi Disciplinary Team and once long-term care was recommended, their families / next of kin would carry out their own enquiries as to which nursing home they wished their family member to be placed [in].

The Mater Misericordiae Hospital did not advocate Leas Cross over any other private nursing home. When clinically indicated (a patient with a complex clinical condition) the Hospital would only advocate St Mary’s, Phoenix Park as the appropriate care destination.”

The Commission also asked whether and to what extent the results of N.A.H.B. nursing home inspections were conveyed to those persons at the Mater Hospital who advised patients in relation to possible nursing home placements. The C.E.O. of the Mater Hospital stated in response that “there was no structure in place by the relevant health board to advise on the results of Nursing Home Inspections”.

Transfer of Patient A

Patient A was admitted to Leas Cross from the Mater Hospital on the 23rd December 2004. Patient A was paraplegic and required total nursing care, including a bowel
evacuation every second day. He had a history of cognitive impairment and seizures. The discharge summary from the Mater Hospital and the enquiry sheet completed by Leas Cross on his arrival record that his sacrum was red, indicating a vulnerability to pressure sores in that area.

Over the ensuing weeks in Leas Cross, Patient A developed serious pressure sores. Film footage of these sores, taken by an undercover reporter, featured in the Prime Time documentary on Leas Cross which was broadcast on the 30th May 2005.

The Commission has received a written submission from Ms Denise Cogley, a former matron of Leas Cross Nursing Home, which contains a number of allegations regarding the transfer of Patient A from the Mater Hospital to Leas Cross. The relevant portion of Ms Cogley’s statement reads as follows:

“He [Patient A] was inappropriately transferred from the Mater Hospital in late 2004 and inappropriately admitted to LCNH [Leas Cross Nursing Home] under the regime of my predecessor [Grainne Conway].

Within weeks of his admission to LCNH it became apparent that not all of this man’s characteristics had been properly disclosed to LCNH. He had significant personality and behavioural issues resulting in a refusal to eat, to get out of bed, or to co-operate with any staff. From admission the condition of his skin was friable and showed signs of early pressure-sore development. I instituted all standard text-book pressure sore interventions... I requested psychiatric review and management from the HSE, which was instituted. I attempted to have him re-admitted to his discharging unit in the Mater Hospital. He was refused re-admission but the Mater provided contact with a specialist nurse who came to see him.

Despite psychiatric intervention his physical overall condition continued to deteriorate. I contacted the Mater again, called an ambulance and attempted to send him to the Mater. The Mater A & E refused to admit him as he now fell outside their catchment area, despite the recommendation of the Mater’s own spinal team registrar and despite a personal explanation from me. He was therefore sent to Beaumont...

[Patient A]’s case was twice flagged to the HSE inspectorate team by me while Grainne Conway was Director of Nursing at LCNH. I requested intervention of the HSE for his care on April 7th 2005. The HSE confirmed what I already knew, that he should not have been admitted to Leas Cross.”

Nursing care notes from Patient A’s file at Leas Cross indicate that the nursing home rang the relevant unit in the Mater Hospital on the 4th February 2005 and expressed concern regarding Patient A’s health and the difficulties caused by his refusal to comply with the medical and nursing treatment being offered to him. The nursing care notes state that the hospital was “unable to take Christopher in [for] re-assessment but will arrange to have him assessed in Leas Cross as soon as possible”. On the 7th February 2005 a specialist nurse came to visit Patient A as arranged.
The nursing care notes at Leas Cross do not record any attempt to have Patient A admitted to the Mater by ambulance. However, an entry for the 17th February 2005 indicates that Patient A was transferred to Beaumont Hospital by ambulance “as [his] condition is deteriorating”. He was returned from Beaumont Hospital at 8.15 a.m. on the following day.

In a letter to the Commission dated the 26th February 2009 the Mater Hospital responded to Ms Cogley’s statement as follows:

“The Mater [Hospital] refutes the allegations contained in the statement of Ms Denise Cogley, former Matron, Leas Cross.

The Hospital would like to bring the following to the attention of the Commission:

As documented in the patient’s medical records this patient was discussed at a Multi-Disciplinary Team meeting on Monday 20th December 2004. On the 22nd December 2004 the Social Worker assigned to this patient spoke with the Matron Grainne (Leas Cross) who agreed to the transfer of this patient on the 23rd December 2004 on the basis of securing a pressure-relieving mattress. Prior to discharge the Clinical Nurse Manager on this patient’s ward also contacted Leas Cross.

In addition a written nursing and medical discharge summary would have accompanied this patient upon discharge to Leas Cross.

Ms Cogley states that when this patient’s condition deteriorated she called an ambulance and attempted to have the patient re-admitted to the Mater Misericordiae University Hospital. The hospital has no documentary evidence to verify this statement.”

The question of whether Patient A was inappropriately transferred from the Mater Hospital to Leas Cross Nursing Home cannot be resolved by the Commission on the basis of the evidence before it. Nor is it possible to draw any conclusions as to whether Patient A’s health problems arose from a lack of care in Leas Cross, given his frail condition, his psychiatric problems and his refusal to co-operate with those responsible for his care.

As we have seen, there is no documentary evidence from the Mater Hospital or from the nursing home to support Ms Cogley’s claim that Patient A was turned away from the Mater Accident & Emergency Department. In a further submission to the Commission, solicitors for Ms Cogley clarified that the decision by the Mater Accident & Emergency Department not to admit Patient A took place, not at the hospital, but before Patient A had left Leas Cross. According to this submission, Ms Cogley telephoned the Mater and spoke to the Spinal Registrar, who said that no beds were available in the Spinal Unit but advised her to send Patient A to A & E:

“Ms Cogley contacted ambulance services to transfer [Patient A] to the Mater Hospital.
On arrival of the ambulance service, Ms Cogley was informed by the ambulance driver that they could not take [Patient A] to the Mater Hospital without approval from the Mater A & E Department as [Leas Cross] was outside the catchment area of the Mater Hospital. Ms Cogley contacted Mater A & E Department and spoke to Clinical Nurse Manager 1... Following an explanation of the case of [Patient A], the A & E CNM1 refused to approve [Patient A]'s admission to the A & E Department based on catchment area, instead advising that Leas Cross transfer [Patient A] to Beaumont Hospital and that if required, medical notes could be sent to Beaumont.”

As to the earlier request by Leas Cross to have Patient A readmitted to the Spinal Unit in the Mater, the Commission considers that the decision by the Mater not to readmit Patient A to that unit, but to send a specialist nurse to assist Leas Cross with his care, was a reasonable decision in the circumstances.

**Reporting of concerns by staff at the Mater Hospital**

The Commission has not been made aware of any formal procedure by which medical staff at the Mater Hospital could raise concerns about standards of care for patients admitted from nursing homes.

A review of 80 patient files, conducted by the Mater Hospital at the request of the Commission, revealed one recorded instance in which a patient’s family appeared to express dissatisfaction with Leas Cross. The patient, had been discharged from the Mater to Leas Cross on the 22nd September 2004 and was re-admitted to the hospital via the Accident & Emergency Department on the 1st October 2004.

According to the hospital’s records, the patient’s niece was “not satisfied that the patient be returned to Leas Cross Nursing Home”. The reasons for her concern are not documented in the hospital files. The patient’s family subsequently secured a placement in another nursing home and the patient was discharged there on the 8th November 2004.

The file review conducted by the Mater Hospital for the Commission revealed one other instance in which concerns regarding Leas Cross were documented. On this occasion, the concern was expressed by a social worker attached to the Hospital.

The patient in question, Patient B, was admitted to the Mater on the 24th January 2005 having been found collapsed on the roadside by Gardaí. Patient B was assessed by a consultant geriatrician at the hospital as requiring long-term care. No placement was available at St Mary’s Hospital. The medical social worker assigned to Patient B contacted the Nursing Home Section to discuss Patient B’s situation. Payment of an enhanced subvention was agreed, and the social worker contacted a number of nursing homes seeking an appropriate placement for Patient B.

A placement was obtained in Leas Cross and Patient B was transferred there on the 28th January 2005. On the 31st January Patient B collapsed in the dining room of the
nursing home after dinner. Resuscitation was attempted, an ambulance was called. Patient B was removed to Beaumont Hospital but was pronounced dead on arrival.

On the 6th July 2005 the social worker wrote to the head of the Nursing Home Inspectorate concerning Patient B, “...in light of the recent media reports about Leas Cross Nursing Home”. The letter stated:

“His death came as a surprise to me and following telephone contact with the Nursing Home Section I was informed that Leas Cross Nursing Home was under ‘review’. As you can imagine I was shocked and dismayed that I was not informed that this nursing home was under ‘review’ and that I had not been party to this information prior to [Patient B]’s placement.”

The head of the Nursing Home Inspectorate has informed the Commission that “there were no major concerns regarding care at Leas Cross in January 2005 and if there were the Mater and other hospitals would have been informed”.

On the 11th July 2005, the social worker wrote a similar letter to the H.S.E. National Director of Primary, Community and Continuing Care, stating:

“I understand ... that you have been charged with the responsibility of the ... review [of deaths at Leas Cross Nursing Home]. In view of this I would like to highlight [Patient B]’s case.”

Michael Walsh, Assistant Chief Officer, H.S.E. Northern Area responded on behalf of the H.S.E. by letter dated the 2nd August 2005. Mr Walsh informed the social worker concerned that Patient B’s death would be reviewed by Professor O’Neill as part of his review of deaths at Leas Cross Nursing Home.

**Some observations regarding the Mater Hospital and Leas Cross Nursing Home**

The information disclosed to the Commission indicates that the majority of Leas Cross residents who required admission to hospital were sent to Beaumont rather than to the Mater. As a result, staff at the Mater Hospital did not have many opportunities to observe the standard of care given to Leas Cross residents.

In the case of the one resident whose family was recorded as being unwilling to have them return to Leas Cross, it is regrettable that no further detail was obtained or recorded by the Mater Hospital staff as to why the family in question were not satisfied with Leas Cross.

The social worker who raised concerns regarding Patient B in 2005 is to be commended for so doing. The Commission has not been informed of the existence of any formal procedure for staff at the Mater Hospital to pass on concerns about standards of care in nursing homes to the appropriate authorities. If such formal procedures do not exist, the Commission is of the view that they should be put in place.
CHAPTER 20

‘HOME TRUTHS’ – THE PRIME TIME PROGRAMME

The *Prime Time* documentary regarding Leas Cross Nursing Home, ‘*Home Truths*’, was broadcast on the 30th May, 2005 and reported events filmed there in March and April, 2005.

The airing of *Home Truths* became a watershed in the history of Leas Cross. The programme placed shocking and distressing information regarding the operation of the nursing home into the public domain. There can be no doubt that entirely unacceptable practices were shown and that the programme revealed serious problems at Leas Cross. These included a nurse sleeping on duty and care staff changing a resident’s dressing on a surface from which food would be served. Unsurprisingly, the documentary led to condemnation of the practices shown, to concern for the safety of residents in Leas Cross and to calls for action and reform to protect those residents and to ensure that such practices did not occur elsewhere.

The Commission considers that it would have been impossible for the H.S.E. to have ignored the national outcry caused by the documentary. The broadcast resulted directly in the appointment of a specialist team to take over the operation of the nursing home, which led, ultimately, to its closure.

As this report has made clear, problems with Leas Cross Nursing Home had been brought to the attention of the Health Board / H.S.E. on numerous occasions since it opened in 1998. During that time, the Health Board / H.S.E. had made efforts to respond to such problems, principally through the mechanism of nursing home inspections. However, the response of the H.S.E. to the problems identified by *Home Truths* was on a completely different scale to any previous interventions in the running of the nursing home. For that reason, the actions of the H.S.E. from June 2005 onwards cannot be divorced from the context of the *Prime Time* documentary and the public reaction to its broadcast.

The making of ‘Home Truths’

The Commission has received information from R.T.E. regarding the making of *Home Truths* and has also interviewed and received a statement from the individual who filmed covertly in Leas Cross Nursing Home for the programme.

According to R.T.E., the decision to examine the subject of conditions in nursing homes arose in part from media attention accorded to allegations of neglect at another Dublin nursing home in 2004. In addition, the makers of a 2004 *Prime Time Investigates* programme on M.R.S.A. were, in the course of their research, urged by a nurse “with extensive personal experience of the subject” to investigate the subject of nursing home conditions.
In January 2005, a producer and a reporter were assigned to look into the subject of conditions in nursing homes. They set about contacting people who had knowledge of the area. At an early stage they were introduced to the family of Peter McKenna, who had resided in Leas Cross Nursing Home in October, 2000. Contact was also made with the family of another former Leas Cross resident, Dorothy Black, following newspaper reports of the inquest into her death.

In February 2005, the investigative team contacted a care attendant who had nine years’ experience working in a Dublin hospital. They asked him if he would assist their investigation by obtaining a job at a nursing home and reporting his observations. He agreed to do so and sent his curriculum vitae to a number of nursing homes in the counties of Dublin and Meath. Arising from this he was contacted by the matron of Leas Cross who, following an interview, offered him a job as care attendant.

Although the investigative team had, at a early stage, spoken to two families connected with Leas Cross, R.T.E. and the undercover reporter have informed the Commission that their investigation did not target that nursing home specifically from the outset. Rather, the original subject of the investigation was care in nursing homes generally and Leas Cross was the only home which offered a job to the care attendant.

The undercover reporter started work as a care attendant at Leas Cross on the 18th March 2005. He worked there for eight weeks, including two weeks on night shift. The Commission has been informed that R.T.E. ultimately reimbursed Leas Cross for the wages paid to the undercover reported during his time employed as a care attendant at the nursing home.

In his submission to the Commission the undercover reporter stated:

“I did not record anything on film for the first two weeks that I was in the nursing home, but simply observed what was taking place. Having got a sense of the place, I then informed the Prime Time team that I thought it would be worth filming some of what I saw. I was provided with a hidden camera for this purpose.

I did not film continuously during my time in Leas Cross; I turned the camera on only when I considered it appropriate to do so.”

The Commission has viewed the entirety of the undercover footage captured by the undercover reporter, in unedited form. This amounts to some 60 hours of material in total. Because the reporter was selective in choosing when and where to film, it is impossible to draw any definitive conclusions as to whether the footage chosen by the editors for inclusion in Home Truths was a fair representation of the undercover reporter’s time in Leas Cross. However, he has stated to the Commission that he believes the events shown on the Prime Time programme “... were generally representative of the manner in which Leas Cross nursing home was operated” during the time that he was there.
It should be said that a significant proportion of the undercover footage taken by the care attendant shows nurses and care staff going about their duties in an uncontroversial manner. Understandably however, the focus of the *Prime Time* team was on highlighting lapses in care standards, and it is footage of such incidents that was shown in the final programme.

**Contact with the H.S.E. and Leas Cross Nursing Home**

R.T.E. contacted both the H.S.E. and the proprietor of Leas Cross, Mr John Aherne, before airing *Home Truths*, inviting both to respond to the issues that would be shown in the documentary.

**H.S.E.**

Representatives of the H.S.E. were informed of the results of the *Prime Time* investigation into Leas Cross in the week before *Home Truths* was due to be broadcast. On the 27th May, 2005, the Head of the Nursing Home Inspectorate in the H.S.E. Northern Area was shown the undercover film footage which was to be used in the programme, together with expert commentary on that footage. He was then interviewed and a portion of his interview was included in the programme.

The Head of the Nursing Home Inspectorate advised Mr Michael Walsh, Chief Officer of the H.S.E. Northern Area, of contents of the programme and Mr Walsh then made contact with Mr John Aherne, the proprietor of Leas Cross. Mr Walsh described the contents of the programme and advised Mr Aherne of the seriousness of the situation. According to Mr Walsh, Mr Aherne at first denied there was a problem but, after discussion, accepted that the matter required immediate action.

**Leas Cross**

On the 19th May, 2005, R.T.E. wrote to Mr Aherne, informing him that they had “evidence of substandard care being administered to residents” at the nursing home. Mr Aherne was offered an opportunity “to be interviewed for the documentary in order to address the issues which the programme will raise about Leas Cross”. The letter summarised some of the practices at the nursing home which would feature in the documentary and stated that a number of families had been interviewed.

No response having been received, R.T.E. wrote to Mr Aherne on the 23rd May, 2005, once again offering him an opportunity to be interviewed for the programme. This letter informed Mr Aherne that R.T.E. had been filming in the nursing home with a hidden camera and that the footage had been shown to “independent experts who have found many incidents of substandard care being administered to residents at Leas Cross”. The letter listed some of the incidents recorded on camera and named staff members involved. R.T.E. advised Mr Aherne:
“We feel that you should make staff aware of the allegations being made in our programme and extend to them our offer of a right of reply.”

The letter concluded by asking Mr Aherne to reply immediately, as it was intended to broadcast the programme on the 30th May.

Mr Aherne did not accept R.T.E.’s offer to participate in the documentary. Instead, on the 27th May 2005, both the proprietors and the matron of Leas Cross, Denise Cogley, applied to the High Court for an injunction restraining the broadcast from taking place. Mr Aherne has informed the Commission that he saw the programme for the first time on the morning of the court case. The applications were unsuccessful and the broadcast went ahead on the evening of the 30th May.

In a detailed written submission to the Commission, Ms Cogley has made serious criticisms of the manner in which Home Truths was made. She has stated that the programme portrayed her inaccurately and unfairly. She has also pointed out that she had been acting matron at Leas Cross since only the 28th March, 2005, ten days after the care attendant who filmed the undercover footage commenced employment there, although she had previously been employed as assistant matron. In a letter to the Commission dated the 4th March, 2009, Ms Cogley’s solicitors have indicated that defamation proceedings issued by her against R.T.E. remain in existence. As the matter is before the High Court, the Commission considers that it would be inappropriate to make any finding as to the accuracy of the documentary’s portrayal of Ms Cogley or the nursing home.

**Reaction to Home Truths**

The broadcast of Home Truths provoked a strong reaction from the public and from relevant organisations, much of which was reported in the media. The Irish Nurses Organisation condemned the practices highlighted in the programme as “disgraceful and indefensible” and voiced concern that it might not represent an isolated incident. The Irish Association of Directors of Nursing and Midwifery called for an Ombudsman for Older Persons to be established. Age Action Ireland called on the Minister for Health and Children to follow up immediately on promises for an effective inspectorate.

Issues arising from the programme were debated in the Dáil on the 31st May and the 1st June, 2005. The Taoiseach described the programme as having uncovered “shocking treatment of vulnerable people”. He continued:

“No excuse should be offered to defend what happened, as there is no defence for it. It was distressing and upsetting. There was a lack of training, management, supervision and almost everything else in that elderly care unit. On behalf of the Government, I express deep concern with the situation described on “Prime Time” regarding Leas Cross nursing home.”
Leas Cross Deaths Relatives Action Group

A number of families of former residents of the nursing home formed the Leas Cross Deaths Relatives’ Action Group in response to issues raised by *Home Truths*. The group was established in November, 2006. The group has informed the Commission that it is “non-political and is focused on putting the truth into the public domain regarding the treatment of residents at Leas Cross Nursing Home”. The members consist, in the main, of families who met following the broadcast of the *Prime Time* programme and represent a cross-section of Irish society.

The group has informed the Commission that its primary aim was “to establish a public inquiry into the circumstances surrounding the death of their loved ones, who were, or had been, residents at Leas Cross”. This aim was achieved when the Minister for Health and Children announced the establishment of this Commission of Investigation. The group made submissions to the Department of Health regarding the Commission’s terms of reference.
CHAPTER 21

DEVELOPMENTS FOLLOWING ‘HOME TRUTHS’

A series of meetings took place in late May and early June, 2005 between the proprietors of Leas Cross Nursing Home and representatives of the H.S.E. Northern Area. These meetings occurred in response to ‘Home Truths’, the Prime Time documentary regarding the nursing home. They resulted in the appointment of a H.S.E. team to take over the operation of Leas Cross, which led ultimately to the closure of the nursing home.

This chapter examines events immediately before and after the broadcast of Home Truths, the appointment of the H.S.E. team and its findings regarding Leas Cross. The closure of the nursing home is addressed in the following chapter.

Initial meetings between the H.S.E. and Leas Cross

27th May, 2005

A meeting between the H.S.E. Northern Area and Leas Cross was held at the H.S.E.N.A. headquarters in Swords on the 27th May, 2005. The meeting was organised at the request of Michael Walsh Chief Officer of the H.S.E.N.A. to discuss the pending broadcast of Home Truths. It was attended by Mr Walsh, the Head of the Nursing Home Inspectorate, and John and Raymond Aherne, on behalf of Leas Cross. The Commission has been furnished with minutes of the meeting, which were prepared by Mr Walsh.

The Head of the Nursing Home Inspectorate had seen a preview of the documentary and gave the Ahernes an overview of the items contained in it. In response to a question as to where he saw the home going, Mr Aherne is recorded as having said that “most likely it would close”. The key elements of the meeting are recorded as follows in the minutes:

“Mr Walsh said that the main issue was whether the home could survive and that he had a concern with regard to how patients could be catered for in alternative services; he said he had in mind the H.S.E.N.A. taking over the clinical management of the nursing home, with Mr Aherne’s agreement, and with the director of nursing stepping down. After a brief discussion on this issue, Mr Aherne said he would be very happy with this arrangement.

Mr Walsh then suggested that he would also like to have a governance board put in place in the home to protect the interests of patients, nurse management and also to bring aboard professional input into the management of the home.
Mr Aherne had some difficulty with this proposal. There was some further discussion between both parties and the meeting adjourned for ten minutes.

On return, J. & R. Aherne both agreed that they would find this could be a very useful development and they agreed to same in principle. It was felt that a board of six people – three nominated by Mr Aherne (to include an independent outsider with an interest in services for older persons). M. Walsh and [the Head of the Nursing Home Inspectorate] had suggested they would nominate three people who had an involvement in healthcare but who were not directly employed by the H.S.E.”

In relation to the “unsatisfactory practices” shown on the Prime Time programme, the minutes record Mr Walsh’s proposal to appoint “an independent inquiry team to review the case and produce a report including recommendations for action”. Mr Aherne is recorded as having welcomed this arrangement and stating that he “would co-operate fully with it”.

28th May, 2005

The Head of the Nursing Home Inspectorate visited the nursing home on the following two days. These were not official inspections. According to his written submission to the Commission, he was asked to visit Leas Cross by Mr Walsh. He met John Aherne, visited one of the residents who featured in the television programme and inquired about staffing levels.

The H.S.E. has provided the Commission with a summary of communication between Leas Cross and the H.S.E.N.A. in May and June, 2005. The H.S.E. has been unable to identify for certain the author of the document, although the Commission has been informed that it was prepared in Michael Walsh’s office.

The summary states that, on the 28th May, Mr Aherne advised the Head of the Nursing Home Inspectorate “that he could not fulfil agreement of the 27th due to court proceedings”.

This appears to be borne out by handwritten notes from the Head of the Nursing Home Inspectorate’s visit to the nursing home, which include the following:

“Until Monday – put anything in place
Undermine the High Court”

The Commission understands this to be a reference to injunction proceedings brought by the proprietors and the matron of Leas Cross, seeking to restrain the broadcast of Home Truths. That application was due to be heard before the High Court on Monday, the 30th May.

29th May, 2005
A meeting was held at a hotel on the 29th May between Michael Walsh, the Head of the Nursing Home Inspectorate, the Assistant C.E.O. for Community Services and General Manager A and John and Raymond Aherne, from Leas Cross Nursing Home. The Commission has been furnished with the minutes of the meeting.

Mr Walsh stated that the meeting had been called in light of Mr Aherne’s decision that he could not agree to the proposals discussed on the 27th May in advance of the High Court hearing scheduled for the 30th May. The minutes record that Mr Walsh set out the H.S.E.’s position as follows:

“Mr Walsh outlined that the N.A. had no choice but to fulfil its duty of care to clients and their families to advise of our concerns re: standards of care and furthermore advise clients / families that it is in their best interest to seek alternative accommodation.

In relation to clients placed by the H.S.E., medical / nursing staff would be consulting with the clients and their families regarding alternative care arrangements.

Mr Walsh also advised that he would be seeking a District Court order regarding management of the home.”

The minutes state that the proprietors raised two points in response. Raymond Aherne asked what was meant by ‘management’, to which Mr Walsh responded that “the specifics would have to be explored”. John Aherne asked for the basis of the decision, to which Mr Walsh stated that “the final decision was based on the video footage that [the Head of the Nursing Home Inspectorate] had seen”.

Following the meeting, the proprietors’ solicitors hand-delivered a letter to Mr Walsh. That letter claimed that the H.S.E.’s proposed action was “highly precipitous, unfair and in breach of our clients’ constitutional rights” and called on Mr Walsh to “desist from any actions which would in any way impact upon our clients’ management of their business” pending determination of the High Court injunction application.

30th May, 2005

Solicitors for the H.S.E. replied to the letter from the Ahernes’ solicitors the following day. Their letter stated that Mr Aherne’s decision not to proceed with the proposals “agreed in principle” on the 27th May had caused the H.S.E. “grave concern that the care of the elderly and/or vulnerable patients would be compromised”. The letter continued:

“Our client’s inspectorate team have been working very proactively with your client over some considerable time regarding the standards of care at Leas Cross Nursing Home. Mr Aherne was already aware that the H.S.E. had concerns regarding the level of care Leas Cross and the film footage seen by [the Head of the Nursing Home Inspectorate], coupled with the inspections carried out at the weekend, raised these concerns considerably.
The H.S.E. is cognisant of the fact that the patient group is elderly and that decisions significantly affecting their care must be taken only after the most careful consideration. The H.S.E. did not take the serious decisions outlined above [i.e. the decisions communicated at the meeting of the 29th May] based on the film footage alone. The H.S.E. have had ongoing concerns which have been the subject of meetings between our respective clients for a number of months. Those concerns have been highlighted by your clients’ withdrawal from the process even after further concerns were identified following receipt of the information from R.T.E. and the subsequent inspections.

At both meetings on the 27th and 29th May, the H.S.E. have outlined that its primary concern is its duty of care to the patients at Leas Cross and arising from those concerns the H.S.E. is obliged to pursue whatever steps are necessary.”

Also on the 30th May, the nursing home was visited by Nursing Home Inspectors J and K. The visit was not a formal inspection: its purpose was to determine staffing levels and the health status of the residents. Their report to the Nursing Home Section Manager is dated the 1st June, 2005. It records that there were 94 residents present at the time of the inspection, five of whom had pressure sores. The report makes no comment as to the standard of care at the nursing home.

On the same day, the High Court refused the injunctions sought by the proprietors and matron of Leas Cross. The programme was broadcast on national television that evening.

31st May, 2005

The following day, a meeting took place between the H.S.E.N.A. (Michael Walsh, the Assistant C.E.O. for Community Services and Nursing Home Inspector J) and Leas Cross (John Aherne, Raymond Aherne and their financial advisor).

The Commission has not been furnished with minutes of this meeting. The summary of communication between the H.S.E.N.A. and Leas Cross which has been provided to the Commission refers to the meeting as follows:

“Agreed:
  ▪ Assignment of director of nursing and support staff to Leas Cross
  ▪ Setting up of inquiry team
  ▪ Establishment of clinical governance committee”

A separate meeting was held on the same date at H.S.E.N.A. headquarters for directors of nursing and the chief executive’s office. Its attendees included Michael Walsh, General Manager A and a number of H.S.E. directors of nursing. The minutes of the meeting state that its purpose was “to agree a Northern Area plan to stabilise the situation in Leas Cross”.

295
Mr Walsh informed the directors of nursing that he had asked Mary Flanagan “to review and project manage the situation at Leas Cross”. He asked the directors of nursing to release personnel to assist Ms Flanagan, and their commitment to support her with necessary resources was recorded. Two nursing home inspectors joined the meeting to discuss dependency levels and staff ratio at the nursing home.

On the evening of the 31st May, the H.S.E.N.A. issued a press release, setting out the steps agreed with the proprietors of Leas Cross. The purpose of this action was expressed to be “to address a number of concerns regarding the standard of care as identified by the nursing home inspectorate and reflected in last night’s Prime Time programme”.

The appointment of a H.S.E. team to Leas Cross

1st June, 2005

The H.S.E.’s team was assigned to Leas Cross on the 1st June. It was headed by Mary Flanagan, as acting director of nursing. The team included two assistant directors of nursing, two nurse managers grade 2, two education co-ordinators and two practice development staff. It was anticipated that a further nurse manager, with expertise in wound care, would join the team subsequently. Psychiatric services from St Ita’s were also available to provide on call support at weekends to the nursing home staff.

A meeting took place at Leas Cross on the 1st June to introduce Ms Flanagan to Mr Aherne. The meeting was attended by Michael Walsh, the Head of the Nursing Home Inspectorate, John and Raymond Aherne, the current matron Denise Cogley and Mary Flanagan. The summary of communication provided by the H.S.E. states that “agreement was reached on the role of the director of nursing” at the meeting.

The Commission has been furnished with a draft “memo of understanding” between the H.S.E.N.A. and John Aherne, dated the 1st June, 2005. The text of the memo is as follows:

“The purpose of the memo of understanding is to define both parties’ understandings of what has been agreed in principle and progress to a formal agreement.

The Health Service Executive Northern Area in partnership with Leas Cross have discussed the immediate need to stabilise the situation in Leas Cross. The following arrangements have been agreed which relate to structures, systems and resources that need to be put in place with regard to an immediate plan.

- The H.S.E.N.A. assigned director of nursing who is accountable to the H.S.E.N.A. with a working relationship with Mr Aherne, proprietor.
The H.S.E.N.A. has assigned a director of nursing who will have full responsibility for the management of Leas Cross and all staff will report to her.

The H.S.E.N.A. have assigned a team of senior management to support the director of nursing (H.S.E.N.A.).

All communications will be channelled through the H.S.E.N.A. Director of Communications with the prior agreement of Mr Aherne.

The H.S.E.N.A. director of nursing will put a process in place to meet with families and relatives.

In addition, one session with a psychologist will be available.

The recruitment of additional staff will be the responsibility of the new director of nursing with financial clearance from Mr Aherne.

The H.S.E.N.A. director of nursing will have responsibility for the day to day budget.

A governance committee will be established.

An independent inquiry team will be established.

The draft memo has space for the signatures of Michael Walsh and John Aherne, neither of whom has signed the version of the document that has been made available to the Commission.

3rd June, 2005

On the 3rd June, a meeting was held between Michael Walsh, Mary Flanagan, John Aherne, Raymond Aherne and a recruitment consultant who had recruited nursing and care staff for Leas Cross. The summary of communications provided by the H.S.E.N.A. states that the purpose of the meeting was as follows:

“To primarily discuss and clarify insurance cover, communication with families, legal position and general issues on communication.”

The Commission has also seen a memo from Leas Cross dated the 3rd June, 2005 setting out a list of questions on which clarification is sought. It is not clear whether this memo was sent and, if so, to whom. The issues listed include the role of the H.S.E. staff in Leas Cross and the role of the proposed governance committee. The memo also states:

The proprietors of Leas Cross wish to make it totally clear that they wish, and are happy, to co-operate fully with the H.S.E. in taking whatever action is necessary to achieve and maintain a standard and quality of care delivered to all residents which is in full compliance with all necessary legislation and regulations applicable to nursing homes. However, to date, we have not been given any clear indication of precisely what is planned, required or intended by the H.S.E.”
Mary Flanagan, acting director of nursing, provided a progress report to the H.S.E.N.A. on the 8th June, 2005. Her report contained the following findings:

“Health & Safety

... the new director of nursing has identified a number of high risk activities that she is addressing. They include:

- **Patient Safety**
  In the past week there have been two absconsions from the home. This is due to the ease at which residents can get out of the doors and windows, which open out. This is to be rectified by the end of this week by the proprietor and a search and rescue policy will be in place in the unlikely event of a resident going missing.

- **Fire Safety**
  There are no evacuation sheets on the beds and as the beds do not come through the doors this is an extremely dangerous situation and will be rectified in the next 24 hours.

- **Violence and aggressive behaviours**
  There is an extreme amount of this in the home and a log is now being kept of all outbursts affecting the staff and residents. In addition, this will be addressed in the training schedule and an analysis is now taking place by one of the team on the possible reasons for the high number. This may be a result of residents not getting their medication on time, i.e. missing their depot injections.

- **Infection Control**
  There are no facilities for staff hand washing, no paper towels, soap, no bedpan washer and a very limited supply of alcohol hand rub. All of these have been ordered with effect from 7th June, 2005.

- **Waste Management**
  The system for collection and storage needs to be reviewed. An Assistant Director of Nursing will do this in the next week.

**General Housekeeping**

- **Stores.**
  There is a complete lack of organisation on stores/stocks including laundry; clinical and patient care equipment and pharmacy. There were no sheets in the home last weekend and no clinical wipes available to staff. A number of stock items are kept in the matron’s office such as Hoover bags, shaving foam, etc. She goes to a local Cash & Carry as needed, which is an inefficient use of her time. There are some standing orders in the home for incontinence wear, gloves, etc. A number of suppliers have been sourced and linen, etc. ordered
to ensure that the events of the past weekend are not repeated. Agreement has been reached with the proprietor to reassign a staff member to work with the director of nursing on reorganising stores. The home has run short of a number of medicinal products resulting in one case where a resident had to wait until analgesia was collected from a pharmacy before it could be administered.

- **Laundry.**
  This area is not working effectively and a cost benefit analysis will be undertaken to ensure the efficiency of this service. There is a large number of complaints from families about the laundry services, e.g. soiled underwear in drawers.

- **Cleaning.**
  This is of a high standard.

- **Maintenance.**
  Leas Cross has its own maintenance service.

- **Catering.**
  The food prepared for residents is varied and appetising. The manner in which care is delivered may adversely affect residents getting the full value of this.

**Provider Competence**

- **Staffing & Skill Mix.**
  The total nursing compliment is 12 RGNs including the Director of Nursing supported by 45 care attendants and other support staff. This leaves large deficits in the provision of 24-hour care with care being delivered in a task-oriented manner by untrained care attendants with limited supervision from RGNs. This results in a lack of continuity of care for residents and families.

  Medical cover is provided by a visiting G.P. and a physiotherapist is available for four hours per week.

  The Assistant Directors of Nursing are carrying out a review of skill mix and patient dependency. Recruitment of appropriate staff is now identified as a critical concern.

- **Education and training.**
  It is difficult to ascertain what training if any other than manual handling had taken place. Care staff report that a peer attendant has trained them in. There appears to be limited induction in place. A training analysis will be carried out in the next two weeks.

- **Clinical Practice.**
  There is a complete absence of policies and procedures in the organisation. Care standards are very poor in all areas, continence
promotion, personal care, mouth care (five sets of dentures were observed steeping in a solution in the treatment room) and care planning is non-existent.

The ability of staff to care for the dying resident and those with an acute illness at present is questionable based on skill mix and competency.

Pressure area care and wound management are also cause for concern. The types of mattresses and beds in the home are outdated to a large extent. This will be addressed next week by the CNM2 joining the team.

- Staff.
  Staff is feeling extremely vulnerable at present. They are very welcoming of all the support and open to changing the way care is being delivered. They have already identified a number of areas for improvement at a meeting held by the Director of Nursing on her arrival. There is a huge cultural diversity amongst the staff. The crucial incident debriefing team have been contacted and will come in to offer support to the staff.

Residents & Relatives

There is a lack of stimulation for residents and families have identified this over the past few days. The Irish Advocacy Network has expressed an interest in working into this service.

Relatives had been quite emotional to date and have been observed shouting at staff and dealing largely with non-Irish staff. A relative notice board is be placed in the front hall to keep them up to date and a counselling support service is also being put in place.”

A meeting was held on the 8th June attended by John Aherne, Michael Walsh, Mary Flanagan and the Assistant C.E.O. for Community Services. The Commission has not been furnished with minutes of this meeting. The H.S.E. has informed the Commission, that to the best of its knowledge, no minutes were taken at the meeting. The H.S.E.’s summary of communications refers to the meeting as follows:

“H.S.E.N.A. advised Leas Cross of their concerns following director of nursing’s immediate assessment of patient care at Leas Cross. Key issues of concern raised were:
(i) inadequate nursing levels;
(ii) inappropriate skill mix;
(iii) general management.

Outcome:
Mr Aherne was advised that in excess of twenty additional nurses (including middle and senior nurse management) would be required to provide an
appropriate standard of care. A meeting was set up for the next day to allow Mr Aherne time to respond to this request.”

9th June, 2005

A follow-up to the meeting of the 8th June was held the next day. It was attended by Michael Walsh, the Assistant C.E.O. for Community Services and Mary Flanagan, for the H.S.E., and John Aherne, Raymond Aherne and their recruitment consultant, on behalf of Leas Cross. The H.S.E.’s summary records the following:

- Leas Cross advised the H.S.E.N.A. that the necessary nursing structure outlined would cost €700,000, making Leas Cross unviable.
- H.S.E.N.A. advised that in the event that Leas Cross did not increase the level of staffing and were in a position to provide quality care to high dependent patients, the H.S.E.N.A. would fund accordingly.
- H.S.E.N.A. outlined that they had been advised by their law agent that the H.S.E.N.A.’s intervention/support to Leas Cross was lawful in the context of ensuring a safe level of patient care.
- The H.S.E.N.A. outlined their concerns regarding the overall management of Leas Cross.
- Leas Cross advised that they were not in a position to recruit the required staffing levels identified by the H.S.E.N.A.
- The H.S.E.N.A. confirmed that their continued level of nursing support was not sustainable and could not meet the objective of upskilling Leas Cross staff when these staff were not available.
- Leas Cross expressed the view that a scaled down operation was not viable and they could have to consider:
  - closure
  - sell or lease to a third party and wondered if the H.S.E.N.A. would have an interest in buying the facility. The H.S.E.N.A. advised that Leas Cross would have to reach their own decision on this matter.
- The H.S.E.N.A. agreed to formalise their position so that Leas Cross could consult with their advisors and, on reaching a decision, would revert to the H.S.E.N.A.

10th June, 2005

Michael Walsh wrote to John Aherne on the 10th June, setting out the H.S.E.’s understanding of communications with Leas Cross over the preceding two weeks. The letter set out the agreed steps, including the appointment of a director of nursing to the home, the establishment of a clinical governance committee and the establishment of an independent inquiry team.

The letter continued:

“Concurrently the H.S.E.N.A. are in ongoing discussions with Leas Cross in relation to the standards of care at the nursing home. While the staffing
numbers are adequate, the nursing levels are totally inadequate to provide the necessary level of care to patients. This is a fundamental prerequisite to patient care.

The H.S.E.N.A. have also expressed their concerns in relation to the overall management at Leas Cross and the impact this is having on delivery of patient care.

On June 8th, the H.S.E.N.A. stated that there was an immediate requirement for Leas Cross to provide the necessary nursing staff, as identified. On 9th June, the H.S.E.N.A. were advised by Leas Cross that they were not in a position to identify and recruit the necessary staff. The H.S.E.N.A. advised that their assignment of a senior nurse management was made in the first instance to:

- Ensure patient safety,
- Improve the level of care,
- and, following the recruitment of the necessary staff, to provide training and support to them.

Leas Cross stated that they were not in a position to identify and recruit the necessary staff. The H.S.E.N.A. confirmed that the deployment of the Director of Nursing and senior nursing management could not continue indefinitely as they could not meet the objective of upskilling Leas Cross staff when those staff were not available. The H.S.E.N.A. also expressed their concern with regard to the standard of care which continues to be provided due to the low level of nursing staff deployed”.

The letter concluded by inviting Mr Aherne to respond by the 14th June.

15th June, 2005

Ms Flanagan furnished a second progress report to the H.S.E. on the 15th June, 2005. She set out the following findings:

**Health & Safety**

- The Proprietor has been appraised of the situation in regard to ease of exit, fire safety and a number of actions were identified. No action to date.
- There has been a reduction in the number of violent and aggressive behaviours.
- Infection control – hand-washing facilities not available in all areas. A number of other areas will be addressed in the coming weeks.
- The Director of Nursing has not received a copy of the independent survey carried out. She will follow this up.

**General Housekeeping**
• Stores – Work has commenced on ordering, storing, collection and delivery of goods.
• Pharmacy – the adherence to any policy for the receiving, dispensing and disposing of pharmacy is not evident and is a serious cause of concern. The Director of Nursing will liaise with Pharmacy next week to address this and implement an appropriate policy and protocols.
• Laundry – An additional staff member will be assigned to the laundry to rectify the matters here.
• Catering – there are no catering assistants and the systems of work cause confusion between roles for catering and care assistants. This would also not be in line with HACCP [Hazard Analysis and Critical Control Points] regulations. It is hoped that an external Catering Manager can guide this process.

Provider Competence

• Staffing and Skill mix: Due to annual leave etc the nursing compliment is depleted to 10 RGNs. In order to support resident centred care team nursing has been introduced led by the Nursing managers from HSENA. The cultural diversity of the staff poses a big challenge to the cohesiveness of these teams.
• Education and Training: All staff are participating in a training needs survey. Training will commence formally next week. In the interim a number of informal sessions have begun.
• Clinical Practice: A planned programme of policy introduction has been identified covering basic clinical, resident care and will include care planning. This will be supported by education and training. A standard operating policy folder has been identified, however staff are unaware of its contents and there is no evidence of adherence to this. A mattress audit has been completed and pressure area care and wound care has been prioritised.
• Staff: The Critical Incident Debriefing Team are offering their services to the staff. This commenced on Tuesday 14th June. Staff have suggested a number of areas where they would like to see improvements, which will be acted upon by nursing management.

Residents and Relatives

• A representative from the Irish Advocacy Network has visited and will link with [Consultant Psychiatrist B].
• A member of staff has been allocated to commence an activities programme with the residents.
• [Consultant Geriatrician A] has commenced his medical review.
• Awaiting Report from Occupational therapy services to action.
• Counselling support service for relatives progressing.
• Nutritional assessments commencing this week.

On the same day as Ms Flanagan’s progress report Mr Walsh wrote to John Aherne. He noted the H.S.E.’s concern that no response had been received to the letter of the
10th June. For the first time, he indicated the H.S.E.’s decision to close the nursing home.

The closure of Leas Cross Nursing Home is addressed in the next chapter of the Commission’s report.76

**Medical review of residents**

One of the elements of the agreement between the H.S.E.N.A. and Leas Cross was the appointment of a consultant geriatrician and a consultant psychiatrist to review residents in the nursing home.

The geriatrician engaged for this task was Consultant Geriatrician A. He visited Leas Cross on the 9th, 16th, 22nd and 29th June and the 6th and 20th July, 2005. The residents he examined had been selected in advance by the nursing staff in consultation with Mary Flanagan.

In a written submission to the Commission, Consultant Geriatrician A explained that his role in visiting the nursing home was “to give advice and opinions about patient care, which was being requested by the senior nursing staff”. The medical issues he encountered included the following:

- Requests for opinions and advice about persistent skin rashes. Consultant Geriatrician A advised about appropriate treatment and gave prescriptions where necessary.

- Advice on general care, particularly concerning residents with chronic progressive illnesses requiring a lot of physical care (e.g. Parkinson’s disease). In the case of such residents, Consultant Geriatrician A was asked for advice on nutrition and feeding, seating requirements and physiotherapy. He has informed the Commission that he understands that his advice was included in the residents’ notes for attention in the nursing homes to which they were ultimately transferred.

- Assessment and advice for about fifteen clinical cases, where clinical management had been difficult. For these residents, Consultant Geriatrician A arranged admission to Beaumont Hospital and follow-up at his own or other medical clinics. He provided referrals to previous clinicians where appropriate and gave advice on appropriate management decisions.

Consultant Geriatrician A summarised his findings as follows:

“For all of the patients that I was asked to see (about 50 referrals) it was clear to me that very few of the patients had ongoing contacts with the hospitals who had referred them to the nursing home in the first place with no follow up appointments. All or most of the care was left in the hands of the nursing home and the associated staff. It was clear to me from my visits and

76 See Chapter 22.
patient assessments at this time that this approach was not adequate for the ongoing care of frail older patients with complex care needs and multiple medical problems.”

The Clinical Governance Steering Committee

The agreement between Leas Cross and the H.S.E.N.A. included the establishment of a ‘clinical governance committee’. The Commission has been furnished with the following draft terms of reference for that committee, dated the 2nd June, 2005:

- To support the development and implementation of all aspects of clinical governance throughout the Nursing Home.
- To oversee and advise on the development, implementation and monitoring of clinical guidelines and policies on clinical governance and support their implementation.
- To oversee and ensure that arrangements for clinical governance are appropriate and functioning effectively (i.e. appropriate nurse staffing structures, skill mix etc).
- To promote an open culture of continuous improvement in the Nursing Home through supporting development of effective organisational structures, models of good practice and effective communication mechanisms for staff.
- To ensure that the necessary arrangements are put in place to enhance and monitor the quality and effectiveness of clinical care and that these are communicated effectively.
- To support the development and implementation of a comprehensive incident reporting system for clinical incidents.
- To review reports on clinical negligence, complaints, incidents, inspection reports, near misses and record keeping and to ensure appropriate action is taken where required.
- To support the development and monitoring of comprehensive risk management systems and ensure that these are integral to operational policies and planning processes within clinical areas.
- To support the development of continuing professional development in partnership with Human Resources for all staff within the Board.
- To support the development of an effective multi-disciplinary approach to clinical management within the nursing home in order to ensure best quality of care is afforded to all patients.

The committee’s first meeting took place on the 9th June, 2005. The attendees included the Assistant C.E.O. for Community Services, H.S.E.N.A., Doctor B (G.P. for Leas Cross Nursing Home), Consultant Psychiatrist A (Psychiatry of Old Age) and Mary Flanagan.

The minutes of the meeting record that the Assistant C.E.O. for Community Services explained the purpose of the committee as follows:
“... while the future of the nursing home and its clients is unsure, it is still vital that planning for the future continues, hence the reason this committee has been assembled.”

It was agreed that the committee’s work could not be progressed without a decision on the future of Leas Cross. Ms Flanagan agreed to bring a list of issues to the next meeting, at which point the committee’s terms of reference might be re-drafted.

The committee met again on the 16th June, 2005. Following an update from Mary Flanagan, a proposed plan of action was circulated. The plan proposed that a programme covering areas such as basic care requirements, medication and education be run over a seven-week period.

The Commission has no further minutes from meetings of the clinical governance committee and is unaware whether any further meetings were held.

The purpose of the H.S.E.’s intervention

Ms Flanagan has informed the Commission, in oral evidence, that the purpose of her appointment was:

“... to stabilise the situation following the [Prime Time] programme and to put in place a safe environment to improve the quality of care and standards of care in the home.”

In evidence to the Commission, the proprietors of Leas Cross have alleged that the purpose of Ms Flanagan’s appointment was not to improve conditions for residents, but rather to gather evidence to close the nursing home.

Ms Flanagan has denied that allegation. She stated that her team carried out day to day nursing duties at Leas Cross. She acknowledged that she did look for information regarding the operation of the home, such as policy documents on care issues. However, she stated that the purpose of this was to assist her team in carrying out their nursing duties.

The Commission has found no evidence that Ms Flanagan’s team was appointed solely to gather evidence for the closure of the nursing home. A number of former care attendants and nurses have given evidence to the Commission. Their impressions of the H.S.E. team that took over in June, 2005 are mixed, some of them having negative comments to make regarding their relationship with the H.S.E. team. The Commission considers that this is to be expected, in circumstances where management of the home changed virtually overnight and ultimately led to the closure of the home and loss of jobs for the staff, at least temporarily. However, the evidence of the staff suggests that the H.S.E. team did carry out nursing duties at Leas Cross.

The proprietors have also complained of “heavy tactics” employed by the H.S.E. following the Prime Time broadcast. Mr Aherne states that they “bullied and abused” residents and their families. He informed the Commission that the H.S.E.
“threatened to close us down by removing subventions, which means ... that Leas Cross couldn’t operate financially”.

The Commission asked Michael Walsh to comment on these allegations in oral evidence. He was unable to respond definitively to the suggestion that residents were told that the H.S.E. would no longer provide subventions for them to remain at Leas Cross. However, he emphasised that the H.S.E. had a paramount duty of care to the residents. He said that no decision regarding the residents was made until the H.S.E. was satisfied as to what was appropriate for them. He also acknowledged that the proprietors of the nursing home were entitled to “due process” before any decision was made to close Leas Cross.

The staffing requirement

Evidence received by the Commission reveals a certain confusion over what was discussed at the meeting of the 8th June, 2005 regarding additional staffing requirements. Ms Flanagan and Mr Michael Walsh, both of whom attended the meeting, have stated that the nursing home was asked to replace twenty care attendants with twenty nurses. Ms Flanagan told the Commission in oral evidence that she recalls telling Mr Aherne that he had the right number of staff but not the right mix of staff. Mr Aherne disputes this and has told the Commission that he understood he was being asked to hire twenty nurses in addition to his existing staff complement.

A letter written some time later from Michael Walsh to the National Director of Primary and Continuing Care in the context of the closure of the home tends to corroborate the version of events proffered by Mr Walsh and Ms Flanagan in this regard. That letter, dated the 23rd June, 2005, notes that “a significant number of care staff will be superfluous to need when the necessary nursing staff are recruited”. However, it is possible that the H.S.E.’s intention in this regard was not clearly communicated to Mr Aherne or that he misunderstood what was being proposed.

Ms Flanagan has also explained to the Commission that she was not proposing that twenty nurses be rostered for work at any one time, but that the employment of twenty additional nurses was required to ensure that a sufficient number was on the roster each day. She stated that there should be a nurse manager on duty at all times, with six to eight nurses on duty in the daytime and three nurses on night duty.

The Commission considers it most unsatisfactory that the meeting of the 8th June, which was extremely significant for the future of Leas Cross Nursing Home, was not recorded in writing. Indeed, the Commission has found no correspondence in which reference is made to the apparent imposition of a requirement for “in excess of twenty additional nurses”.

It appears to the Commission that the communication of the H.S.E.’s requirements in this regard lacked clarity. The Commission does not understand why Mr Aherne was not simply told that six to eight nurses needed to be on duty during the daytime and three at night. Presumably the number of nurses he employed to make this happen
was an internal matter for the nursing home, as long as the minimum requirements were met.

The Commission also notes that the staffing requirements laid down on the 8th June, 2005 were far in excess of the minimum levels advised on any previous occasion. For example, when the nursing home inspectorate visited in April, 2005 – a comparable period in terms of resident numbers and dependency – “the immediate employment of three staff nurses” was sought. In addition, “in order to optimise standards of care and based on the current dependencies of residents” two clinical nurse managers grade 2 and one clinical nurse manager grade 3 were also to be appointed.

In oral evidence to the Commission, Michael Walsh sought to explain this inconsistency on the basis that Mary Flanagan’s team had a much better opportunity to observe the operation of the nursing home over a period of two weeks in June, 2005 than the inspection team had over only two days the previous April. The Commission has commented elsewhere in this report on the implications of this for the inspection system.77

In the absence of a contemporaneous record, it is difficult to draw firm conclusions regarding the events at this time. However, the Commission considers that the imposition of a requirement for twenty additional nurses – which appears to have been sudden, out of step with previous staffing requirements and poorly communicated – was unfair. This is not to say that the H.S.E. was not entitled to require extra nurses: it was duty bound to ensure that adequate care was provided to nursing home residents. However, the Commission is of the view that the true staffing requirement should have been identified and communicated much earlier, when the home expanded and took on high dependency residents, so that it did not come as a surprise to the proprietors of Leas Cross.

The fact that this did not occur suggests that either (a) the inspection system was inadequate or (b) the number of additional nurses sought by the H.S.E. in June, 2005 was unnecessarily high. This is of particular concern to the Commission in light of the fact that the failure to comply with the H.S.E.’s requirements in this regard formed part of the basis for the closure of the nursing home.

77 See Chapter 13.
CHAPTER 22

THE CLOSURE OF LEAS CROSS NURSING HOME

The H.S.E. has authority under the Health (Nursing Homes) Act 1990 to remove a nursing home from the register of nursing homes in certain circumstances. Those circumstances include where the H.S.E. finds a breach of the Nursing Home Regulations.

In the case of Leas Cross, it was formally notified by the H.S.E. in July, 2005 of the proposal to remove it from the register of nursing homes. Leas Cross was removed from the register in October, 2005. In the meantime, the H.S.E. made arrangements for the relocation of all residents in contract beds and all residents in receipt of subventions, and the proprietors closed the nursing home on the 1st August, 2005.

Legislative provisions regarding the closure of nursing homes

Section 4(5) of the Health (Nursing Homes) Act 1990 provides that a health board may remove a nursing home from the register.

Section 4(6) sets out the basis on which a decision to remove a nursing home from the register may be made:

“A health board shall not—
...
(b) remove a nursing home from the register
unless—
(i) it is of opinion that—
(I) the premises to which the ... registration relates do not comply with the regulations, or
(II) the carrying on of the home will not be or is not in compliance with the regulations,...”

Under section 4(13), where a health board proposes to remove a nursing home from the register, it must notify the proprietor in writing of its intention to do so, stating the reason for its decision. The proprietor is then entitled to respond within a period of 21 days and his representations must be taken into consideration by the Health Board.

Under section 5 of the Act, the proprietors of a nursing home which is removed from the register may appeal the decision of the Health Board to the District Court.
Chronology leading to the closure of Leas Cross Nursing Home

Initial communication of the proposal to remove the home from the register

The H.S.E. first notified the proprietors of its proposal to remove Leas Cross from the register of nursing homes on the 15th June, 2005. This was communicated by letter from Michael Walsh, Chief Officer of the H.S.E.N.A., to John Aherne.

Mr Walsh’s letter followed a train of meetings and correspondence, during the course of which Leas Cross agreed to the assignment of a H.S.E. team to manage the nursing home. That team, under acting director of nursing Mary Flanagan, reported its findings to the H.S.E. on the 8th and 15th May, 2005.\(^{78}\)

Arising from Ms Flanagan’s preliminary findings, the proprietors of Leas Cross had been asked to employ twenty additional nurses. There is some dispute between the relevant parties as to the details of that request and the nursing home’s response. However, it seems clear that Leas Cross was unable to satisfy the H.S.E. that its requirements would be satisfied. On the 10th June, Mr Walsh wrote to Mr Aherne indicating that Ms Flanagan’s team would not remain in Leas Cross indefinitely and stating that there was an “immediate requirement” to increase staff numbers. Mr Aherne was invited to reply by the 14th June.

In the absence of a reply from Mr Aherne, Mr Walsh wrote again on the 15th June. He set out the H.S.E.’s concerns as follows:

“As highlighted in the letter of June 10th, this situation cannot continue where the H.S.E. has no guarantee in relation to the availability of the required competent staff. The H.S.E. also highlighted its concerns regarding the overall management of Leas Cross Nursing Home and has formed the opinion that the carrying on of Leas Cross Nursing Home is not in compliance with the Nursing Homes (Care and Welfare) Regulations 1993 ...

As a consequence of our inspections of the home, and most recently the involvement of Ms Mary Flanagan and her support team the following matters cause us grave concern:

- staffing skill mix (unqualified staff)
- infection control
- record keeping
- fire safety

in relation to how they impact on patient care and safety.”

Mr Walsh went on, for the first time, to propose the removal of the nursing home from the register:

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\(^{78}\) See further Chapter 21.
“The H.S.E. now propose to remove Leas Cross from its register of nursing homes pursuant to section 4(5) of the Health (Nursing Homes) Act 1990 and in consultation with its law agent to this end.

The H.S.E. must fulfil its duty of care and obligations immediately to the patients in Leas Cross and in this context alternative arrangements will be made for the provision of care to

(i) patients placed in Leas Cross Nursing Home by the H.S.E.
(ii) patients subvented by the H.S.E. in Leas Cross Nursing Home.

This will be effected in consultation with the patients (their families / next-of-kin or advocates where necessary). ... The H.S.E. will also consult with the private patients in Leas Cross Nursing Home (as well as their families / next-of-kin) apprising them of the H.S.E.’s concerns in relation to patient safety and the overall level of patient care and will be advising them to make alternative arrangements.

Response of John Aherne

Mr Aherne sent two letters to Michael Walsh on the 16th June, 2005. The first was a substantive response to the issues raised in Mr Walsh’s letter of the 10th June; the second acknowledged, with “surprise”, receipt of the letter of the 15th June and stated that a response would be furnished following discussion with the nursing home’s lawyers.

Mr Aherne pointed out that Mr Walsh’s letter of the 10th June showed that there had been “close cooperation” between Leas Cross both before and after the Prime Time programme and he stated that “at all times Leas Cross has been anxious to address all issues of concern to the H.S.E.”. He continued by setting out the manner in which the nursing home was endeavouring to comply with the H.S.E.’s requirements:

“You will be aware that Leas Cross has listened carefully to the H.S.E.N.A.’s advice proffered in relation to the running of Leas Cross. We are committed to implement such reasonable recommendations as soon as practicably possible.

To that end we have placed a comprehensive recruitment campaign which will incorporate a media campaign commencing today. The office of the H.S.E. will be well aware that the task of staff recruitment presents serious challenges to all employers in the health sector. To that end we have offered terms and conditions to prospective employees that will be attractive to candidates and incorporate salaries in excess of the market place standard. We anticipate a positive response to this campaign and would be glad to keep you informed of progress in this regard.

In view of the extensive efforts we are making to comply with the H.S.E.’s recommendations, we trust the H.S.E. will not make it impossible for us to run
Leas Cross and will have due regard as to the standards being demanded of Leas Cross compared to those in other nursing homes.”

The letter then sought a list of the H.S.E.’s requirements for the nursing home:

“In ease of both Leas Cross and the H.S.E. we would now request that you furnish us in writing a full set of the H.S.E.’s requirements for Leas Cross so that we can know exactly what is required of us by the H.S.E.”

Michael Walsh replied by fax on the same date acknowledging receipt of Mr Aherne’s letters. He continued:

“I wish to confirm that my letter of the 15th June sets out the H.S.E.’s position clearly and that this remains the H.S.E.’s position.”

John Aherne’s offer to the H.S.E.

On the 21st June, 2005, John Aherne hand-delivered a letter to the H.S.E.N.A. It is stamped as having been received by Michael Walsh’s office on the 22nd June.

The letter recorded Mr Aherne’s concern that relocating residents may cause them distress. It stated that Leas Cross had “endeavoured to work with the H.S.E. over the past three weeks” and had “[invested] additional resources to recruit the staff recommended by the H.S.E.”.

Mr Aherne continued:

“Notwithstanding these efforts, the H.S.E. would appear unwilling to allow Leas Cross appropriate time to achieve the standards it has set, which exceed the market norm.

Faced with the prospect of the residents’ best interests being jeopardised by the H.S.E.’s proposed course of action, I now publicly offer the facilities of Leas Cross free of charge to the H.S.E. for a period of six months whilst the newly recommended staffing levels are put in place.”

Mr Aherne’s offer was addressed in a letter dated the 23rd June from Michael Walsh to the National Director of Primary, Community and Continuing Care. Mr Walsh set out the following reasons why the offer should not be accepted:

“The director of nursing [appointed by the H.S.E.] and her senior staff are concerned that the level of care provided in Leas Cross is such that it cannot be brought to an acceptable standard without the deployment of 24 skilled nursing staff, as well as upskilling existing staff over an extended period of time. This could not be achieved within six months.”

The Commission notes the reference to 24 nurses in this letter. Previously, the H.S.E. had informed the nursing home that twenty additional nurses would be required. As indicated elsewhere in this report, the Commission considers that the communication
of the H.S.E.’s requirements in this regard lacked clarity. In a submission to the Commission dated the 24th March 2009, Mr Walsh explains that the new number of nurses required reflected resignations by nursing staff which had occurred since the 8th June 2005, and the fact that a staff member listed on the nursing roster “had a fulltime commitment elsewhere with limited availability to Leas Cross”.

Mr Walsh’s letter continued:

“Arising from the above it is clear that:

- The home is unsafe for residential care and cannot be brought to an acceptable level within a six month period.
- H.S.E. would take over caring for the current residents in an unsafe environment.
- H.S.E. would have concerns with regard to taking on risks that could make the H.S.E. liable going forward; liabilities that might arise during the six month period of management and risks that might arise thereafter, the risks at the time of handing back the facility, from staff, residents, families / relatives, media and the political environment.

The concerns highlighted above are so compelling that the public offer from Leas Cross could not be considered.”

In addition to the foregoing, Mr Walsh listed a number of “secondary considerations”:

“Staff
- A significant number of care staff will be superfluous to need when the necessary nursing staff are recruited.
- Will staff expect H.S.E. conditions of employment?
- Recruitment difficulties by the H.S.E. and assignment of staff to Leas Cross in the current environment.
- Governance issues regarding the management of existing staff for a six month period.

Status of residents
- Approximately half of the residents are either private or subvented. Should H.S.E. take over Leas Cross, all residents will then be part of a public service and will have eligibility rights, raising a major shortfall in income which one could not expect to be restored at the time of hand-back.

Finance / H.R.
- Whilst finance and H.R. issues are secondary to the residents’ needs, they nonetheless raise serious concerns. An approximate overview of financial exposure over six months would be in the region of €2.7 million.”

See further Chapter 21.
Mr Walsh stated that the H.S.E. “could not contemplate the risks associated with handing [Leas Cross] back to the same management” at the conclusion of the proposed six-month period. He concluded by stating that it was clear from discussions with the proprietors of the nursing home that “the operation of Leas Cross would not be viable with a scale down of numbers”. At the time of writing his letter, the process of relocating residents had begun so that, if the H.S.E. took over the nursing home, resident numbers would have to be returned to full capacity to make the operation financially viable. It appears that this statement by Mr Walsh was based on the opinion of John Aherne, expressed at an earlier stage in negotiations with the H.S.E. regarding the future of the nursing home.

**Inspection of the nursing home**

An unannounced inspection of Leas Cross was carried out at 7 p.m. on the 22nd June by a team led by the Head of the Nursing Home Inspectorate. The inspectors reported to the Nursing Home Section Manager by two letters dated the 23rd June.

The inspection reports identified a number of breaches of the 1993 Regulations, including the following:

“Staffing levels were not sufficient having regard to the number and dependency of residents levels and the general layout of the facility. The inspection team considered that this insufficiency of staffing levels did not support good professional nursing practice, as evidenced by:

(i) failure to comply with good practice in relation to the receipt, storage, administration and recording of drugs, including scheduled controlled drugs;
(ii) lack of clarity in relation to care plans, and lack of evidence that current nursing/care practice was informed by the care plans;
(iii) non-availability of consent forms for restraints (bed sides / Buxton chairs) then in use;
(iv) lack of evidence to indicate that a highly dependent resident, who had a fluid balance chart, had any fluid intake since 4.00 p.m.”

The inspectors also identified a number of “breaches of good nursing practice as per professional guidelines and Misuse of Drugs Acts / Regulations”. These included a failure to sign for drugs in the controlled drugs book, a failure to return drugs to the pharmacy on the death of a resident and the absence of a clear system for the receipt of drug deliveries.

In light of the proposal already made by the H.S.E. to close Leas Cross, it appears that this was not a routine inspection. The focus of the inspection seems to have been on breaches of the nursing home regulations and other relevant legislation.
The decision to remove Leas Cross from the register

Formal notification of the decision to remove Leas Cross from the register

The decision to remove Leas Cross Nursing Home from the register of nursing homes was formally communicated to the proprietors by letter from Michael Walsh dated the 6th July, 2005.

The letter from Mr Walsh set out the decision of the H.S.E. as follows:

The Health Service Executive has carefully considered the findings and experience of its personnel whilst they have been involved on a daily basis in the management of the home and is now of the opinion that the carrying on of the home will not be, or is not, in compliance with the provisions of the Nursing Home (Care and Welfare) Regulations 1993. The Executive is also of the opinion that aspects of the premises to which the registration relates do not comply with the requirements of those regulations.

You are hereby notified that the Health Service Executive has determined to propose the removal of Leas Cross Nursing Home from the Register of Nursing Homes, pursuant to section 4(5) of the Health (Nursing Homes) Act 1990."

The letter set out the following thirteen reasons for the decision:

1. There is an insufficient number of competent staff employed to provide the necessary high standard of nursing care to each of the residents of the home, having regard to the number of persons resident there and the nature and extent of their dependency. This is in breach of both Regulation 5(a) and Regulation 10.5(d) of the Nursing Home (Care and Welfare) Regulations 1993.

2. There is a failure to provide a high standard of nursing care in relation to the following:
   - pressure area management
   - continence management
   - wound management
   - skin care
   - care for persons with dementia
   - general provision of care
   - infection control (note patient with M.R.S.A.)
   in breach of Regulation 5(b) of the Nursing Home (Care and Welfare) Regulations 1993.

3. There is no person in charge of the nursing home as recommended by Regulation 10.1 of the Nursing Home (Care and Welfare) Regulations 1993. The person in charge, Ms Denise Cogley, having vacated the role of person in charge as of June 1st, and she has not been replaced.
4. The nursing records of patients do not adequately record the health, condition and treatment given on a daily basis and signed and dated by the nurse on duty, in accordance with Regulation 19.1(d) of the Nursing Home (Care and Welfare) Regulations 1993.

5. Arrangements for the administration, storage, recording and control of drugs are not in accordance with the provisions of Regulation 29 of the Nursing Home (Care and Welfare) Regulations 1993.

6. There are inadequate arrangements for the prevention and spread of infection within the home and amongst its residents in breach of Regulation 14(b) of the Nursing Home (Care and Welfare) Regulations 1993. You failed to ensure that a high standard of hygiene in relation to the storage and preparation of food and the disposal of domestic refuse was maintained in breach of Regulation 14(e) of the Nursing Home (Care and Welfare) Regulations 1993.

7. There are inadequate arrangements for the proper disposal of clinical waste and ‘sharp boxes’ were observed to be over filled. This is contrary to Regulation 15(g) of the Nursing Home (Care and Welfare) Regulations 1993.

8. The equipment facilities and bedding are not suitable, or sufficient, or appropriate having regard to the nature and extent of the dependency of persons maintained in the nursing home, which is contrary to Regulation 11.2(f) and Regulation 11.2(g) of the Nursing Home (Care and Welfare) Regulations 1993.

9. There is a failure to ensure that safe floor covering in the home is provided in the main entrance and in the nursing home. This is not in accordance with Regulation 12(e) of the Nursing Home (Care and Welfare) Regulations 1993.

10. There is a failure to keep a bound register of all dependent persons resident in the home, including the following particulars in respect of each resident person:

(a) the first name, surname, address, date of birth, marital status and religious denomination of the person;

(b) the name, address and telephone number, if any, of the person’s relative or other person nominated to act on the person’s behalf as a person to be notified in the event of a change in the person’s health or circumstances;

(c) the name, address and telephone number of the person’s medical practitioner;

(d) the date on which the person was last admitted to the nursing home;

(e) where the person has left the nursing home, the date on which he or she left and a forwarding address;
(f) where the person is admitted to hospital, the date of and reasons for the admission and the name of the hospital;

(g) where the person dies in the nursing home, the date, time and certified cause of death.

This is contrary to Regulation 18.1 of the Nursing Home (Care and Welfare) Regulations 1993.

11. There are inadequate records maintained regarding staff working at the nursing home. There is no evidence of current ‘An Bord Altranais registration’ for nursing staff working in the home, contrary to Regulation 21 of the Nursing Home (Care and Welfare) Regulations 1993.

12. There are inadequate fire precautions in the home in breach of Regulation 27 of the Nursing Home (Care and Welfare) Regulations 1993.

You failed to take adequate precautions against the risk of fire; you failed to make adequate arrangements for detecting, containing and extinguishing fires or for the giving of warnings. You failed to ensure that the materials contained in bedding and the internal furnishings contained fire retardancy properties.

13. Contrary to Regulation 28.1(b) of the Nursing Home (Care and Welfare) Regulations 1993, you failed to keep in a safe place a record of all fire alarm tests carried out at the home together with the result of any such test and the action taken to remedy defects, and contrary to Regulation 28.2 of the Nursing Home (Care and Welfare) Regulations 1993 you failed to display in a prominent place the procedure to be followed in the event of a fire.

Further detail regarding the issues outlined above was set out in two appendices, which accompanied the letter.

In addition, Mr Walsh indicated that it was proposed to remove Leas Cross from the register of nursing homes for the further reason that the premises failed to comply with the Nursing Home (Care and Welfare) Regulations 1993. The reasons for this were set out as follows:

1. The sluice room and the laundry room in Leas Cross 1 is combined in one room whereas Regulation 14(d) of the Nursing Home (Care and Welfare) Regulations 1993 requires a separate well ventilated room for sluicing.

2. The sluice room in Leas Cross 2 is inadequately ventilated, contrary to Regulation 14(d) of the Nursing Home (Care and Welfare) Regulations 1993.
3. The window openings in patients’ rooms are unrestricted contrary to Regulation 12 (a) of the Nursing Home (Care and Welfare) Regulations 1993.

4. The floor tiling is cracked and there is an uneven surface on some tiles contrary to Regulation 12(a) of the Nursing Home (Care and Welfare) Regulations 1993.

The letter concluded by notifying the proprietors of their entitlement to make a written representation to the H.S.E. concerning the proposed removal of Leas Cross from the register of nursing homes within a period of 21 days.

Representations of the proprietors

John Aherne responded to Mr Walsh’s letter on the 27th July, 2005. He forwarded a copy of his response to the Minister for Health and Children.

In his letter, Mr Aherne impugned the manner in which the H.S.E. had reached and communicated its decision to remove Leas Cross from the register of nursing homes. He claimed that, contrary to what Mr Walsh had stated in previous correspondence, it was not true that Leas Cross had refused to recruit the staff required by the H.S.E., but rather that they had indicated that it would take three or four months to do so.

Mr Aherne then referred to Mr Walsh’s letter of the 15th June, 2005:

“I was appalled to note from that letter that the H.S.E. proposed to remove the nursing home from its register of nursing homes pursuant to section 4(5) of the Nursing Homes Act 1990 for the reasons set out in that letter. That decision to remove the nursing home from the register of nursing homes was in breach of the natural and constitutional rights of the proprietors of the nursing home, in circumstances where, firstly, no adequate opportunity was given to the nursing home to deal with complaints made by the H.S.E. prior to the said letter of 15.6.05 and, secondly, by reason of the fact that the further complaints in relation to the running of the nursing home were made for the first time in the letter from the H.S.E. which simultaneously proposed to remove the nursing home from its register of nursing homes. I consider that way of carrying on business by the H.S.E. is totally arbitrary, precipitous and unfair.”

Mr Aherne pointed out that he had not been furnished with a full list of the H.S.E.’s requirements as requested on the 16th June. He complained that the nursing home faced “a series of contradictory statements by the H.S.E.” since communication with the nursing home began prior to the Prime Time broadcast. These communications culminated in Michael Walsh’s letter of the 6th July, which included “numerous other allegations which are made in that letter for the first time”.

Mr Aherne went on to suggest that the H.S.E. had intended from an early stage to close the nursing home:
“We can see no logic in the approach of the H.S.E. in this matter. When the H.S.E., with our agreement, appointed a director of nursing and senior management staff to run the nursing home, we fully cooperated with that in the hope that any matters in respect of which the H.S.E. had complaints against the nursing home, if justifiable, would be shortly put right. It now seems to us that the H.S.E. appears to have been determined from an early stage to remove from the nursing home all residents funded by the H.S.E. …”

The proprietors’ view was summarised by Mr Aherne as follows at the end of his letter:

“In summary, the proprietors of the nursing home feel that they have been very unjustly dealt with by the H.S.E. in this matter. Again and again the H.S.E. have indicated to the proprietors the requirements of the H.S.E. in relation to the nursing home and the proprietors have indicated a willingness to comply with those requirements as soon as possible.

It is not without significance that in the 21 months prior to May 2005 the nursing home received no written formal report on any inspection of the nursing home from the H.S.E.

It is of further significance that the H.S.E. appear to have changed their positions in relation to the requirements of the nursing home on several occasions. An example of this was the requirement of the H.S.E. made on the 8th / 9th June, 2005 that the nursing home employ twenty additional nurses including middle and senior nurse managers. This was in direct conflict with the agreement reached with the H.S.E. Inspectorate on the 7th / 8th April, 2005 that a total of six nurses including middle and senior nurse managers was all that was required. When it was indicated by the nursing home to the H.S.E. that it would be impossible to achieve their 8th / 9th June target of twenty nurses within three months, due to the massive shortage of nursing staff in Ireland, but that the nursing home was willing to strive to do this, the H.S.E. then changed their position and said that those additional nurses must be employed immediately. …

The H.S.E. has been determined since 29.5.05 to bring about a situation which will result in the closure of Leas Cross Nursing Home and in that regard has used the requirements in its letters of 15.6.05 and 06.7.05 to achieve that purpose.”

The letter from Mr Aherne was accompanied by two appendices setting out in detail the nursing home’s response to each of the breaches of the 1993 Regulations alleged by the H.S.E.

Assessment of the breaches relied upon by the H.S.E.

The Commission has found that some of the alleged breaches of the 1993 Regulations relied upon by the H.S.E. as the basis for its decision to close the nursing home were well-founded, while others were not borne out by the evidence or were adequately
addressed by the proprietor in his response. Examples of each of these are set out below.

In some cases, it has not been possible for the Commission to resolve a conflict of evidence between the allegations made by the H.S.E. and the response of the nursing home proprietors.

**Alleged breaches which do not appear to be well-founded**

The Commission is satisfied on the available evidence that, in some cases, the alleged breaches relied upon by the H.S.E. were not well-founded.

One example of this is the statement by the H.S.E. that there was “no person in charge of the nursing home” on the basis that Ms Cogley had apparently vacated her position on the 1st June, 2005 and not been replaced. Mr Aherne pointed out that this was factually incorrect: first, because the H.S.E. themselves had temporarily assigned an acting director of nursing on the 1st June and, secondly, because Ms Cogley had not resigned but had taken annual leave.

Another example of an alleged breach which does not appear to be borne out by the evidence is the suggestion by the H.S.E. that the nursing home failed to keep a bound register of all residents, containing details specified by the 1993 Regulations. Mr Aherne stated in his response that Leas Cross did keep such a register. The Commission has seen the register, which does appear to comply with the statutory requirements. In addition, on each occasion when the nursing home was inspected by the Health Board / H.S.E., the inspectors found that there was an up-to-date register available for inspection.

Mr Aherne correctly pointed out that some of the breaches identified by the H.S.E. were raised for the first time on the 6th July, 2005. This is particularly striking in the case of the four structural issues raised by Mr Walsh. Leas Cross had been granted registration by the H.S.E. in 1998 and had been re-registered a number of times thereafter. On each occasion, a technical assessment of the home had been carried out by the Health Board and it had been deemed structurally acceptable.

In particular, the Commission notes Mr Walsh’s reference to the location of the sluice room in Leas Cross 1. The location of the sluice had been at issue when the nursing home first sought registration in 1998. In May of that year, Health Board inspectors expressly agreed that the sluice should be relocated to the laundry area, yet its location there is cited by the H.S.E. as a breach of the 1993 Regulations.

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80 See further Chapter 7.
81 See further Chapter 8.
Alleged breaches which appear to be well-founded

There are other elements of Mr Walsh’s letter which the Commission considers contain well-founded allegations of breaches of the 1993 Regulations or to which Mr Aherne has failed to provide an adequate response.

An example of this is the alleged failure to provide a high standard of nursing care in specified areas, such as pressure area management and continence management. In the case of pressure area management, Mr Aherne stated that residents had been assessed in May, 2005 using a recognised scoring tool and that pressure relieving mattresses were in use in the nursing home. However, the H.S.E. pointed out that the assessment of residents had not been used as part of any “individualised care plan” and that all but one of the 30 pressure relieving mattresses were found to be at the incorrect setting. There seems to have been considerable confusion within the nursing home as to who was responsible for setting the mattresses. The Commission considers that the nursing home failed to show that a high standard of nursing care could be provided in this area.

In relation to continence management, the H.S.E. stated that it had found “no evidence of any continence promotion activity or patient assessment for continence” and that there was “a distinct lack of knowledge among staff regarding the management of incontinence and the importance of continence promotion”. In reply, Mr Aherne stated that a previous matron had attended a continence promotion and management course and that in-house training in the area for all staff planned by the current matron had been postponed due to “planned wedding arrangements”. Again, the Commission does not consider that this was an adequate response to this alleged failure to provide a high standard of nursing care.

A further example of a well-founded allegation by the H.S.E. is the inadequacy of staff files. The Commission has been furnished with the staff files from Leas Cross, which provide very little information, particularly in relation to staff qualifications. In 1999, Health Board inspectors had emphasised to the then matron the need to obtain references for all employees. In most cases there is no evidence of references in the files.

General standard of care

Under the heading ‘general provision of care’, the H.S.E. identified a number of deficiencies. These included the following:

- the absence of any apparent leadership or supervision of staff or system of work within the nursing home;
- care attendants’ lack of ability to identify when nursing or medical input is required and their failure to seek advice from qualified staff;

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82 See further Chapter 11.
83 See further Chapter 13.
- the failure to review and evaluate residents’ needs;

- the existence of “large gaps in the provision of care for specific client groups”, such as residents with neurological disorders or dysphagia.

In response, Mr Aherne stated that three care teams had been established by Denise Cogley in February, 2005 to improve standards and continuity of care. He went on to emphasise the stress suffered by staff as a result of the H.S.E.’s intervention in the nursing home.

While aspects of the H.S.E.’s allegations, as identified above, are open to question, the Commission considers that the over-arching concern regarding the standard of care to residents has not been adequately addressed in response by the proprietors of the nursing home. Ms Flanagan’s team spent a number of weeks at Leas Cross and the Commission does not consider it possible, four years later, to second guess her findings regarding the standard of care at the nursing home.

**Objections to the closure of the nursing home**

On the 20th June, 2005, Mary Flanagan wrote to the residents and their families in the following terms:

“To fulfil its duty of care H.S.E. Northern Area has decided to relocate its contract and subvention clients from Leas Cross Nursing Home. ...

As a matter of urgency I would like to meet with you to discuss the future care needs of you / your relative.

To arrange an appointment with me or my team please contact me at Leas Cross Nursing Home.

I understand this is a very difficult time for you and your relative and I will endeavour to assist you in any way possible.”

The letter was accompanied by a ‘briefing document’ referring to the H.S.E.’s concerns arising from its inspection of the nursing home in April, 2005, which had been “escalated” by the *Prime Time* documentary. The document explained that the decision to relocate residents was based on the nursing home’s proprietor having “agreed that he would not be in a position to identify and recruit the necessary staff”.

In oral evidence to the Commission, John Aherne stated that many residents and their families did not want to leave the nursing home when it was closed. He also pointed out that only two residents left voluntarily in the immediate aftermath of the *Prime Time* documentary, both of whom returned to the nursing home shortly afterwards.

A report compiled in 2006 by the H.S.E. on the relocation of residents from Leas Cross stated that nine residents or their families objected to their removal from Leas Cross.
The Commission has been furnished with a letter dated the 21st June, 2005 to the H.S.E. from solicitors acting for an undisclosed number of residents, which states that their clients do not wish to be removed from the home. The solicitors also state that “medical advice has been received to the effect that same may be detrimental to our ... clients’ health”.

On the 22nd June, a U.K.-based organisation representing the interests of elderly people, Action on Elder Abuse (‘A.E.A.’), wrote to the Head of the Nursing Home Inspectorate and to the Minister for Health and Children. The letter states that A.E.A. supports the H.S.E.’s assessment of safety and security at Leas Cross. However, the organisation raises concerns regarding the immediate transfer of residents:

“Our concerns ... relate exclusively to the potential impact of any hurried transfer of very old residents from the home into new environments. It is our experience, and one that has increasing evidence in support, that such moves often have a traumatic effect on the older people themselves and may in fact hasten their deaths. Could you therefore ... indicate why you cannot put qualified nursing staff into the home to maintain it until more cautious transfers are effected; and secondly give reassurances that safe, planned transfers will occur that allow these residents to acclimatise themselves appropriately to their new environments before being transferred.”

The correspondence to the Minister included a report from a consultant psychiatrist to back up the concerns of A.E.A. regarding the potentially detrimental effect on the health of residents caused by moving residence. The report describes that effect as “only marginally less significant than the death of a spouse”.

Michael Walsh responded on behalf of the Minister by letter dated the 26th August, 2005. He explained the manner in which residents were relocated and stated that “a two to three week period would have been assigned to each resident move, thus giving ample time for consideration, consultation and support”. He also pointed out that all residents were assessed by a consultant geriatrician and a consultant psychiatrist, who were “fully supportive of the programme”. Mr Walsh concluded by stating that there had “not been any deterioration in the health of any of the residents and in fact ... the health status and mobility of a number of former residents has improved significantly in their new homes”.

Closure of the nursing home and relocation of residents

Leas Cross issued a press release on the 7th July, 2005 stating that the nursing home would close on the 1st August. The press release stated that, “due to the actions of the H.S.E. it is no longer possible, financially or operationally, to continue providing a nursing home service”. It also stated that “inexplicably, unilaterally and without either consultation or due process, the H.S.E. effectively decided to close Leas Cross”.

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In oral evidence to the Commission, Mr Aherne acknowledged that it was his decision to close the nursing home on the 1st August. However, he stated that he was forced to make the decision owing to the removal by the H.S.E. of all contract beds and subvention residents, which amounted to between 70 and 80% of the occupancy of the nursing home in 2005.

**Relocation of residents**

The H.S.E.'s 2006 report on the relocation of residents from Leas Cross stated that 91 residents were transferred to alternative accommodation. 84 of those residents moved to 28 nursing homes, four residents were discharged home and three went to Beaumont Hospital.

A team was assigned by the H.S.E. to monitor the residents after they had been moved. The team visited each nursing home to which a resident had been relocated on at least three occasions. They observed the residents and spoke to them privately. They also spoke to nursing staff in the new homes regarding the residents’ physical and mental wellbeing.

The report states that some residents who had been seriously unwell in Leas Cross made a significant improvement in the nursing home to which they moved. This included one resident whose pressure sores healed and another who became comfortable sleeping in a bed, not having done so for some time in Leas Cross. Three former residents of Leas Cross are recorded as having become seriously agitated by the move and having difficulty settling into their new homes, while two other residents did not settle into their new homes at all and had to be transferred again. Both ultimately settled into a new nursing home. The report also records that twelve former Leas Cross residents died during the seven months after the closure of the nursing home.

**Removal of Leas Cross from the register of nursing homes**

On the 14th October, 2005, the H.S.E. wrote to the proprietors of Leas Cross. The letter referred to the notification of the 6th July that the H.S.E. proposed removing Leas Cross from the register of nursing homes and referred to the representations made by the proprietors on the 27th July. The letter continued:

“The Health Service Executive, in accordance with section 4(13)(b)(i) have considered those representations before deciding on the matter. Much of what is relied upon in your representations is aspirational but does not alter the findings of the H.S.E. as to the actual day to day management of the nursing home and the standard of nursing care to be observed there. ... Regrettably, the Health Service Executive has therefore determined to proceed with its proposal for the removal of the nursing home from the register.”

The letter repeated the reasons set out in the letter of the 6th July for the decision to remove Leas Cross from the register of nursing homes. It then set out a detailed response to the proprietors’ representations regarding each of those reasons.
The proprietors of the nursing home issued a District Court appeal against the H.S.E.’s decision. That appeal was listed for hearing in May, 2006. However, following discussions between legal representatives for both sides, the appeal was withdrawn and the District Court judge affirmed the decision of the HSE to remove Leas Cross Nursing Home from the register.

**Sale of the nursing home**

After Leas Cross Nursing Home closed in August 2005, Mr and Mrs Aherne entered into an agreement with Mowlam Healthcare for the sale of the nursing home. This took place by way of two contracts for sale dated the 29th August, 2006. Both transactions included the sale of equipment from the nursing home.

Mowlam Healthcare now operates a nursing home in the newer part of the Leas Cross complex. The Commission has been informed that the original building is scheduled for demolition.

**Some observations on the closure of Leas Cross Nursing Home**

The starting point for any consideration of the events leading to the closure of Leas Cross Nursing Home is to recognise that the paramount interest was that of the residents. While other matters, such as financial considerations and the entitlement of the proprietors to fair procedures were important, the Commission considers that they were secondary to the need to ensure that appropriate care was provided to the residents of the nursing home. Accordingly, the Commission has evaluated the closure of Leas Cross in that light.

It is clear that the H.S.E. had concerns regarding the standard of care at Leas Cross prior to the broadcast of *Home Truths*. There had been an increased focus on the nursing home by the Health Board inspectors in light of complaints received in late 2003 and early 2004, and the two-day inspection carried out by the dedicated nursing home inspectorate in April, 2005 confirmed a serious deficiency in staffing. That inspection resulted in a request for the home to engage three additional staff nurses and three nurse managers.

The level of attention accorded to Leas Cross by the H.S.E. increased dramatically after the *Prime Time* documentary. The programme revealed serious problems at the nursing home, which the inspection process had evidently failed to uncover. In correspondence prior to the closure of the nursing home, the H.S.E. stated that the footage “raised [its] concerns considerably”, while a press release issued the day after the programme was broadcast outlined steps to be taken by the H.S.E. “to address a number of concerns regarding the standard of care as identified by the nursing home inspectorate and reflected in last night’s Prime Time programme”.

84 See Chapter 21.
Those statements suggest that *Home Truths* merely confirmed or compounded what the H.S.E. already knew. However, minutes of a meeting held on the 29th May indicate that Mr Aherne was told that the decision to take over the management of the nursing home was “based on the video footage that [the Head of the Nursing Home Inspectorate] had seen”.

The Commission considers that H.S.E.’s decision to assign a team to the nursing home, which ultimately led to its closure, was prompted by the shocking events shown in the *Prime Time* documentary and the public and political reaction to its broadcast. It is true that the nursing home inspectorate was already working with Leas Cross to improve staffing and elements of care. However, the Commission has found no evidence to suggest that action of the magnitude of that taken in June, 2005 had been contemplated previously.

This is not to say that the H.S.E. was necessarily wrong to act in the way it did. However, the fact that the H.S.E.’s actions appear to have been driven as much by the media and the public as by its own inspection process gives rise to disquieting questions regarding the adequacy of that inspection process and the standard of care at other nursing homes not the focus of public attention.

In this regard, the Commission notes that the Minister for Health and Children has recently approved new standards for nursing homes drawn up by the Health Information and Quality Authority (‘H.I.Q.A.’). The Commission also notes that it is intended that an independent Social Services Inspectorate, operated by H.I.Q.A., will take over the role of nursing home inspections from the H.S.E.

The proprietors of the nursing home informed the Commission of their belief that the H.S.E.’s decision to assign a team to Leas Cross was for the purpose of closing the home. It is not possible for the Commission to determine conclusively the H.S.E.’s motives at the time. However, there are a number of observations which can be made on the available evidence.

First, there is a widely recognised shortage of public nursing home beds in Ireland. This has necessitated the use of contract beds and enhanced subventions in private nursing homes. In addition, acute hospitals continue to encounter difficulty discharging elderly and highly dependent patients to appropriate care settings. For these reasons, it would seem unlikely that the H.S.E. would choose to close a nursing home accommodating so many contract beds and subvention residents unless it was absolutely necessary to do so.

On the other hand, correspondence quoted above from Michael Walsh to the National Director of Primary and Continuing Care highlighted a number of practical concerns for the H.S.E. in taking over the operation of Leas Cross for even the relatively short period of six months proposed by the proprietors. Mr Walsh cited concerns regarding the potential liability of the H.S.E. towards residents and staff. He also referred to conditions of employment for the staff, the “financial exposure” of the H.S.E. and the viability of running the home without a full complement of residents. Of course, Mr Walsh also emphasised serious problems regarding the standard of care and the

85 See further Chapter 20.
perceived risk of returning the nursing home to its current management following the proposed six-month period. However, his letter suggests that, from a pragmatic point of view, the H.S.E. preferred to close the nursing home than to invest the necessary resources in keeping it open.

The requirements imposed by the H.S.E. on the nursing home changed dramatically from its request for six nurses in April, 2005 to twenty nurses just two months later. In his letter to the National Director of Primary and Continuing Care, Mr Walsh acknowledged that the necessary recruitment and training of staff “could not be achieved within six months”. This appears to mean that the H.S.E. knew that it was setting an impossible task for the proprietors when it sought the immediate engagement of twenty additional nurses.

The H.S.E. began the process of relocating residents from Leas Cross in late June, 2005. It appears from the 2006 report into this process, that support was provided to residents and their families and that efforts were made to ensure that they settled in to their new homes. However, the question arises as to whether it was necessary to close the nursing home with such haste. This is of particular concern to the Commission in light of the correspondence from Action on Elder Abuse, referred to above, which was received by the H.S.E. at around the same time that the first residents were moved out of Leas Cross.

Undoubtedly the Prime Time documentary showed entirely unacceptable practices at Leas Cross, but nothing significant had changed in the operation of the nursing home to suggest that the standard of care had dropped since the previous inspection in April, 2005. Indeed, since the 1st June, matters had, presumably, improved under the stewardship of Mary Flanagan and her team. Accordingly, the Commission finds it difficult to understand the urgency with which the H.S.E. moved to relocate residents.

Although the 2006 report on the relocation of residents reports that twelve of them died within a period of seven months, there is no evidence before the Commission to suggest that this was necessarily caused by the move. However, the Commission is concerned that the fact that there was a risk to the health and wellbeing of residents may not have been given adequate consideration in deciding to relocate them with such haste.

Taking all the circumstances into consideration, the Commission finds that the H.S.E.’s actions strongly suggest that they were anxious to close the nursing home quickly, in order to be seen to react to Home Truths and/or because of the potential costs and risks associated with keeping Leas Cross open longer. While ultimately the decision to remove the home from the register of nursing homes, leading to its closure, may have been the correct one, the Commission considers that the manner in which it was implemented may not have been in the best interests of the residents.
CHAPTER 23

FURTHER RESPONSES TO ISSUES RAISED BY LEAS CROSS NURSING HOME

The broadcast of *Home Truths* and the closure of Leas Cross Nursing Home gave rise to a number of investigations and have also led, directly or indirectly, to the introduction of various new rules and guidelines in the area of care for the elderly.

Each of these investigations and developments constitutes a response to issues raised by Leas Cross Nursing Home and, as such, falls within the Commission’s terms of reference. The Commission has not considered it necessary to analyse these matters in detail, but has referred to them throughout this report, where they relate to specific issues addressed by the Commission.

The purpose of this chapter is summarise briefly each of these responses to the issues raised by Leas Cross Nursing Home. The responses can be divided into two broad categories:

1. Reports into events at Leas Cross, commissioned by the H.S.E. and the proprietors of the nursing home.


Reports into events at Leas Cross Nursing Home

A number of investigations have been carried out into events at Leas Cross. They are as follows:

- Report on the closure of Leas Cross Nursing Home, Elderly Care Consultancy Services (October, 2005), commissioned by the proprietors of Leas Cross

- Review of the deaths at Leas Cross Nursing Home 2002-2005, Prof. Desmond O’Neill (February, 2006), commissioned by the H.S.E.

- N.A.H.B. / H.S.E.N.A. Overview of the management and delivery of health and social services (April, 2006)

- Report on complaints received by the HSE in 2005 and 2006 (November, 2006)

- Reports on meetings with families of Leas Cross residents, Consumer Affairs Department of the H.S.E. (April and June, 2007)
- Investigation into complaints regarding residents at Leas Cross Nursing Home, Michael Brophy (2007), commissioned by the H.S.E.

- Investigation into the transfer of a patient from St Michael’s House to Leas Cross Nursing Home, Conor Dignam B.L. (2009), commissioned by the H.S.E.

**Report on the closure of Leas Cross Nursing Home**  
(Elderly Care Consultancy Services, October 2005)

The proprietors of Leas Cross commissioned an English consultancy body called Elderly Care Consultancy Services to report on the closure of the nursing home. The report provides no information on the background or qualifications of the two individuals who are named as authors.

The report is dated October, 2005. The consultants addressed a number of aspects of the nursing home, including the quality of the environment, the quality of staff, the quality of care and the quality of management. The report does not indicate the basis of its findings on any of these issues. As it was written after the closure of the nursing home, the Commission considers that the report’s conclusions regarding these issues are of limited value.

The report concludes that “Leas Cross Nursing Home and retirement complex was the victim of the H.S.E. inspection team’s failures”. The Commission can find no basis for this finding in the body of the Levy / Craig report.

The report also includes a “medical review of morbid case studies”, which was carried out by one of the consultants. He reviewed the records of 30 randomly selected deceased residents. His review leads him to comment that “of the cases investigated all had serious medical conditions that were either pre-terminal or terminal”. The consultant suggests that this level of serious illness was unusual for a nursing home. He notes that many of the residents transferred from hospitals to Leas Cross were high dependency and “many of them required 24 hour nursing care”.

Having apparently reviewed 30 files, the consultant briefly summarises his findings in relation to just five cases. He concludes as follows:

“In summary, of the 92 people who have died since Leas Cross II was opened – either at the nursing home or in a local hospital – I could find no evidence of contributory negligence to those deaths and all the patients were properly cared for in a warm, caring environment in a building that was state of the art.”

The Commission is concerned that this report, commissioned by the proprietors of the nursing home, draws conclusions which appear to have little or no basis in the information contained in the report itself. In the absence of information as to the qualifications and experience of the consultants, their methodology and the evidence available to them, the Commission considers that it would be unsafe to rely on their findings.
Review of the deaths at Leas Cross Nursing Home 2002-2005  
(Prof. Desmond O’Neill, February 2006)

Prof. Desmond O’Neill, M.D., F.R.C.P.I., A.G.S.F., consultant geriatrician at the Adelaide & Meath Hospital and Trinity College Dublin, was commissioned by the H.S.E. to review deaths at Leas Cross between 2002 and 2005. His report was completed in February, 2006.

Prof. O’Neill’s terms of reference were as follows:

(i) To review the deaths of residents of Leas Cross (for the period 2002-2005) though inspection and analysis of written documentation including:
   − medical, nursing and prescribing notes,
   − hospital records,
   − post-mortem summaries,
   − death certificates,
   − notification to coroner and inquests,
   − correspondence to E.R.H.A., N.A.H.B., H.S.E. (N.A.), H.S.E. and Department of Health and Children regarding concerns over Leas Cross,
   − nursing home inspection reports and
   − other relevant documents.

(ii) To relate these to national and international data and guidelines on morbidity and mortality in institutional care for older people.

(iii) To make recommendations as appropriate to the H.S.E. and Department of Health and Children arising from these findings.

Prof. O’Neill’s report includes the following conclusion:

“The principal finding was that the care at Leas Cross was deficient at many levels, and could best be summed up as arising from inadequate numbers of inadequately trained staff, in conjunction with inadequate and under-informed clinical leadership. At a basic level there was a failure to recognise the appropriate scope of practice among senior nursing staff and the overall findings are consistent with a finding of institutional abuse: ‘institutional abuse can occur which may comprise of poor care standards, lack of positive response to complex needs, rigid routines, inadequate staffing, and an insufficient knowledge base within the service’. The regulatory process of the Health Board at all levels was deficient in its response to the clear deficits uncovered and misguided in its assessment that senior clinical management at Leas Cross had the insight or capability to effect meaningful change. Senior management in the H.S.E. (N.A.) did not appear to give due weight to written concerns by senior clinicians about standards of care.’"
The report received a critical response from a number of relevant parties, particularly employees and former employees of the H.S.E. and N.A.H.B. with responsibility for services to the elderly. In general it may be stated that it was felt that Prof. O’Neill had gone beyond his terms of reference and had failed to consult with H.S.E. management. The process was also considered deficient insofar as the report had been completed and submitted to the H.S.E. without an opportunity for relevant parties to respond to the proposed findings. In this regard, it should be noted that Prof. O’Neill’s terms of reference required him to conduct a ‘desk-top’ review of patient records only: he did not interview any relevant persons.

The publication of Prof. O’Neill’s report has been challenged before the High Court by way of judicial review proceedings by a former employee of the H.S.E. Those proceedings were heard in October and a judgment is awaited.

The publication of the report has also been criticised by some families of former Leas Cross residents, who were apparently excluded from the launch of the report and who were disappointed not to have been consulted in the preparation of the report.

The Commission considers that the decision to engage a consultant geriatrician to review deaths at Leas Cross was a positive response by the H.S.E. to issues arising from events at the nursing home. However it appears that the limited nature of Professor O’Neill’s terms of reference, combined with controversy over the manner in which the report was published, may have detracted from the impact of its findings.

**Overview of the management and delivery of health and social services**  
(H.S.E., April 2006)

The purpose of this report, which was completed in April, 2006, was to provide an overview of the establishment of the Northern Area Health Board, how the board fulfilled its governance remit and its accountability to the Eastern Regional Health Authority. The report included sections on the development of the dedicated nursing home inspection team, the St Ita’s bed initiative and Leas Cross Nursing Home. The report also included a response to aspects of Prof. O’Neill’s report.

This report does not appear to have been intended solely as a direct response to events at Leas Cross, but has been used as an opportunity to include some material of relevance to issues arising from those events.

**Report on complaints received by the HSE in 2005 and 2006**  
(H.S.E., November 2006)

The H.S.E. received a number of complaints from the families of Leas Cross residents following the broadcast of the *Prime Time* programme. A complaints review group was established to respond to the complaints, to compile a report and to make recommendations to the Local Health Manager.
The Commission has considered this report in some detail elsewhere. The Commission notes that the team was unable to visit the home or interview staff or residents owing to the closure of the home and the fact that the residents were all deceased. Accordingly, the Commission considers that the conclusions reached by the review team should be viewed with a degree of circumspection. However, it is also to be noted that the findings tend to corroborate concerns raised by residents and their families both before and after the closure of Leas Cross.

Reports on meetings with families of Leas Cross residents (Consumer Affairs Department, H.S.E., April and June 2007)

The Consumer Affairs Department of the H.S.E. produced two reports, in April and June, 2007, regarding meetings with a number of families of former Leas Cross residents. The purpose of the report is stated to be “to tell the story from the relatives’ perspective only”. The report notes that no staff members from the nursing home were interviewed in the compilation of the report.

The Consumer Affairs Department contacted 192 families. 75 of those agreed to meet the Consumer Affairs Department between December, 2006 and March, 2007. The reports set out briefly the principal issues of concern raised by those families. The following recommendations, described as “recommendations of the families” are contained in the reports:

1. That reviews of the complaints from the families take place under section 9 of the Health Act 2004.
2. That this report [i.e. the Consumer Affairs report] should be considered by the P.C.C.C. [i.e. the Primary Community and Continuing Care directorate of the H.S.E.].
3. That an apology to the families whose relatives died in Leas Cross should be forthcoming from the H.S.E.
4. That a copy of this report [i.e. the Consumer Affairs report] should be given to each of the families.

The Commission considers that the exercise of meeting families and affording them a formal opportunity to air their concerns and grievances regarding their experience of Leas Cross was a valuable one. It is unfortunate that in some cases, owing to the absence of a formal complaints procedure in the home and/or a lack of awareness of the entitlement to complain to the Health Board / H.S.E., those families found themselves unable to raise similar concerns while their family member was alive and resident in the nursing home.

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86 See chapter 15.
Investigation into complaints regarding residents at Leas Cross Nursing Home
(Michael Brophy B.L.)

The Health Act 2004 provides for the investigation and review of complaints by the H.S.E. The Regulations governing such investigations and reviews were introduced in 2006.

In June 2007, the Consumer Affairs Department of the H.S.E. appointed Mr Michael Brophy B.L. as a review officer pursuant to regulation 5(2) of the Health Act (Complaints) Regulations 2006. He was asked to review thirteen formal complaints relating to Leas Cross Nursing Home, which had been investigated by the H.S.E. in 2006.

Mr Brophy contacted each of the families concerned and wrote to relevant persons within the H.S.E. He has informed the Commission that, whilst he was in the course of making arrangements to meet some of those persons, he was advised by the H.S.E. to suspend his review. Presumably this was owing to the establishment of this Commission of Investigation. Consequently, Mr Brophy did not report any findings.

Investigation into the transfer of a patient from St Michael’s House to Leas Cross Nursing Home
(Conor Dignam B.L.)

In September 2007, the H.S.E. established a non-statutory inquiry into the transfer of a patient from St Michael’s House to Leas Cross Nursing Home. That inquiry is continuing.

Rules and guidelines

In addition to the various reports and investigations outlined above, events at Leas Cross led directly or indirectly to the following new rules and guidelines relating to care for the elderly:

- National Quality Standards for Residential Care Settings for Older People in Ireland, H.I.Q.A., February 2009
- Professional Guidance and Standards for Nurses Working with Older People, An Bord Altranais, January 2009
- Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre, Mental Health Commission, March, 2009
National Quality Standards for Residential Care Settings for Older People in Ireland
(H.I.Q.A., February 2009)

The Health Information and Quality Authority (H.I.Q.A.) is an independent authority established pursuant to the Health Act 2007. Its statutory functions include setting standards on safety and quality in relation to services provided by or on behalf of the H.S.E. and services provided by private nursing homes. It also has a role in monitoring compliance with standards and it is intended that an independent Social Services Inspectorate, operated by H.I.Q.A., will take over the role of nursing home inspections from the H.S.E. Those inspections will encompass all nursing homes, both public and private.

H.I.Q.A.’s standards for residential care settings for older people were approved by the Minister for Health and Children in February, 2009. It is intended to introduce new regulations for nursing homes based on these standards.

H.I.Q.A. has created 32 standards for nursing homes. They are grouped into the following areas:

- **Rights**
  These include residents’ right to be consulted regarding their care and their right to privacy and dignity.

- **Protection**
  This section encompasses the requirement to protect every resident from all forms of abuse and to safeguard their finances.

- **Health and social care needs**
  These standards include assessments of every resident’s care needs, the promotion of residents’ health, medication monitoring and review and end of life care.

- **Quality of life**
  This section recognises the need to give residents a level of autonomy and independence, a nutritious and varied diet and social contact. It also addresses the issue of responding to challenging behaviour.

- **Staffing**
  Recruitment of staff, staffing levels and qualifications and training and supervision are addressed in this section of the standards.

- **The care environment**
  This section encompasses the physical environment of nursing homes together with health and safety.

- **Governance and management**
  Operational management of nursing homes, financial procedures and record keeping are included here.
It is outside the Commission’s terms of reference to analyse critically these standards. In some cases, they may, if implemented, address some of the concerns raised by the Commission regarding care of the elderly in nursing homes. While this development is to be welcomed, it will have a positive effect for nursing home residents only if the standards are implemented, independently enforced and regularly reviewed.

**Professional Guidance and Standards for Nurses Working with Older People (An Bord Altranais, January 2009)**

An Bord Altranais has furnished the Commission with new standards for nurses working with older people, which were “developed arising from the Leas Cross Review (O’Neill, 2006)”.

The standards address the following issues;

- Person-centred holistic care
- Therapeutic relationship
- Care environment
- End of life care
- Quality of care
- Professional development

They also set out “core competencies for nursing care of the older person”, including ethical practice, interpersonal relationships and organisation and management of care.

The Commission has been informed that a copy of the standards will be issued to all nurses on the register and will be launched formally by the Minister for Health and Children in May. Again, the Commission welcomes the introduction of these new guidelines and standards and hopes that they will be applied effectively.

**Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (Mental Health Commission, March 2009)**

In May, 2006, the Mental Health Commission published a guidance note entitled ‘Discharge from Approved Centres to Alternative Care Settings (including Nursing Homes)’. The guidance note was published in advance of the intended publication of a full code of practice dealing with the issue if discharging residents from approved centres.

The Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre was completed in March, 2009. It will come into effect in January 2010.

The Mental Health Commission has informed the Commission that these documents were not specifically prepared in response to issues arising from Leas Cross, but that they are intended to address, among other matters, issues such as those raised by the transfer of residents to that nursing home.
The primary objectives of the Code of Practice are stated to be as follows:

“To create a more positive journey for service users through the mental health service by improving the continuity and co-ordination of mental health care and treatment;

To encourage the active involvement, from admission to discharge, of residents and their families/carers or chosen advocate, where appropriate (i.e. with the consent of the resident) including the provision of adequate information;

To promote collaboration and improved communication between all parties involved in these processes, including between approved centre staff and primary care/community mental health services, and other relevant agencies, and to emphasise the importance of adequate exchange of information between healthcare providers to ensure continuum of care from admission to aftercare;

To aid in the safe and efficient transfer of a resident from one facility to another;

To promote the view of discharge as an ongoing and active process.”

It is outside the Commission’s terms of reference to analyse or review the Code of Conduct in any detail. The Commission welcomes the code as a positive step in improving care for users of mental health services, in particular when they are cared for in nursing homes.

The Commission also notes that the Mental Health Act 2001 (Approved Centres) Regulations 2006 contain some provisions regarding the transfer of patients from approved centres.

**Implementation of procedural changes**

On the 1st May 2009, the H.S.E. provided the Commission with a document which “sets out the achievements and progress of the Health Service Executive in implementing changes in the monitoring and enforcement of the current Nursing Home legislation.” The accompanying submission stated:

“It is important to note that significant changes have been implemented in relation to the registration, re-registration and inspections of nursing homes in the private sector since the removal of Leas Cross Nursing Home from the register in 2005. Given that the findings of the Commission may cause concern amongst the general public we would suggest that such concerns would be greatly allayed if the public was made aware of such changes.”

In the limited time available, the Commission has not been able to consider the effect that these changes, implemented since the closure of Leas Cross Nursing Home, have
had on the issues raised within the Commission’s report. The H.S.E. document can be found in an appendix to the Commission’s report.
CHAPTER 24

CONCLUSIONS

This section of the report contains the conclusions of the Commission in relation to each aspect of its terms of reference. It also contains some general findings, which the Commission believes arise from those detailed conclusions.

It is important to bear in mind that the Commission’s conclusions are based on the information made available to it. That information is limited in a number of respects: for example, the Commission was unable to establish contact with all members of staff or families of former residents. There were also deficiencies in certain aspects of record-keeping at the nursing home.

The Commission’s general findings, which must be considered in the light of the entire report of the Commission, are as follows:

1. Primary responsibility for maintaining standards of care at Leas Cross nursing home rested with the nursing home proprietors and with the person in charge of the nursing home. This is acknowledged in the Nursing Homes (Care and Welfare) Regulations 1993.

2. Although the Commission has received some evidence of complaints made regarding care at Leas Cross from its opening in 1998 until the latter half of 2003, the Commission has not found evidence of a sustained pattern of inadequate care at the home during that period.

3. However, for a period of nearly two years, dating from September 2003 until the closure of the home in August 2005, the evidence before the Commission suggests that standards of care at Leas Cross fell below acceptable levels.

4. This decline in standards of care coincided with a significant increase in the number of frail, high dependency residents admitted to the home, between September 2003 and January 2004. Most of these new residents came from St Ita’s Hospital, Portrane, and from other general hospitals.

5. The evidence before the Commission suggests that the principal cause of the decline in care standards between 2003 and 2005 was the failure of Leas Cross Nursing Home to employ a sufficient number of competent staff to provide the necessary standard of nursing care. In practical terms, the ratio of nursing staff to care attendants was inadequate. In addition, there is evidence that many care attendants lacked appropriate training.

6. The registration in 2002 of 73 additional beds at Leas Cross was granted by the Northern Area Health without adequate regard to the wellbeing of the residents, insofar as it failed to take one or more of the following actions:
(i) Giving detailed consideration to the viability of a nursing home for 111 residents and the likely ability of the nursing home’s management to cope with the proposed increase.

(ii) Imposing conditions on registration in order to ensure that numbers increased at a reasonable rate, dependency levels were manageable and staffing was adequate.

(iii) Monitoring developments at the nursing home more closely once registration had been granted.

7. Arising from inspections of the nursing home and the investigation of complaints, the Health Board / H.S.E. had in its possession detailed information regarding Leas Cross, covering a number of years, which included evidence of recurring problems. Taken as a whole, this accumulated information should have alerted the Health Board / H.S.E. to impending problems, which could have been avoided.

8. All relevant information relating to a nursing home should at all times be available to anybody inspecting, investigating or making a decision in respect of that home. For no obviously good reason, the information in the possession of the Health Board / H.S.E. was divided between a number of locations so that no single office or individual within the Health Board had full knowledge of all available information regarding the nursing home. The H.S.E. cannot rely on its administrative arrangements to excuse this failing.

9. The marked difference between the findings of the team assigned by the H.S.E. to take over the running of Leas Cross in June 2005 and those of previous nursing home inspections, including one in April 2005, gives rise to concerns regarding the adequacy of the inspection process. In particular, it highlights the inability of the inspection system to identify deficiencies in nursing home care without adequate time and resources. An effective inspection process clearly requires significant investment.

10. The purpose of investigating a complaint regarding a nursing home is not merely to vindicate either party but to ensure that all residents receive adequate care. The Health Board generally responded efficiently to formal complaints regarding Leas Cross Nursing Home. Investigations were usually carried out within a reasonable time and the findings were communicated to the complainants. However, rarely was there adequate follow up to prevent the recurrence of such problems.

The Commission’s terms of reference required it to examine:

“…the role and responses of such relevant parties as the Commission may determine… in relation to

a) the establishment, ownership, operation, management, staffing and/or supervision of Leas Cross Nursing Home (hereinafter ‘the nursing home’);
b) complaints made by or in respect of residents or former residents of the nursing home; and

c) the transfer of residents from medical and residential care facilities to the nursing home.”

The detailed conclusions of the Commission in relation to each of the headings in the terms of reference are set out below.

Establishment of Leas Cross Nursing Home

Procedure for registering and re-registering nursing homes

- The Commission is concerned that, from the year 2000 onwards the manner in which Northern Area Health Board procedures for the registration of nursing homes were applied did not ensure adequate consideration of relevant material at a senior level. The certificates of registration were signed without reference to reports of previous inspections of the home.

- In registering and re-registering nursing homes, it appears that the Northern Area Health Board may not have always have given proper consideration to the possibility of imposing conditions. From the evidence submitted to the Commission, there was some confusion within the N.A.H.B. as to who was responsible for considering whether conditions should be imposed.

Initial registration of Leas Cross, 1998

- The application to register Leas Cross as a nursing home clearly indicated that the home could cater for maximum dependency residents. Mr Aherne has not provided the Commission with any basis for this assertion on the application form, which was repeated on subsequent applications for re-registration and for the expansion of the nursing home.

- The decision to register Leas Cross Nursing Home in 1998 has been criticised on the grounds that the building was not entirely suitable for the purpose. On the basis of the evidence before it, the Commission finds that the decision of the Northern Area Health Board to grant registration to Leas Cross Nursing Home was reasonable.

- Six residents were admitted to Leas Cross Nursing Home before a formal decision to register the home had been made and, significantly, before a fire safety certificate had been granted. This was done in spite of the fact that Mr Aherne had been informed by the Nursing Home Section of the Northern Area Health Board that this would not be acceptable.

Re-registration of Leas Cross, 2001
• The Commission notes that Health Board inspectors had expressed concerns regarding the level of staffing at the home during inspections in January, June and August, 1999 and concerns regarding the drugs recording system in February and July, 1999, such that they found it necessary to conduct a number of spot checks in addition to the routine inspection. It appears from the inspection reports from 2000 and 2002 that the inspectors were satisfied that those issues had been resolved by the end of 1999.

• On that basis, the Commission makes no criticism of the decision to re-register the nursing home in 2001.

Decision to expand Leas Cross, 2002

• The Commission notes that the Eastern Health Board and latterly the Northern Area Health Board expressed support for the proposed expansion of Leas Cross Nursing Home before the extension had been built and before any application for registration of the new beds had been made. It does not appear that the individuals involved in expressing such support on behalf of the health boards were later involved in determining the application for registration. However, the Commission considers it undesirable for the registering authority to have expressed support in advance for a development which would necessarily be the subject of an application for registration. The actions of the health boards in this regard give rise to a perception that the authorities may have been predisposed to grant registration for the extension to Leas Cross Nursing Home.

Registration of expanded Leas Cross, 2002

• The Commission is concerned to note that the decision to approve the expansion of Leas Cross from 38 to 111 beds was taken at a high level within the N.A.H.B. without regard to the history of the nursing home and based solely on the outcome of one standard inspection. Although one nursing home inspector informed the Commission that, as a matter of practice, she considered previous inspection reports at the time of an inspection, the person ultimately making the decision to register the expanded nursing home was not, as a matter of practice, furnished with routine inspection reports for the nursing home.

• The Commission considers that the registration of 73 additional beds at Leas Cross was granted without adequate regard to the wellbeing of the residents who would occupy the new wing. There were three approaches open to the Northern Area Health Board, which might better have protected future residents:

  i) The pre-registration inspection should have included consideration of the implications of registering such a large nursing home and a discussion of the likely staffing and other requirements. The
The Commission can find no evidence in the inspection report or the inspectors’ submissions that these factors were given any detailed consideration.

ii) The grant of registration should have been conditional, to ensure that numbers increased at a reasonable rate, dependency levels were manageable and staffing was adequate.

iii) Developments at the nursing home should have been monitored more closely once registration had been granted.

- The pre-registration inspection should have included consideration of the implications of registering such a large nursing home and a discussion of the likely staffing and other requirements. The Commission can find no evidence in the inspection report or the inspectors’ submissions that these factors were given any detailed consideration. The Commission is satisfied that the terms of the 1993 Regulations were sufficiently broad to permit the inspectors to consider these factors at a pre-registration inspection.

- It was open to the Health Board to have granted registration of the extension subject to conditions, such as:
  
  v) a limit on the level of dependency of residents to be accommodated in the nursing home;
  
  vi) a limit on the percentage of high or maximum dependency residents, relative to the overall population of the nursing home;
  
  vii) a restriction on the rate at which resident numbers increased in between inspections;
  
  viii) specific requirements regarding staff numbers and the ratios of nurses to care attendants.

The Commission considers that the imposition of one or more conditions along these lines would have been desirable, at least temporarily, to allow the NAHB to monitor the capacity of the home to deal with the significant increase in numbers. No conditions were imposed.

- Not only was the newly extended nursing home registered without any restrictions as to the dependency level of those who might be admitted to the home, but the Northern Area Health Board took the opportunity to purchase a number of contract beds from Leas Cross in August 2003, in order to transfer a group of elderly, high dependency patients from St Ita’s Hospital, many of whom had problems with dementia and Alzheimer’s disease and required significant amounts of nursing care.

- The Commission believes that, following the expansion of Leas Cross to cater for 111 residents, the Health Board should have monitored developments at the nursing home more frequently, to ensure that staff numbers increased in
tandem with the increase in residents and to ensure that there was an appropriate balance of nurses to care attendants. This did not occur.

Re-registration of Leas Cross, 2004

- The Health (Nursing Homes) Act 1990 requires the proprietor to submit an application for re-registration at least two months before the registration expires. That was not done in this case.

- The nursing home was re-registered notwithstanding the existence of a serious complaint of which the inspectors and Health Board management were aware. Where there was a serious complaint outstanding, the Commission considers that complaint should have been determined prior to re-registration to ascertain whether the home should be re-registered at all or whether it would be appropriate to impose conditions. It is the opinion of the Commission that the practice of the Health Board in this regard seriously undermined the inspection process and potentially posed serious risks for the residents of nursing homes.

Ownership, operation and management of Leas Cross Nursing Home

Proprietor of Leas Cross

- Leas Cross Nursing Home was owned by Sovereign Projects Limited, of which John Aherne and other members of his family were the directors and shareholders. The owners have informed the Commission that the sole activity of that company during the period under investigation was the operation of the nursing home.

- Responsibility for the operation and management of a nursing home is assigned, by the relevant legislation, to the registered proprietor and the person in charge. In the case of Leas Cross, the registered proprietor was Mr John Aherne and the role of person in charge was held by the matron.

- The Nursing Homes (Care and Welfare) Regulations 1993 assign joint responsibility for the care and welfare of residents to the proprietor and the person in charge. Accordingly, where issues arose – for example, where the inspectors criticised staffing levels – both Mr Aherne and the relevant matron share responsibility.

Management structure at Leas Cross

- Prior to 2004, the matron had full responsibility for the day to day management of the nursing home and there was no other formal management structure in operation. This does not appear to have caused concern to the
Health Board’s nursing home inspectors until June 2004, by which time the nursing home had expanded and resident numbers had reached 96. At that point, the inspectors recommended the appointment of an assistant director of nursing. This role was created in November 2004.

- Evidence received by the Commission from former matrons and staff members suggests that there was no formal system for staff meetings until 2005.

- In 2005, Leas Cross introduced a structure of care teams led by staff nurses: a development that was welcomed by the nursing home inspectorate, during a two-day inspection of Leas Cross in April, 2005.

- In April 2005 the nursing home inspectorate recommended the imposition of a senior nursing structure, with two clinical nurse managers grade 2 and one clinical nurse manager grade 3, “in order to optimise standards of care and based on the current dependencies of residents”. These appointments did not, in fact, occur before the nursing home closed in August, 2005.

**Staffing of Leas Cross Nursing Home**

**Assessment of staffing requirements**

- The Nursing Homes (Care and Welfare) Regulations 1993 provide no guidance as to how one should calculate what constitutes “a sufficient number of competent staff” in any given instance. The Commission considers that it would have been preferable for the Regulations to have specified minimum numbers of nursing and care staff required, or at least to have provided a method by which staffing numbers (in particular numbers of nursing staff) should be calculated.

- The primary responsibility for ensuring that a nursing home has sufficient staff lies with the registered proprietor and the person in charge of the home. In the absence of more detailed legislative guidelines, the Health Board / H.S.E., through the registration and inspection processes, has an important role to play in assessing whether the staffing levels at individual homes are in fact adequate. The Commission is satisfied that there was ample provision in the legislation to enable the Health Board or the H.S.E. to take action in circumstances where they identified a failure to meet the required levels of staffing.

- Calculation of staffing needs must take into account the number of patients, their dependency levels and degrees of mobility, the physical layout of the nursing home, and the experience and qualifications of the staff available. In circumstances where a lack of staff (or of sufficiently qualified staff) could significantly affect residents’ health and quality of life, a nursing home is obliged, in the Commission’s view, to ensure that it exceeds the minimum
staffing requirements, in case its estimate of the minimum turns out to be wrong.

- The Commission has no evidence to establish that any formal assessment tool was employed at Leas Cross Nursing Home in relation to staff levels prior to 2005.

- The Commission considers that a measurement of dependency should be routinely carried out in all nursing homes for the purposes of determining appropriate staff numbers and skill mix. An accurate assessment of staffing requirements in a nursing home is not possible without knowing the dependency levels of residents.

**Staff qualifications and training**

- The staff files maintained at Leas Cross provide very little information regarding the qualification and training of staff. For that reason, there is very little information available regarding the qualifications of staff before they were engaged at the nursing home and the training provided to them while they were there.

- From the Commission’s investigations it appears that most of the nurses at Leas Cross were general registered nurses, without any particular specialisation in care of the elderly. The Commission notes that under the regulations there is no requirement on a nursing home to employ specialist nurses.

- It does not appear that the care attendants at Leas Cross were required to have any qualifications or prior experience in order to be engaged by the nursing home.

**Supervision of Leas Cross Nursing Home**

**N.A.H.B. nursing home inspection process**

- The Commission considers that the Nursing Homes (Care and Welfare) Regulations 1993 and the standard inspection form should have placed much greater emphasis on the physical and mental wellbeing of residents. The inspection form in use during the operation of Leas Cross was primarily concerned with the adequacy of the facilities and record keeping in nursing homes. It appears that the custom and practice of inspectors was to examine residents from time to time. This was in spite of the absence of any such requirement and, therefore, may not have occurred as often or as consistently as would have been desirable, although the Commission acknowledges that it would be appropriate for inspectors to examine residents only where there was an indication to do so and with their consent.
The Commission is satisfied that the H.S.E. had a duty of care to nursing home residents. This was clearly recognised by the H.S.E., as evidenced by its decision to take over the operation of Leas Cross Nursing Home in May 2005 and ultimately, by the decision to remove the nursing home from the register—a decision which, according to Mr Walsh’s letter of 15th June 2005 to Mr Aherne, was taken by the H.S.E. because “*the H.S.E. must fulfil its duty of care and obligations... to the patients in Leas Cross*”, and which arose from “…concerns in relation to patient safety and the overall level of patient care”. It is not appropriate for the Commission to define the limits of this duty, but the Commission is satisfied that the duty, which was exercised principally through the medium of nursing home inspections, included a duty to monitor and address concerns in relation to patient safety and the overall level of patient care.

The Commission considers that, in the exercise of the duty of care identified above, a more consistent approach during inspections to examining residents would have identified care-related problems such as pressure sores and dehydration earlier and would have enabled inspectors to ensure that adequate steps were taken by the nursing home to develop prevention procedures and to treat residents where necessary.

It appears to the Commission that the general approach of inspectors was to follow up matters at the next biannual inspection, rather than to make additional follow-up visits. Inspectors who did make such visits did so on their own initiative. While such initiative is commendable, a more consistent policy would be desirable, to ensure follow-up visits within a short period whenever inspections required remedial action to be taken by the nursing home.

A report prepared for the HSE on complaints received in relation to Leas Cross Nursing Home (November, 2006) recommended the development of a central registry to collate data from Nursing Home Inspectorate visits and identify poorly functioning nursing homes. The Commission considers that a system of that nature, or even a less sophisticated but regular analysis of inspection reports, would have alerted the HSE to potential problems at Leas Cross and possibly averted the closure of the home.

**N.A.H.B. inspections of Leas Cross**

The Commission notes a divergence in practice between the early years of the operation of Leas Cross and the years after the new wing opened in 2002. In 1999, there were three follow-up inspections to ensure adequacy of staffing and, on one occasion, to ensure that medication was being administered properly. The effect of this was that the inspectors eventually satisfied themselves, by the end of 1999, that there was an adequate number of staff in the nursing home and that their recommendations were being adhered to. In contrast, when the nursing home expanded to over 90 residents in 2003, the inspectors did not carry out spot checks to ensure compliance with their recommendations. Indeed, in 2004, there was only one routine inspection,
owing to staff shortages in the inspectorate. Whilst there was intense H.S.E.
activity in the nursing home in May, 2005, that appears to have been mainly in
response to the Prime Time documentary.

- The Commission recognises that the inspectors had limited time and resources
at their disposal and that the nursing home legislation and the standard
inspection form failed to address many of the problems identified at Leas
Cross Nursing Home.

- The Commission notes that a number of inspectors were not constrained by
such limitations: they carried out spot checks at Leas Cross in addition to the
routine inspections and drew attention to problems not necessarily anticipated
by the framers of the standard inspection form. A clear example of this can be
seen in the conduct of the inspectors in 1998 and 1999, whose attention to
Leas Cross eventually achieved acceptable staffing levels at that time. In the
opinion of the Commission, the inspection system overcame its obvious
limitations only where inspectors were prepared and able to act in that manner
and those who did are to be commended for having done so.

Environmental Health Office inspections

- Environmental Health Officers carried out a number of inspections at Leas
Cross Nursing Home. It appears that the infringements found were of a minor
nature. The Commission accepts the opinion of the Senior Environmental
Officer that although some infringements occurred more than once, at no stage
did matters arising from environmental health inspections at Leas Cross
warrant enforcement action.

- The fact that EHO inspections were carried out separately to N.A.H.B.
inspections, and that the results of EHO inspections were not shared with the
N.A.H.B. inspectors, illustrates the fragmented nature of the supervision
procedures for nursing homes.

The closure of Leas Cross

- In June 2005, following the takeover of Leas Cross Nursing Home by a team
assigned by the H.S.E., the proprietors were advised by the H.S.E. that in
excess of twenty additional nurses were required in order to provide an
appropriate standard of care at the nursing home.

- The Commission considers that the imposition of a requirement for twenty
additional nurses appears to have been sudden, out of step with previous
staffing requirements, poorly communicated and was accordingly, unfair.
This is not to say that the H.S.E. was not entitled to require extra nurses: it was
duty bound to ensure that adequate care was provided to nursing home
residents. However, the Commission is of the view that the true staffing
requirement should have been identified and communicated much earlier,
when the home expanded and took on high dependency residents, so that it did
not come as a surprise to the proprietors of Leas Cross.
• In July 2005 the H.S.E. notified the proprietors of Leas Cross of its intention to remove the nursing home from the register of nursing homes, on a number of grounds. The Commission has found that some of those grounds were well-founded, while others were not borne out by the evidence or were adequately addressed by the proprietor in his response. In some cases, it has not been possible for the Commission to resolve a conflict of evidence between the allegations made by the H.S.E. and the response of the nursing home proprietors.

• The Commission considers that the over-arching concern regarding the standard of care to residents expressed by the H.S.E. in communicating its intention to close the nursing home was not adequately responded to by the proprietors of the nursing home.

• Taking all the circumstances into consideration, the Commission finds that the H.S.E.’s actions strongly suggest that they were anxious to close the nursing home quickly, in order to be seen to react to Home Truths and/or because of the potential costs and risks associated with keeping Leas Cross in operation at the appropriate standard. While ultimately the decision to close the home may have been the correct one, the Commission considers that the manner in which it was implemented may not have been in the best interests of the residents.

Complaints made by or in respect of residents of Leas Cross Nursing Home

• The submissions received by the Commission from families who made complaints indicate that most complaints were made, not to the Health Board but to the matron, nurses, care staff or proprietors of the nursing home.

• The management of Leas Cross Nursing Home had no formal policy or procedure in place to deal with complaints internally.

• Notwithstanding the absence of any statutory requirement for a complaints policy, the Commission considers that it would have been desirable for Leas Cross to have set out comprehensively the manner in which complaints could be made by and on behalf of residents and how they would be investigated by the home. This was clearly envisaged by the Code of Practice for Nursing Homes (1995) and, in the opinion of the Commission, should be considered best practice when dealing with elderly people and their families, who are unlikely to be familiar with nursing home legislation and HSE procedures.

• Between 1999 and 2005, as a matter of both policy and practice, Leas Cross management and staff failed to keep a record of the complaints made to them by residents or residents’ families, and the response of the nursing home to those complaints. The absence of such records fatally compromises any attempt to assess the performance of the nursing home management in dealing with the complaints of residents and their families. In the Commission’s view, however, the failure to keep proper records is, in itself, a sign that the
management of Leas Cross did not treat residents’ grievances with the seriousness they deserved.

- Notwithstanding the difficulties caused by (a) lack of documentation and (b) unresolved conflicts of evidence between complainants and nursing home staff, the Commission considers that, having regard to the information available to it, the following, limited observations can be made regarding complaints made to Leas Cross Nursing Home:

1. Residents and visitors who wished to make complaints were frequently frustrated in their attempts to do so by the fact that key staff members, such as the matron or the duty nurse, could not be located.

2. Some complainants experienced difficulties in communicating with staff who lacked fluency in English. This left them uncertain as to whether their complaint would be understood or acted upon.

3. The difficulties experienced by people who attempted to complain were compounded by the fact that Leas Cross had no procedure for keeping written records of verbal complaints, or of the response to such complaints.

4. Three of the five written complaints of which the Commission is aware appear to have generated no response from the management of Leas Cross.

5. Most of the complaints of which the Commission is aware relate to an eighteen-month period beginning in late 2003, when the population of the nursing home had increased substantially following the intake of a large number of high / maximum dependency patients. Whilst this might not be unexpected – even in the best of circumstances one might expect an increase in resident numbers to bring an increase in complaints – when combined with other evidence it suggests that the nursing home was not equipped to deal with the number and dependency level of residents in its care from September 2003 until June 2005.

6. A significant number of the complaints made during that period contain allegations which imply a lack of adequately skilled staff in the nursing home at that time. Those allegations include inadequate supervision of residents, unwarranted use of physical or chemical restraints, and lack of regard for residents’ hygiene and personal care.

7. If complaints received by the nursing home had been systematically recorded and available for inspection, it would have been much easier for both the nursing home management and the relevant health authorities to identify and deal with emerging patterns of inadequate care.
A number of the submissions received by the Commission from the families of former residents of Leas Cross state that residents arrived at acute hospitals with ailments such as dehydration and pressure sores. The Commission considers that a clear procedure should exist for hospitals in such instances to make known to the HSE any concerns regarding standards of care at nursing homes so that such concerns can be investigated.

The Commission finds that the Health Board generally responded efficiently to formal complaints regarding Leas Cross Nursing Home. Investigations were usually carried out within a reasonable time and the findings were communicated to the complainants. However, it appears that, in most cases, complaints were considered to have been dealt with once the complainants had been notified of the outcome: rarely was there adequate follow up to ensure that similar problems did not recur.

Transfers from medical / residential care facilities to Leas Cross Nursing Home

Transfers from St Michael’s House

- The Commission accepts that the decision by St Michael’s House to place clients in nursing homes was driven by a lack of viable alternatives.

- The Commission is of the view that St Michael’s House responded appropriately to the complaints it received concerning Leas Cross in 1999. The complaints were specific in nature; they were brought to the attention of the matron by St Michael’s House, and it was reasonable to believe that the nursing home would take matters from there.

- In relation to the transfer of Peter McKenna to Leas Cross in October 2000, the Commission believes that those responsible for making the decision to move Mr McKenna should either have known or been made aware of the complaints made about Leas Cross in 1999. In particular, the Commission notes that during the course of the hearing before the High Court no mention was made of any previous complaints involving clients of St Michael’s House at Leas Cross. It should have been left open to the High Court to decide the seriousness and relevance of those complaints in the context of considering the transfer of Mr McKenna to Leas Cross.

- Based on the information available to it, the Commission considers that St Michael’s House were not unreasonable in holding the view in August / September 2000 that Leas Cross Nursing Home would be suitable for Peter McKenna’s nursing care needs.

- The Commission is of the view that once Peter McKenna was transferred to Leas Cross, the primary responsibility for his medical and nursing care rested with the nursing home.
• However, although the principal duty of care may have rested with Leas Cross, the fact remains that St Michael’s House had promised Mr McKenna’s family that they would monitor his care and provide “clinical backup”. From the information disclosed to the Commission it seems that no formal, clinical monitoring of Peter McKenna’s nursing care at Leas Cross was carried out by St Michael’s House during the twelve days he resided there.

• The Commission has seen no evidence of any response by St Michael’s House to the concerns expressed by the family in their letter of October 2001. Nor, it would appear, did a complaint voiced by a senior psychologist in St Michael’s House result in any re-examination of Peter McKenna’s case. In light of this, the Commission considers that St Michael’s House did not respond appropriately to the complaints received concerning Peter McKenna in 2001.

Transfers from St Ita’s Hospital

• Between the 17th September and the 28th November, 2003, 23 patients of St Ita’s Hospital were discharged to contract beds in Leas Cross Nursing Home. There is an accumulation of evidence – from families of residents, from nursing home inspectors and from the Psychiatry of Old Age team who co-ordinated the discharge process – which leads to a conclusion that this intake of patients coincided with a significant deterioration in standards of care in the nursing home.

• The Commission accepts that in the long term, keeping those patients at St Ita’s was not an appropriate option. But the Commission questions whether it was necessary for so many of those patients to be transferred to nursing homes within just a few months.

• The Commission has been unable to establish why or by whom it was decided to close the Reilly’s Hill complex at St Ita’s by the 1st December 2003. This deadline put unnecessary pressure on the project team managing the discharge process. It reduced the time available to inspect and evaluate the various nursing homes in which patients could be placed, and left little time to monitor the response of Leas Cross Nursing Home to the arrival of the first group of patients in September, 2003.

• It is not clear on what basis the N.A.H.B. decided that Leas Cross could handle the admission of 23 elderly patients from St Ita’s, many of whom were high dependency. In the Commission’s view, the information provided by the inspectors to the N.A.H.B was not an adequate basis on which to make a decision to transfer 23 patients from St Ita’s Hospital. If anything, the information that almost half the existing residents at Leas Cross were not ambulatory in July, 2003 should have led the N.A.H.B. to question whether the nursing home could cope with a further 23 residents, many of whom were high dependency.

• The Commission considers that the N.A.H.B. did not make sufficient efforts to determine the suitability of Leas Cross to accommodate and care for the St
Ita’s patients. In the Commission’s view, the N.A.H.B. should have arranged for a detailed inspection of Leas Cross to be carried out, with a view to deciding on the specific question of its suitability to care for a large group of patients from St Ita’s Hospital. That inspection should have been carried out with the assistance of a representative from St Ita’s, who could advise the inspectors on the particular needs of the patients.

- Responsibility for the decision to move so many patients from St Ita’s to Leas Cross cannot be ascribed solely to the nursing home. However, although members of the Psychiatry of Old Age team paid regular visits to the home, the management and staff of Leas Cross bear primary responsibility for the manner in which those residents were cared for once they had arrived. Insofar as adjustments were made by Leas Cross to reflect the complex needs of the St Ita’s patients, the Commission considers that those adjustments were inadequate.

- Once the patients from St Ita’s had been discharged to Leas Cross, the Psychiatry of Old Age team was not responsible for their nursing care. The role of the Psychiatry of Old Age team was to monitor the mental health of the patients concerned, and it did this. Moreover, whenever the Psychiatry of Old Age team was made aware of possible nursing care problems at Leas Cross, it sought to bring those problems to the attention of the appropriate person or persons within the health service.

- In addition to alerting others within the health service to the apparent problems at Leas Cross, the Psychiatry of Old Age team also took action on its own behalf, choosing from January, 2004 onwards to use the contract beds at Leas Cross for respite rather than long-stay patients. From March, 2004 (and possibly earlier), visits from Psychiatry of Old Age personnel were increased to once a week.

- When specific complaints were received by the Psychiatry of Old Age team from the families of former patients, those complaints were responded to quickly and thoroughly.

**Transfers from Beaumont Hospital**

- There are two distinct aspects to the relationship between Beaumont Hospital and Leas Cross Nursing Home. In the first place, a significant number of persons admitted to Leas Cross went there following treatment at Beaumont Hospital or assessment by a consultant geriatrician attached to the hospital. Secondly, and perhaps more importantly, Leas Cross was within the catchment area for Beaumont Hospital, which meant that most of the residents who required hospital treatment were admitted to Beaumont.

- The information provided to the Commission by patients’ families suggests that staff at Beaumont Hospital were witnessing a recurring pattern of residents being admitted from Leas Cross with problems which either were or
could be indicators of poor care at the nursing home. These problems included pressure sores, dehydration and urinary tract infections. It seems that the staff at Beaumont did not convey any concerns which they may have had about Leas Cross to the Health Board or to the H.S.E.

- Furthermore, the Commission has seen evidence of only one instance in which a member of Beaumont Hospital’s medical staff raised concerns with the matron of Leas Cross.

- There is no doubt that the absence of any formal procedure for recording and reporting such concerns within the hospital contributed to the failure to identify and respond to the emerging pattern of care problems at Leas Cross. However, the fact that there was no formal procedure does not, in the Commission’s opinion, absolve the hospital’s medical staff from fulfilling their duty of care to their patients. In the Commission’s view, such duty of care must include a duty to report, and if necessary to follow up on, any concerns which they have regarding the care afforded to patients in the nursing home from which those patients have been admitted.

- The Commission considers that the question of the extent to which hospitals can and should follow-up on frail, elderly patients discharged to nursing homes is one that warrants further consideration by the hospitals themselves and by the H.S.E.

**Transfers from the Mater Hospital**

- The Commission has not been informed of the existence of any formal procedure for staff at the Mater Hospital to pass on concerns about standards of care in nursing homes to the appropriate authorities. If such formal procedures do not exist, the Commission is of the view that they should be put in place.
APPENDIX

H.S.E. SUMMARY OF CHANGES IN REGISTRATION AND INSPECTION OF NURSING HOMES IN THE PRIVATE SECTOR
1. The setting up of the Leas Cross Task Force Group:

The Leas Cross Task Force Group was established on 26th January 2007, by the National Director, Primary Continuing and Community Care (PCCC), Laverne McGuinness. The group which was chaired by Tadhg O’Brien, Assistant National Director, PCCC, in the Dublin North East Region, was established to identify, co-ordinate and finalise all outstanding issues pertaining to Professor Des O’Neill’s “Review of Deaths of Residents of Leas Cross Nursing Home”.

The terms of reference were as follows:

1. Review Prof. O’Neill’s report and itemise issues for action in addition to the 12 listed recommendations in the report.
2. Review documentation from the Leas Cross Deaths – Relatives Actions Group and list issues for action.
3. Review the contents of Leas Cross corporate files and list issues for action.
4. Liaise with the Office of Consumer Affairs and request an update on progress to date with regard to their role in respect of the complainants.
5. Establish if there are further files on Leas Cross Nursing Home in the office of the National Director and whether there are further issues that are ongoing.

In his review, Professor O’Neill listed 14 recommendations, 12 that applied nationally and 2 recommendations that applied locally. The HSE accepted the recommendations of the report. The Task Force Group addressed the recommendations through identifying responsibilities for action nationally by high-level committees established to develop policies and procedures for care of the elderly in private and statutory nursing home facilities. Letters were issued to the nominees with national/regional responsibility, by the chairperson of the group indicating the assignment of responsibility to implement the recommendations. Reports were sought from the relevant chairpersons and the Leas Cross Task Force Group reconvenes to review progress on the implementation of the recommendations.

A further twelve issues were identified for consideration by the Task Force Group, including the following:

- Meetings with the Leas Cross Deaths – Relatives Action Group from which was developed the “Report on the Meetings with Families of Leas Cross Residents – December 2006 to March 2007.” This report was forwarded to the families on 2nd July 2007 by the Head of Consumer Affairs.
- Meeting with the Federation of Irish Nursing Homes – The Local Health Manager with lead responsibility for care of the elderly in HSE Dublin North East undertook ongoing discussions with representatives of the Federation to address issues that were raised by them.
- Professor O’Neill’s report was forwarded to An Bord Altranais on 10th November 2006 to facilitate consideration by the organisation’s Inquiry into the Fitness to Practice Committee on the grounds of alleged professional misconduct as may be perceived from the report. Representatives of the Task Force Group and An Bord Altranais met on a number of occasions during 2007. The Fitness to Practice Committee was of the opinion that there was not a sufficient cause to warrant holding an enquiry.
- Professor O’Neill’s report was forwarded to the Medical Council on 10th November 2006 to facilitate consideration by the organisation’s Inquiry into the Fitness to Practice Committee.
on the grounds of alleged professional misconduct as may be perceived from the report. The Committee advised the Task Force Group that it had considered all the material before it, including the HSE’s correspondence, the doctors’ observations and comments and having regard to the provisions of the Ethical Guide decided that there was not a prima facie case for the holding of an enquiry. The Committee’s decision was referred to the Medical Council at its meeting on 23rd July 2007. Further correspondence dated 24th July 2007 advised that the Committee’s decision was accepted by the Medical Council stating that the Council has decided not to uphold the HSE’s complaints.

- Professor O’Neill’s report was forwarded to the Garda Commissioner in December 2006 for his consideration with regard to whether an investigation should be undertaken to establish whether criminal neglect had been perpetrated. A Chief Superintendent was assigned to follow up on criminal matters that may arise from the report. The National Director, PCCC and the Assistant National Director, PCCC who is chairperson of the Task Force Group met with the Chief Superintendent on 27th March 2007 who advised that there will be no criminal investigation pending the outcome of the Commission of Investigation.

The Task Force Group finalised its report on the 21st September 2007 which was subsequently submitted by the chairperson to the National Director, PCCC.

2. **The setting up of the complaints investigation process.**

The HSE has implemented a robust system to investigate complaints made to it by or on behalf of residents in a private nursing home (registered pursuant to the Health (Nursing Homes)Act 1990 in accordance with Article 26 of the Nursing Homes(Care and Welfare) Regulations 1993.

3. **The establishment of a permanent inspectorate/change to inspections etc.**

The Health Act 2007 provided for the establishment of the Health Information and Quality Authority (HIQA) and of the Office of Chief Inspector of Social Services (CISS) within HIQA, with specific statutory functions. The CISS will be required to monitor, against standards set by HIQA, residential care services provided to older persons (amongst others).

Preparatory work has been undertaken and arrangements have been put in place to transfer inspections to HIQA. In the transition period the HSE is continuing to undertake inspections of private nursing homes.

Pending the transfer to HIQA and in response to public concerns in November 2006, the CEO of the HSE established a National Task Force to manage all of the issues relating to the inspection of nursing homes pending transfer of the function to HIQA. This Task Force meets on a fortnightly basis under the chairmanship of the National Director PCCC.

The HSE committed to develop a standardised approach to registered nursing homes inspections and subsequent nursing home reports across the system which includes the development of standardised documentation in all HSE Areas.

Significant progress has been achieved including the following:
• Inspection documentation standardised.
• Nation wide training programme for nursing home inspectors has been completed.
• Publication of nursing home inspection reports on the HSE website.
• Inspection Teams provided with a list of issues (including health and social care issues) to be examined at inspection.
• Standardised registration certificates in use.
• Guidelines in relation to inspection issued to all Inspection Teams.
• All statutory inspections are unannounced.
• Each Nursing Home receives a minimum of two inspections in a twelve month period. Follow up inspections are undertaken to ensure compliance when issues are identified on a previous visit.

In addition to these inspections nursing homes are subjected to unscheduled inspections resulting from complaints or concerns arising in relation to their operation. When necessary, nursing home inspection teams are at liberty to make their inspection at night or at weekends.

The vast majority of nursing homes provide a very high level of care to their residents. As these homes provide varying levels of care to older people from low to high dependency, it is essential that the HSE as the national health authority work with the nursing home proprietors to regulate the work they do and ensure they provide care that is safe and secure.

The HSE is aware that the inspection process, like all processes, can be improved upon, and therefore continues to work with relevant stakeholders to advance its nursing home inspection function pending the transfer of this function to HIQA.

Quarterly regional meetings (one per HSE area) are held with nursing home representatives to ensure that there is clear understanding of the appropriate care required by the Health Service Executive. In addition a National Consultative Forum meets with the nursing home representative group.

The Nursing Home Task Force recognised the need for information in relation to older people services. Following changes made to the Nursing Home Inspection Report format it was agreed that the HSE website would be looked at in relation to the overall information available to Older People. The layout provides information across HSE services as well as relevant information from other statutory and non statutory agencies. Information is set out under the following headings:

• Tips for healthy living
• Benefits and financial entitlements
• Community services for older people
• Residential care for older people
• Carers and relatives
• Useful contacts

There is also a section called Protection of Vulnerable People, which is repeated, in a number of sections outlined above. This piece of work provides information on elder abuse; it includes a definition of elder abuse, explains the different types of abuse and provides contact details of the dedicated officers for elder abuse in each HSE area.
In the context of the development of an independent inspectorate the government has brought forward a new legislation which will transfer the responsibility for the inspection of private nursing homes to the HIQA. In March 2009, HIQA published the National Quality Standards for Residential Care Setting for Older People in Ireland.

There are 32 standards which aim to promote best practice in residential care settings for older persons and improvements in the quality of life of residents in these settings. The regulations which underpin these standards have been subjected to a Regulatory Impact Assessment, once this has been finalised HIQA will then assume the responsibility to register and inspect the delivery of care in all public, private and voluntary residential care settings for older people in accordance with the new quality standards.

Local implementation of the standards is of paramount focus and each residential setting within the HSE has been undertaking work to benchmark their facility against the 32 standards. The HSE have established a National Residential Care Standards Reference Group as a forum to address areas of the standards which require a national approach and to offer support to the local health offices. The National Residential Care Standards Reference Group’s composition has been drawn from a wide forum. It is intended that the main objectives of the national group will be to:

- provide a forum through which local health offices can highlight areas that require a national approach
- develop appropriate responses to areas of the standards the require a national approach
- serve as a mechanism to review and share best national and international practice
- support the regulatory impact assessment process

The National Reference Group aim to deal with issues as they arise during the implementation period and to provide a consistent response and standard approach by the HSE.

Areas highlighted included:

- Infrastructure
- Staffing /Skills Mix
- Medical Cover
- Audit Tools (Completed)
- Roles and Responsibilities
- Terms of Reference for Regional and Local Steering Groups (Completed)
- National Policies(See below Recommendation – Point 6)
- Level of Support for Director of Nursing
- Complaints Process
- Local Management Team Linkages

The National Reference Group endorsed the benefits of the introduction of the Standards as follows:

- They provide a common set of requirements applied across all health care organisations to ensure that services are provided in a safe and equitable manner.
• They provide a framework for continuous improvement in the overall quality of care for service users.

• Provide organisations with a systematic means for ensuring that they comply with their statutory duty.

• The standards incorporate minimum standards for quality & safety and also developmental standards

• Evidence based and best practice within Ireland and internationally

• Based on legislation

National Reference Group Actions to date:

1. A Communication Update was issued to all LHO’s outlining the establishment of the National Reference Group and monitoring requirements going forward in relation to status of implementation.

2. Implementation Framework Action Plan developed

3. A ‘snapshot’ Monitoring Template was issued to all residential units to determine status of implementation in each LHO area against the 32 Standards. The monitoring template will be updated in July 2009 to track progress.

   In the interim, the analysis by the National Reference Group of current status of implementation would provide valuable information to guide the National Reference Group to agree a national work plan, which would address specific areas that require additional support either through exchange of information or best practice.

   Secondly, to identify specific standards that could be progressed by a Local Implementation Group and then the outcomes/best practice etc would be populated across all regions in a standard consistent format.

4. Establishment of INTRANET Site

   a. Communication Updates – National Reference Group and Information and Awareness Sessions for Staff
   b. Audit Tools and User Guide were designed and circulated via Regional Leads and INTRANET
   c. National Policies updated on INTRANET e.g. Elder Abuse etc
   d. National Advocacy Update

5. Established links with HSE National Template and Procedure for Developing Policies, Procedures, Guidelines and Templates (PPPGs) (Phase I) and Development of HSE National PPPGs (Phase II). A number of Residential Units have agreed to participate in Phase I.
The HSE is engaging with HIQA concerning the orderly management of the transfer of function and responsibility for inspections to that organisation. Several meetings have been held in relation to the transfer of this function, areas which have been discussed include; protocols for complaints and appeals, protocols for exchange of information, registrations of residential units etc.

The HSE have also engaged in a process which will involve the voluntary transfer of staff from the HSE to HIQA. Sixteen staff are due to transfer from the HSE to HIQA before commencement date of 1st July.

In preparation for the commencement of registration and inspection function, the Social Services Inspectorate has requested information on an ongoing basis from each Residential Care Setting for Older People including: Annual Return for Providers of Designated Centres, etc

In advance of the 1st July 2009, the Office of the Chief Inspector of Social Services (OCISS) has developed methodology, systems, processes and documentation to support the registration and inspection process for designated centres for older people in Ireland in accordance with the Health Act 2007.

As part of the consultation process, and active engagement with stakeholders, the OCISS are undertaking a pilot of the registration and inspection documentation and processes in a number of designated centres for older people.

The overall aims of the pilots are to:

- Road test the registration and inspection documentation and processes.
- Receive feedback on the registration and inspection process.
- Identify and revise any issues prior to commencement of registration and inspection.
- Inform the guide on registration, inspection and the section on “frequently asked questions” for service providers.
- To enhance and ensure consistency in the registration and inspection process.
- To enhance the consultation and engagement process with service providers.

There will be support and guidance from the Social Services Inspectorate staff throughout the process who will meet with staff from the designated centres prior to, or at commencement and at various stages during and after the pilot. Designated centres involved in the piloting process will also inform their residents and staff of the designated centre’s involvement in the pilot process.

Primary Recommendations:

Recommendation 1:
The Department of Health and Children and the HSE must in its policy, as a matter of urgency, clearly and formally articulate its recognition of the complex health and social care needs of older Irish people requiring residential long term care.

Response:
The Department of Health and Children and the HSE have acknowledged the complex health and social care needs of older people requiring long term care whether care be provided in the older person’s home or in a residential care setting. The Government prioritised work in this area and an interdepartmental group of senior officials was established to advise Government on how best to address the wide range of needs involved. This group drew on National and International evidence which confirms the preferred wish of older people is to remain at home as long as possible. Based on the work of this group Government decisions were made to develop a range of responses with substantial investment being provided in the last number of years specifically targeted at services for older people. The Government and social partners together, set out a comprehensive framework of investment and development in the Towards 2016 agreement.

In line with this agreement the focus of the HSE therefore is that;
- Community & Home Based services should keep people in their own communities for as long as possible
- Quality Residential Care should be available when required by older people
- The HSE are working with HIQA which has responsibility for monitoring of services in line with new standards launched in March 2009 - National Quality Standards for Residential Care Settings for Older People in Ireland. The Standards will be underpinned by Regulations set by the Department of Health and Children.

In this context significant progress has been made and continues to be made in relation to the development of community based services for those who are assessed as needing them - Home Care Packages, Home Helps, Day Care Centres and Sheltered Housing. Provision has also been made to expand residential care and a new nursing home support scheme is to be introduced. Progress has also been made in the streamlining of the inspection and registration process in relation to registered nursing homes and residential care generally. Fulltime inspection teams have been appointed and statutory inspections reports are published on the HSE website.

Inspection of Private Registered Nursing Homes
The HSE established a process to develop a standardised approach to nursing home inspections. In November 2006 the CEO of the HSE established a National Task Force to manage all of the issues relating to the inspection of nursing homes pending transfer of the function to HIQA.
This Task Force meets on a fortnightly basis under the chairmanship of the National Director PCCC. The HSE is engaging with HIQA concerning the orderly management of the transfer of function and responsibility for inspections to HIQA.

In the intervening period the HSE is committed to developing a standardised approach to registered nursing homes inspections and subsequent nursing home reports across the system which includes the development of standardised documentation in all HSE Area. Actions to date include:

- A national inspection process has been implemented
- A training programme for Inspection Team members has been rolled out
- Establishment of dedicated nursing home inspection teams is significantly advanced – additional posts approved are in the process of being assigned/appointed.
- Inspection reports are published on the HSE website.

Standards of Care and Quality:
The HSE are working with HIQA which has responsibility for monitoring of services in line with new standards published by the Minister for Health and Children in March 2009 - National Quality Standards for Residential Care Settings for Older People in Ireland. The Standards will be underpinned by Regulations set by the Department of Health and Children.

Service Level Agreements for Contract Beds:
Service Level Agreements are being put in place in relation to “Increased capacity Initiative” in the Dublin area, which clearly specifies the responsibilities of the nursing home and the HSE including arrangements for monitoring and review of patient care and welfare.

National Needs Assessment of Long Stay Care:
In line with the recommendations of the Long-Term Care Working Group and associated Government decisions, the DoHC requested the HSE to undertake an up-to-date needs assessment of residential care services for older people, including respite care beds.

A joint HSE and Prospectus Task Force was established to conduct this piece of work. The first phase involved the preparation by the Task Force of the National Assessment of Need which required the development of a clear and accurate estimate of the Residential Care Needs of Older People throughout Ireland and which was completed on 30th June, 2006.

- The report has been submitted to the Interdepartmental Long Term Care Group to inform their recommendations to Government on the development of long term care.
- The report was used by the DoHC to inform the National Development Plan
- The Report was also used to underpin decisions in relation to prioritisation of additional public and private continuing care bed capacity over 2007/2008.
- The report will inform deliberations of the HSE and the DoHC on the procurement options for long term care going forward.
**National Standardised Care Needs Assessment:**
The HSE established a working group under the PCCC Directorate to seek to develop a national common assessment tool which would underpin a standardised assessment process that can be used by all health care professionals to ensure a co-ordinated approach in the care of the older person.

The HSE has now established a high level group representative of PCCC and the NHO to oversee the implementation of the national standardised care needs assessment process. The HSE Expert Advisory Group (EAG) for Older People under the chair of Dr. Declan Lyons, Consultant Geriatrician, is being involved as part of the implementation process in order to build a system wide consensus across all stakeholders.

The National Standardised Care Needs Assessment will be rolled out on a phased basis to meet the timeline for the implementation of “A Fair Deal – The Nursing Home Care Support Scheme” in 2009.

The Nursing Home Support Scheme Bill 2008 was published on the 9th October 2008. The Minister for Health and Children intends to bring the legislation through the Houses of the Oireachtas as soon as possible. Budget 2009 provided €55 million for the implementation of the Nursing Homes Support Scheme next year. The scheme will be introduced in the context of this funding allocation, once the legislation has been passed and the Act commenced.

**Recommendation 2:**
The provision of this care should be clarified formally in terms of adequate numbers of adequately trained nursing and health care assistant staff, with adequate governance structures in terms of senior nursing staff. The minimum numbers of nursing staff should be calculated using a modern instrument such as the RCN Assessment Tool or the Nursing Needs Assessment Tool, and at least half of nursing staff should have the diploma in Gerontological nursing. A sufficient number of middle and senior grade nursing staff, relative to the size of the nursing home, will be needed to be added to the calculated total to ensure an adequate care infrastructure. Directors of nursing in all long term care facilities should have the Diploma in Gerontological nursing or equivalent. All health care assistants should have FETAC training or equivalent. Appropriate acculturation and gerontological training should be provided for all non-national staff.

**Response:**
- A number of nursing needs assessment tools is available such as the RCN assessment tool. It is important that any tool used, ensures that there is an adequate number of skilled and qualified staff available to ensure that all services are delivered to a high standard; therefore any tool used must incorporate all these factors. The report of the Working Group to Examine Appropriate Systems to Determine Nursing and Midwifery Staffing (DoHC, 2005) concluded that no one system could be adopted across the Irish healthcare system due to its diversity and complexity.
- Numbers of nursing staff in HSE are provided in line with HR WTE control Framework. The private sector is independent.
- A number of educational institutions offer the higher diploma in Gerontological nursing. A total of 86 Nurses qualified with Higher Diploma in Gerontological nursing in 2006 /2007.
- The private sector is now providing the Higher Diploma in Gerontological with support of provider - Health Partners.
- Gerontological Higher Diploma is now a required qualification for Director of Nursing posts in line with HIQA standards.
- The SKILLS project is currently addressing the educational needs of health care assistants in the public sector (appendix 1)
- In Academic Year 2006 – 2007 702 HCAs trained to level 5
- In Academic Year 2007 – 2008, 612 HCAs trained to level 5
- The SKILLS VEC project is currently addressing educational needs of health care assistants in the private sector.

Appropriate acculturation and Gerontological training is provided for all non-national staff in the public and private sector when processed through An Bord Altranais in order to register as a nurse in Ireland.

**Recommendation 3:**
An electronic version of the Minimum Data Set should be made mandatory for all patients in nursing home care to assist in the development of individual care plans, the monitoring of quality and the provision of national statistics on dependency, morbidity and mortality.

**Response:**
The need to have available a standardised set of information in relation to each nursing home resident, is in line with best practice and as outlined in the HSE response in the Leas Cross Review, is a recommendation which is fully supported by the HSE. This topic is now being considered by HIQA in light of the new draft standards for residential care. Any development of a minimum data set needs to be done in consultation with HIQA.

The HSE has now established a high level group representative of PCCC and the NHO to oversee the implementation of the national standardised care needs assessment process. The HSE Expert Advisory Group (EAG) for Older People under the chair of Dr. Declan Lyons, Consultant Geriatrician, is being involved as part of the implementation process in order to build a system wide consensus across all stakeholders.

The National Standardised Care Needs Assessment will be rolled out on a phased basis to meet the timeline for the implementation of “A Fair Deal – The Nursing Home Care Support Scheme” in 2009

**Recommendation 4:**
Funding arrangements for nursing home care should be urgently reviewed by the DoHC and HSE to ensure that it is matched to the provision of high quality care to older people in long term care.
**Response:**
Additional funding has been provided to older persons services in 2007/2008. While the focus of this funding has been on the development of ‘Home Support’ services; including Home Help, Home Care Packages, Day Care and Respite, to assist in maintaining and supporting older persons to remain living in their own homes (as is their wish), monies have also been set aside towards residential care. In this regard, additional funding was provided in 2008, towards the costs of private nursing home care, as an interim measure leading to the implementation of ‘A Fair Deal’. New National Subvention Guidelines issued, to ensure equitable treatment in relation to subvention assessment across the HSE.

**Nursing Home Subvention Scheme**
In December 2006 the Minister announced a new “Nursing Home Care Support Scheme- A Fair Deal” to be in place from 2009. This new scheme will replace:
- The current system of charges for public beds and
- Replace the private nursing home subvention scheme. It will ensure the same level of support for public and private nursing home residents.

As a transition to the new scheme funding has been provided to:
- Fund the increase in basic rate subvention up to €300 per week (maximum)
- Provide extra support for the enhanced subvention scheme

**Dedicated Nursing Home Inspection Teams**
In addition funding has been provided to enable the establishment of Dedicated Nursing Home Inspection Teams. The HSE is working closely with HIQA on arrangements for the smooth transfer of the inspection and registration (of nursing homes) function in line with Government Policy.

**Service Level Agreements**
As outlined in the response to Recommendation 1 above, Service Level Agreements are being put in place in relation to “Increased Capacity Initiative” in the Dublin area and other areas across the country, which clearly specifies the responsibilities of the nursing home and the HSE including arrangements for monitoring and review of patient care and welfare.

Under the Health Act 2007 statutory responsibility is given to the Chief Inspector of Social Services for inspecting and registering all residential centres for older people, including private nursing homes. Once this part of the 2007 Act is commenced, the Chief Inspector will inspect centres against the regulations governing these centres and standards set by HIQA.

**Recommendation 5**
The Nursing Home legislation needs to be urgently updated to put the above provisions into place, to place the older person at the centre of its deliberations, and to adequately guide both provision of quality of care and quality of life, as well as providing timely and appropriate powers to the Social Service Inspectorate to effect change.
Response:
HIQA will take over the registration and inspection function for all nursing homes - private, public and voluntary in 2009, and we will have in place an effective, robust and independent inspection regime for all residential services for older people in place in 2009.

Recommendation 6
Pending the introduction of the Social Services Inspectorate, Nursing Home Inspection teams need to be immediately developed and staffed with relevant expertise to be able to detect poor practice patterns, and vigorously supported by the HSE in their recommendations. All written queries/concerns should have a rapid assessment and written response.

Response:
The HSE established a process to deal with the issues arising in relation to inspection and registration of nursing homes which included the establishment of a National Task Force in November 2006 to manage all of the issues relating to the inspection of nursing homes pending transfer of the function to HIQA. This Task Force meets on a fortnightly basis under the chairmanship of the National Director PCCC. The HSE is engaging with HIQA concerning the orderly management of the transfer of function and responsibility for inspections to HIQA.

In the intervening period the HSE is committed to developing a standardised approach to registered nursing homes inspections and subsequent nursing home reports across the system which includes the development of standardised documentation in all HSE Areas.

Significant progress has been achieved including the following:

- Inspection documentation standardised.
- Nation wide training programme for nursing home inspectors has been completed.
- Publication of nursing home inspection reports on the HSE website.
- Inspection Teams provided with a list of issues (including health and social care issues) to be examined at inspection.
- Standardised registration certificates in use.
- Guidelines in relation to inspection issued to all Inspection Teams.
- All statutory inspections are unannounced.
- Each Nursing Home receives a minimum of two inspections in a twelve month period. Follow up inspections are undertaken to ensure compliance when issues are identified on a previous visit.

In addition to these inspections nursing homes are subjected to unscheduled inspections resulting from complaints or concerns arising in relation to their operation. When necessary, nursing home inspection teams are at liberty to make their inspection at night or at weekends.

The vast majority of nursing homes provide a very high level of care to their residents. As these homes provide varying levels of care to older people from low to high dependency, it is essential that the HSE as the national health authority work
with the nursing home proprietors to regulate the work they do and ensure they provide care that is safe and secure.

The HSE is aware that the inspection process, like all processes, can be improved upon, and therefore continues to work with relevant stakeholders to advance its nursing home inspection function pending the transfer of this function to HIQA.

The HSE has implemented a policy for the management of complaints. The majority of concerns/complaints received in public residential centres (controlled and operated by the HSE) can be dealt with under Part 9 of the Health Act 2007. When a complaint is submitted in writing it must be acknowledged within five working days and investigated within thirty working days. If the complaint/concern is not dealt with appropriately there is a right of review to the Head of Consumer Affairs HSE. Private Nursing Homes are still governed by the Nursing Home Act.

**Recommendation 7**
The Irish Health Services Accreditation Board process for long term care must be radically reviewed to reflect the realities of long term care in Ireland. This would include the determination of not only training but also appropriate numbers of nursing and health care assistants proportionate to the case-mix of residents, as well as congruity with MDS data from the nursing home.

**Response:**
The IHSAB under the auspices of HIQA are engaged in addressing standards in older persons’ care. In March 2009, HIQA published the National Quality Standards for Residential Care Setting for Older People in Ireland. There are 32 standards which aim to promote best practice in residential care settings for older persons and improvements in the quality of life of residents in these settings. The regulations which underpin these standards have been subjected to a Regulatory Impact Assessment, once this has been finalised HIQA will then assume the responsibility to register and inspect the delivery of care in all public, private and voluntary residential care settings for older people in accordance with the new quality standards. Local implementation of the standards is of paramount focus and each residential setting within the HSE has been undertaking work to benchmark their facility against the 32 standards. The HSE have established a National Reference Care Standards Reference Group as forum to address areas of the standards which require a national approach and to offer support to the local health offices.

**Recommendation 8**
For those who are not looked after by the GP who provided their care while at home, the medical cover must be more clearly and unambiguously specified in terms of relevant training (at least the Diploma in Medicine for Elderly or equivalent), responsibilities and support from the HSE.
Response:
A working group between the HSE and the ICGP is proposed to review the role of general practitioner/medical officer in nursing homes with a view to describing best practice and make recommendations regarding the way forward, **addendum to follow.**

**Recommendation 9**
Multi-disciplinary team support must be clearly specified in terms of both meeting need but also the facilitation of team work, and requires at a minimum; physiotherapy, occupational therapy, speech and language therapy, clinical nutrition and social work.

Response:
The unified health service demands that a clear and standardised approach to continuing care placements is a matter of priority. The HSE is developing a model of agreed process which will integrate acute care and continuing residential care of older people in order to provide an equitable and standardised best practice model for the assessment and placement of older people with continuing residential care needs. The model is applicable to all continuing residential care placements whether in the public or private nursing home sectors.

This model recognises many existing examples of good practice around the country and also that gaps do exist which will need to be addressed to facilitate the implementation of the model. PCCC has also developed a “Case Management” model for the governance of the increasing numbers of complex cases being supported at home through Primary and Community services.

The approach to the implementation of Case Management takes account of the development of Primary Care Teams and Networks and provides for an integrated approach to care at client and PCT level cutting across the care groups.

**Recommendation 10**
Specialist medical support (geriatric medicine and psychiatry of old age) need to be developed to provide formal support to the medical officer, nursing staff and therapists not only in the care of patients but also in the development of appropriate care guidelines and therapeutic milieu. These services need protected access to dedicated specialist in-patient facilities for appropriate assessment and support of those in long term care.

Response:
While there is some variation throughout the country depending on resources, access to a geriatrician is mainly through an out-patient clinic in the acute hospital (referral by GP or medical officer). Only a small number of elderly care units have dedicated time or support from a Geriatrician or Psychiatrist of Old Age. It is acknowledged that the existing resource needs to be developed further and that geriatrician led community teams will be a key element of future older persons care. A pilot consultant led outreach team operates from Connolly Hospital, Dublin and has proved a success with nursing home owners and management and has improved the quality of care for residents. There has also been a reduction of re-admissions from private
nursing homes to acute hospitals due to this initiative. The HSE service plan for 2009 proposes to develop 4 of these teams across the 4 HSE Areas.

**Recommendation 11**

Professional bodies with regulatory responsibilities for healthcare workers should clarify the highly specialised needs of older people in residential care in guidance to their members, with particular emphasis on the scope of practice of those who accept senior positions.

**Response:**

Professional bodies with regularity responsibility would need to respond directly to this recommendation.

**Recommendation 12**

The public health overview of residential care must be strengthened. The HSE must coordinate data nationwide, not only on the MDS of all residents of long term care but also of all deaths of residents, including those that occur in hospital, and should also ensure seamless communication with coroners throughout the country.

**Response:**

The HSE is making progress in the area of developing a means by which patients who use health services can be tracked. There is at present no unique identifier within the health care system and the HSE has therefore progressed, as part of the transformation process, a national client index project. Such a project is required to ensure that patients can be identified and tracked as they move between care settings. Given that there is at present no unique identifier for patients, and even if that should change, the national client index and related projects will continue to be required to ensure accurate identification of patients. For instance, many nursing home patients do not die in the nursing home itself, but are often transferred to hospital. It is not possible using current information systems to determine which nursing home such patients are admitted from, which adds to the difficulty of monitoring trends.

The Health Intelligence Unit in the HSE has begun work in hospitals which may in the future have the potential to be used in nursing homes – this is a statistical modelling process that looks at death rates adjusted for case mix and other variables such as age and sex. Such techniques have the potential to allow identification of hospitals where rates may be outside expected rates. However these techniques cannot at present be applied to nursing homes.

**Local Recommendations:**

**Recommendation 1**

As the review did not replace standard complaints and redress procedures of the NAHB/HSE (NA), the HSE (NA) must ensure that it provides a timely and appropriately supported service to address the concerns of older people and their relatives about the quality of care that they or their loved ones may have received, or are receiving in long term care in the HSE Northern Area.
**Response:**

In January 2007 The Forum on Services for Older People in Residential Care was established under the Task Force on Nursing Homes. It was lead by the Consumer Affairs Division/ Office of the CEO HSE. Membership of the Forum was comprised of statutory, non-statutory and private providers of long stay care for older people, advocacy groups were represented in addition to nursing and other clinical staff. There was strong representation from older persons’ services in the HSE.

The objectives of the Forum were to:

- Enable older people and their families to become active consumers of health services
- Offer consumer based advice and comment on older people’s health services.

The Forum recommended a programme of work and prioritised the following:

- **Advocacy**
- **Information**
- **Training and education of staff in residential units for older people.**

These are consistent with the HIQA standards for residential care. The section of the Standards dealing with rights includes the requirement for provision of information and the development of a National Advocacy Programme.

This Forum has brought a strengthened collaboration between public and private sectors and an opportunity to share practices and attributes which ultimately benefit the residents. The projects initiated have now been part-funded by the HSNPF and funding has also been provided by the innovation fund. It is anticipated that in the longer term and when evaluated that these initiatives will be integrated into all Primary, Community and Continuing Care areas.

The HSE has implemented a policy for the management of complaints in response to Recommendation 6, “that all written queries/concerns should have a rapid assessment and written response” The majority of concerns /complaints received in public residential centres (operated and controlled by the HSE) can be dealt with under Part 9 of the Health Act 2007 When a complaint is submitted in writing it must be acknowledged within five working days and investigated within thirty working days. If the complaint/concern is not dealt with appropriately there is a right of review to the Head of Consumer Affairs HSE. Private Nursing Homes are still governed by the Nursing Home Act.

The HSE invited all individuals and families who had relatives who died in Leas Cross to meet individually with senior members of staff of the HSE in 2007. All families who requested meetings were met.

Families who requested a review of their previous formal complaint were offered review by Mr Michael Brophy BL Former Senior Investigator Office of the Ombudsman. On legal advice this process was terminated on the commencement of the Commission of Investigation.
Recommendation 2
Residents (and their families) of any nursing homes that scored poorly in the ERHA tendering process in 2005 for Heavy Dependency/Intermediate Care Beds should be informed of this as a matter of some urgency, as there is a high likelihood that there are residents with high or maximum dependency in all of these nursing homes.

Response:
The tendering process for Heavy Dependency/Intermittent Care Beds was carried out based on specific criteria focussed on the needs of these patient groups i.e. availability of Allied Health Professionals/multi-disciplinary teams in the nursing homes, and only homes who could provide for patients with complex needs were awarded these contracts. Not all patients entering nursing homes have these complex needs. A ‘risk assessment’ has been carried out on all of the unsuccessful tenders, and they have also been subject to a statutory inspection at least once every 6 months, and the HSE is satisfied that there is no risk to current residents in these homes.

5. Any other actions undertaken by the HSE.

(1) Protected Disclosures of Information:
Section 103 of the Health Act 2007, which came into operation on 1st March 2009, provides for the making of protected disclosures by health service employees. If an employee reports a workplace concern in good faith and on reasonable grounds in accordance with the procedures outlined in the legislation it will be treated as a “protected disclosure”. This means that if an employee feels that they have been subjected to detrimental treatment in relation to any aspect of their employment as a result of reporting their concern they may seek redress. In addition, employees are not liable for damages as a consequence of making a protected disclosure.

The HSE has appointed an “Authorised Person” to whom protected disclosures may be made. The Authorised Person will investigate the subject matter of the disclosure.

(2) Quality and Risk Management Standard (November 2007):
This document describes the standard to be used as part of the implementation of an integrated quality and risk management framework across the HSE. Effective risk management underpins healthcare quality management activity and can result in:
- Better patient care.
- Improved public perception and confidence.
- Reduction in errors.
- Reduction in staff turnover.
- Fewer complaints.
- Improved reputation.
- A more open culture.
A more proactive approach to managing risk.
Systematic identification of organisational weaknesses.
Improved communication with stakeholders.
Improved performance and effectiveness.
Reduced likelihood of unexpected events.
Better decision making at all levels.
Improved project management.
Better outcomes.
Better resource planning and utilisation.
Compliance with legislation.
Greater rationality and transparency in decision making.
Protection of public funds.
Assurance to Risk and Audit Committees and thereby assurance to the HSE Board and all stakeholders and the public.

This document outlines the components of this standard comprising a ‘statement of standard’ together with supporting ‘criteria’ and brief ‘guidance’. Each criterion reflects the elements of a higher level management model describing a ‘system of internal control’ for a healthcare organisation, the risk management aspects of which conform to the requirements of the Australian/New Zealand risk management standard AS/NZS 4360:2004, which has been formally adopted as the process for managing risk in the HSE.

Examples of verification for the criterion for Proactive Risk Management Process:

- Risk management/governance strategy.
- Risk identification tools.
- Hazard reporting policy and forms.
- Risk assessment tools and forms.
- Completed risk assessments.
- Risk treatment options.
- Evidence of risk treatment.
- Business plans.
- Annual report.
- Risk registers.
- Minutes of committees.
- Job descriptions.
- Training programmes.
- Action plans.
- Evidence of communication with stakeholders.
- Evidence of communication with staff.
- Monitoring and review procedure.
- Performance indicators.
- Evidence of monitoring and review.
- Management minutes.
- Patient surveys.
- Incident, complaints and claims analysis.
• Evidence of prominent placement of risk management on management team agendas.
• Board Risk Committee.

(3) Nursing Home Database in HSE Dublin North East:
The HSE DNE has developed a database which contains all relevant information on nursing homes in DNE e.g. complaints, inspection reports etc.