

Response C

On the establishment of the Northern Area Health Board (NAHB) on March 1st 2000, I was appointed Assistant Chief Executive Operations for all service areas except James Connolly Memorial Hospital, with Planning and Evaluation being carried out by an Assistant Chief Executive colleague.

Hospital and community managers would have had their delegated authority; this would include the responsibility of the General Manager for the registration and inspection of nursing homes in his/her particular area, as well as the investigation of complaints.

Over time an Assistant Chief Executive was appointed with responsibility for Childcare; later, following a review of service planning and delivery, the planning and operations function were merged at which stage the Addiction Service was transferred from my portfolio to the Assistant Chief Executive with responsibility for Childcare.

In November 2003 I was appointed Deputy Chief Executive when the Community and Primary Care Services were transferred to a colleague Assistant Chief Executive - as this person worked 4/5 I had responsibility for her service for 1/5.

The Chief Officer transferred to the HSE Corporate in January 2005, when I was appointed Chief Officer. I held this post until June 30th when the new HSE administration function took over. As it took some time for the new managers to take over their portfolios, I continued to manage/hand over areas of service where appropriate, completed the due diligence work in relation to handover, and in particular dealt with the process of transferring patients from Leas Cross Private Nursing Home to other homes leading to the closure of the Home.

GENERAL CONCLUSIONS

I have difficulty in responding to the comments in the report highlighted by BCM Hanby Wallace in isolation from the main report and the recommendations arising from the report.

I engaged Professor O'Neill to carry out this work; we discussed the broad parameters of the report; Professor O'Neill drafted the terms of reference which I agreed. This was to be a desk top exercise in the main relating to the medical/nursing notes at Leas Cross.

Professor O'Neill's expectation was of a project of three months duration and he generously made himself available - the CEO of Tallaght Hospital was fully supportive on the basis that the HSE NA funded the locum costs.

I was involved in background support to Professor O'Neill (before my retirement) for a month or so, particularly in organising access to files in Leas Cross, office accommodation, admin and IT support. On retiring, I advised Professor O'Neill that I would be available, if required, to provide information or discuss issues of concern - I considered this important due to the number of senior staff who had left the services at transition. particularly,
and myself personally. Professor O'Neill did not contact me.

From my perusal of the information provided, it appears that Professor O'Neill has moved beyond the terms of reference to highlight his perception of system failure at health board level through a limited desk top exercise. Likewise, due process was not exercised in as much as conclusions appear to have been drawn in some instances from informal communication or access to senior management files. In particular I would have expected a more formal process where he would have provided me with copies of any correspondence and other relevant information, including notes of meetings, for my views before drawing conclusions.

Professor O'Neill could have had concerns that there was perceived system failure from a macro perspective in overall health management in relation to services for older persons and service arrangements with the management of Leas Cross Private Nursing Home. If so, it would have been appropriate for him to consult with HSE Management with a view to having his terms of reference extended and to broaden the membership of the investigation team in line with *Trust in Care*, particularly to include an independent senior manager with relevant experience in health service management.

The main focus in the terms of reference in relation to the deaths of patients in Leas Cross Private Nursing Home relates to a review of the medical and nursing notes of patients who received care in Leas Cross.

I have no difficulty with Professor O'Neill's findings in relation to the level of patient care at Leas Cross.

It is now clear that the standards of care at Leas Cross Private Nursing Home fell short of expectations and best practice.

Professor O'Neill's report does not reflect the context and climate in which we were operating at that time. I do have difficulty in how he approached his task from a micro perspective and also in relation to:

- *Correspondence to ERHA, NAHB, HSE NA, HSE and Department of Health and Children regarding concerns over Leas Cross*
- *Nursing home inspection reports*
- *Other relevant documents*

and conclusions reached in relation to the NAHB's service relationship with Leas Cross and in delivering services for older persons in general. It is important that these matters are reviewed in a macro perspective as services for older persons were an integral component of the NAHB's statutory obligation in the delivery of health and social services across all care groups.

I have concerns on the shortcomings in Professor O'Neill's report from a procedural point of view. As an overriding comment, his report fails to apportion due weight to the statutory obligations imposed on the proprietor and the referring agencies by the Nursing Home Regulations.

Professor O'Neill does not apportion due weight on the professional responsibilities of the medical and nursing staff.

He has criticised the inspection process without appreciating that the new process was innovative and was in the course of implementation over a number of months before the events in Leas Cross took place.

He has criticised NAHB management of not appreciating concerns raised in relation to care issues in private nursing homes. In establishing a dedicated Nursing Home Inspectorate Team and revised complaints procedures NAHB management dealt with those concerns. NAHB management were satisfied that they had put a robust system in place that could adequately deal with issues arising in the course of inspection.

I am concerned that Professor O'Neill did not make reference in his report as to whether management at Leas Cross and in particular the clinicians, had adequate and appropriate access to the acute hospitals in relation to diagnostic services; A & E; outpatients and acute in-patient care in a timely manner.

I will deal with contextual issues in Part I and respond to points from the Executive Summary as relevant in Part II.

PART I

The NAHB took over responsibility in March 2000 for the delivery of health and social services Dublin City (north of the Liffey) and Fingal, following the dissolution of the EHB and the establishment of ERHA and the three Area Health Boards. The immediate task of the CEO, involved the recruitment of a management team and support staff and formalising reporting/accountability procedures with the Board, with ERHA, and the Minister for Health and Children. In this context a seamless takeover of services was expected from a public and political perspective.

It is important to highlight that the NAHB was statutorily obliged to deliver services in line with health legislation (particularly the Health Acts 70, 96 & 99) in the context of operating within the financial allocation (annual) with no discretion to raise funds and within the approved staff ceiling number.

As can be appreciated, the rationalisation of services between the three Boards (NAHB, SWAHB, ECAHB) after March 2000 was quite a difficult task and was not fully complete by 2005 with the NAHB continuing to have responsibility for major services across the three Areas - community welfare, adult homeless, asylum seekers, domestic violence, psychology, mental health – special care services.

The CEO adopted an inclusive management approach holding regular meetings with the main agencies and staff groups e.g. monthly meetings with management of Mater and Beaumont Hospitals; Fingal County and Dublin City Councils, Geriatricians and Psychiatrists in the Psychiatry of Old Age. Regular meetings were held with the Consultants in Connolly Hospital and the Psychiatrists in the four service areas.

A major development programme was undertaken with the General Practitioners which led to the establishment of GP Partnership (with management support provided) and a management framework established between the GP Partnerships as appropriate and their local hospital - Mater, Beaumont and Connolly Hospitals. This facilitated good communication, improved access to services and a more effective use of resources. During the lifetime of the NAHB there was mutual trust and respect between the CEO and management team with Consultants and General Practitioners in all service areas.

By 2002 the population in the NAHB area had increased to 486,305 - an increase of 6.9% on the 96 census - the accelerating population increase was evident throughout the area - this was confirmed by the preliminary 2005 census figures with a population increase of 22% highlighted for Fingal.

The NAHB had areas of significant deprivation - 6 designated RAPID Areas as against 23 nationally - e.g.

- The community welfare budget for Dublin 15 equated to the community welfare budgets for the MHB or ECAHB.

- The number of asylum seekers and non nationals settling in the area continued to grow rapidly e.g. in 2004, 2,400 clients (ethnic minorities with 60 different languages) were availing of services in Roselawn Health Centre; 65% of those in receipt of rent supplement in Dublin 15 were non nationals.
- High prevalence of substance misuse.

The NAHB was allocated 35% approx. of the EHB budget in line with population overall rather than morbidity without any allowance for social deprivation. The NAHB was further compromised by a significant budget deficit in Connolly Hospital and 132 beds closed in St. Mary's Hospital due to recruiting difficulties. With the introduction of overseas nursing and care staff, the beds in St. Mary's were recommissioned (increasing the budget deficit) and in addition the new community unit in Lusk was fully commissioned bringing on stream a further 50 beds for older persons.

Most of the NAHB's hospital and community facilities were aged, of poor design and unsuitable for modern health service delivery - particularly St. Mary's, St. Ita's, St. Brendan's and Connolly Hospitals, and Verville Retreat (a private nursing home - limited company - taken over by the NAHB, and continued to operate as a limited company). The NAHB undertook the 1st phase of the redevelopment of Connolly Hospital €70m and continued the deinstitutionalisation programme at St. Brendan's and St. Ita's - part of this programme involved the assessment and transfer of a significant number of older persons with psychiatric disorders (and persons with intellectual disability) from St. Brendan's and St. Ita's to private nursing homes, the closure of Verville Retreat and the transfer of its residents to a private nursing home.

It is important to highlight that the number of public nursing home beds in the Northern Area was 480; as of December 2004, 913 beds (576 subvented and 337 contract) were funded in private nursing homes with the number of private nursing homes in the NAHB area increasing from 24 to 31. Due to the low level of public beds in Dublin, the concept of a contract bed (fully funded) in a private nursing home was introduced by the EHB in the early 90s - this gave a level of flexibility in service provision, particularly for patients with high dependency; the scheme was phased out by ERHA in 2003.

Public bed provision in the NAHB was totally out of line with provision nationally e.g. the NAHB would require 2,670 public beds on a population basis to equate with the public bed provision in the NWHB or 1,599 to equate with the public bed provision in the WHB.

The enhanced subvention (maximum) payment was €680 per week (less client's contribution) whilst the 2006 cost of a public bed in Lusk Community Unit was €1,300 (excluding capital depreciation). The subvention rates were fixed by the DOH&C; the NAHB had no discretion in this regard and was obliged to phase out contract beds in line with ERHA policy and directive in 2003.

Minister Martin and the DOH&C agreed to the provision of an additional 450 public nursing home beds in Dublin; with 150 allocated to the NAHB area (3 x 50 beds). These units were to be developed as a Public Private Partnership project. Senior staff from the NAHB worked proactively in developing the brief for these units -

regrettably, this proposal was not pursued to the development stage due to contractual/funding/operational difficulties.

The low level of public nursing home beds in the NAHB's area was an ongoing concern of the clinicians (Geriatricians, Psychiatrists in the Psychiatry of Old Age) and particularly beds to meet the needs of high dependent patients and patients requiring rehabilitation programmes. This issue was continuously raised at NAHB level by the Board Member who represented the acute hospitals. There was unanimity by the CEO, Management Team, and clinicians that the Minister's proposals in relation to the PPPs would go some way towards alleviating the problem and that over time progress would be made on the residential projects agreed by the NAHB.

NAHB management worked proactively over the years on proposals to increase and enhance bed capacity for older persons in the area. Proposals adopted by the NAHB and submitted to ERHA are set out in Appendix 1.

Notwithstanding the low level of public beds in the NAHB; the outdated and inadequate facilities in St. Mary's; the ongoing pressures on the A & E services, community services generally, and services for older persons in particular, none of these projects were progressed by ERHA. Likewise, NAHB management did not have a formal reply to these proposals as submitted.

From the outset there was ongoing pressure on the three A & E Units in the acute hospitals and significant numbers of acute beds blocked by older persons who had completed their acute state of treatment. The situation in each hospital was kept under review at the monthly inter-management meetings NAHB/Hospital and at the monthly meetings with the Geriatricians/Psychiatrists in Psychiatry of Old Age:

- To effect maximum usage of nursing home beds (public and private) the NAHB developed a Bed Management System (including equitable division of beds x community/hospital). Representatives from Beaumont and Mater Hospitals and the Consultants worked proactively on this project. The baseline for the system was a combined hospital/community waiting list which facilitated equity of access and placement.

The monthly management meetings with Mater and Beaumont Hospitals; Geriatricians and Psychiatrists in the Psychiatry of Old Age; GP Partnerships; were very constructive and led directly/indirectly to the development of innovative ways to improve services for older persons, particularly in the community - Appendix 2.

I have already referred to the finite budget allocated to the NAHB on establishment and service pressures. In 2002 the DOH&C introduced the Government Programme of Service Readjustment - this Programme continued through 2003 and 2004 with the main impact occurring in 2003 where overall expenditure had to be reduced by 6% by the NAHB so that the Board could remain within overall funding available. A requirement of the Programme was that service agencies would continue to provide ELS (existing level of services). The Service Plan was agreed by the NAHB and the associated Provider Plan signed off by ERHA.

Extract from NAHB Provider Plan 2003
Chief Executive's Introduction

Our Board is aware that we are facing an extremely challenging year, in particular due to:

- *The impact of continuing deficits in a number of service areas.*
- *Increased demand for services and continually rising expectation levels among clients.*
- *Increased activity levels provided without specific funding.*
- *The limited level of additional funding in 2003 for new service developments.*
- *The long-term effects of inadequate capital funding to facilitate planned maintenance.*
- *Continued erosion over a number of years of our non-pay allocation by price inflation.*
- *Increased costs of technological advances, most notably in the acute hospital sector.*

.....
Monitoring

The financial position will be monitored on a monthly basis and performance measured against targets and cost containment initiatives. The financial plan and service targets will be reviewed and amended as necessary to comply with our Board's statutory obligation to provide services within the allocation available and the ERHA will be kept advised in this regard. As in previous years, our Board will be seeking the flexibility afforded to us by the Eastern Regional Health Authority in the application of all available funding including new service development funding to meeting our statutory obligations of responding to service needs whilst operating within our approved allocation.

This programme also involved a reduction in staff ceiling in those 3 years; the main impact related to 2003 when a staff ceiling adjustment downwards of x 3% (196 posts) was required. As core funding related to an historical base and as no allowance was made for the major population increase and pressures on service delivery arising from the cultural mix in the population, language barriers, etc., the concept of service delivery at ELS level was aspirational across all services.

The programme did not take account of posts filled by agency and overtime due to recruitment difficulties, nor did it take account of unfilled approved development posts 292.6 and services transferred to the NAHB (e.g. St. Joseph's Hospital) 150 posts.

This of necessity was a major challenge for all concerned - Board Members, management and staff - however, by year end the NAHB had met its target.

From an operational perspective, staff at all levels were experiencing consistent service pressures and as a consequence senior management had the additional task of meeting and supporting local management and their staff in their strained situations e.g.: -

- Wait list for out-patient psychiatric appointment in Dublin 15 grew to six months.
- Due to staff pressures and lack of clinical space in Balbriggan Health Centre, service users in nominated DEDs in Balbriggan were required to travel to an inner city clinic to avail of services.
- Children's Audiology Assessment Clinic, traditionally staffed by AMO/PHN, reverted to staffing x 2 PHNs and later to staffing by PHN assisted by care staff.
- Post natal domiciliary home assessment visits in Dublin West could not be provided - mother and baby expected to visit local clinic.

Likewise, whilst ERHA was in a position to provide funding for the further roll out of Home Care Packages and the further development of the Home First Programme, the NAHB could not further develop these projects from a quality, health and safety, and governance perspective, as approval could not be given for professional staff to support these programmes.

Recruitment and retention of staff across all professions posed a problem for all service providers in Dublin; this was further exasperated by the pull to the West for a variety of reasons, particularly financial, quality of life, etc.. All services in the NAHB had major problems, which were overcome as far as practicable by assigning staff on overtime, employment of agency staff, and the recruitment of overseas staff.

Community services had particular problems due to:

- Lack of continuity in service provision.
- Loss of local knowledge and networking skills.
- Commitment of professional staff to service for short period and move to alternative deployment.
- Depletion of staff numbers in key professions, e.g. Area Medical Officers.
- Inadequate numbers of General Practitioners practicing in the area with associated recruitment and retention difficulties (Ref: Review of General Practice – Manpower Needs Recruitment Retention - NAHB).

Dedicated services for older persons had problems similar to those experienced in the community - these problems were further exacerbated by language and cultural difficulties with the number of overseas staff deployed.

In 2003 the CEO and Management Team were concerned regarding their ability to meet the requirements of the inspection process under the Nursing Home Regulations, due to:

- recruitment/retention difficulties as highlighted
- service pressure on staff and competing clinical priorities
- the increase in the number of private nursing homes in the area and the overall size of some homes, e.g. Leas Cross 100+ beds.

In 2003 there were 25 private nursing homes in the NAHB area:

- 1 in CCA6
- 9 in CCA7
- 15 in CCA8

The number of homes increased to 30 in 05 with an overall bed capacity of 1,700. In addition 124 patients were subvented in private nursing homes outside the NAHB, mainly in Co. Meath. This represents a ratio of available public to private beds of 20% to 80%.

Effective regulations on inspection of nursing homes is essential if residents and their families are to have confidence that the care they receive will be competent and safe.

The Nursing Home Regulations specify that inspections of nursing homes are carried out by officers designated by the Chief Executive/Deputy Chief Executive of a health board. Traditionally, the designated officers were Director of Public Health Nursing (DPHN)/Assistant Director and Senior Area Medical Officer (SAMO)/Area Medical Officer (AMO). Environmental Health Officers (EHOs) were also designated to inspect nursing homes from an environmental/food safety perspective - in some boards the EHO was a member of the core inspection team.

This in effect meant that the SAMO/DPHN carried out nursing home inspections as part of their day-to-day duties. The inspection process dealt, in the main, with environmental and regulatory issues set out in the Regulations.

The Nursing Home Section (EHB) was based in Dr. Steevens' Hospital and was managed by the Programme Manager for Acute Hospitals. This section also dealt with complaints.

The NAHB established a dedicated Nursing Home Section in temporary accommodation (in September 2001) and transferred files as appropriate from Dr. Steevens' Hospital - the Unit moved to a permanent location in St. Mary's Hospital in September 2003. This unit:

- manages the nursing home budget;
- assesses clients and families for subvention.
- interfaces with nursing home proprietor and person in charge as appropriate.
- retains files on all clients, including complaints.
- monitors registration.

Nursing home inspections were carried out by the Director of Nursing (or Assistant) / SAMO (or Assistant) team in each of the ten Community Care Areas. Complaints were in general made to the Nursing Home Section and were referred to the Director of Nursing for investigation (this could also involve the SAMO).

Whilst the three Area Health Boards took over the management and delivery of services in their areas from March 2000, services were in the process of transition over time whilst the transition of some services was not effected during the lifetime of the three Boards.

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. Arising from concerns, as highlighted, management decided to put in place a dedicated Nursing Home Inspection Team led by a Director of Nursing with proven management experience - Appendix 3. The team was based at St. Mary's Hospital when established.

This in effect meant the Inspection Team worked alongside the Nursing Home Section which dealt with individual contracts, assessment of eligibility, approval of subventions, payment of fees to nursing homes, etc..

A database for nursing homes, including all information relevant to inspections, was set up. The inspection process heretofore spent significant time in checking environmental issues (insurance certs; fire certs; status and qualifications of person in charge; pin numbers for nurses; complaints background) - quite often relevant information was not available and follow up required. The purpose of the database was that all such information would be supplied in a timely fashion and on hand with the Inspection Team when making their inspection visit thus allowing the team more time to review standards of care, etc..

The Inspection Team was aware that the review of complaints (2) was ongoing between a HSE NA's review group and Leas Cross; the first formal inspection of Leas Cross by the new team took place on 7th/8th April 2005 when the above work was complete.

This was done to ensure that teams were not overlapping and that the outcome of the review on complaints would be available to the Inspection Team when it made its first visit (including its meeting with the proprietor).

Following a review of all the nursing homes in May 2005, *it was noted that six nursing homes, including Leas Cross, needed attention and a "red flag" alert system was put in place, including a cap on bed numbers.* The six nursing homes *red flagged* were subject to ongoing input/support and review so as to bring them up to an acceptable standard.

A programme of follow up visits was put in place to all of those homes. The Inspectorate was satisfied that improvements continued to be made on an incremental basis with the homes over time meeting the requirements as set out. One home had met most of the requirements of the Inspectorate with some work yet to be done.

Whilst a schedule of improvements in staffing and care requirements had been agreed with the proprietor of Leas Cross and a follow up enforcement programme was in place, the programme was overtaken by events which led to the transfer of residents from Leas Cross to other homes and its eventual closure. During the period when transfers were taking place a further inspection of the home took place.

Reasonable periods of time were afforded to the nursing homes to update policies/procedures, infrastructure, etc., with areas that required immediate attention also specified.

From a service perspective the development of the new Inspectorate facilitated:

- A uniform approach to inspection with a dedicated team appropriately trained.
- The team dealt initially with the proprietor of the home, which meant that the team had an opportunity to review and agree with the proprietor his/her statutory responsibilities and also to achieve buy in and agreement with the new inspection templates.
- A data system was put in place to facilitate collection of relevant certificates.
- Programmed follow up visits to pursue areas noted for concern until identified service requirements/improvements were fully met.
- A new complaints management policy was put in place which included a complaints register and training programme for staff panelled to investigate complaints.

This was a major improvement in the system in operation and as set out in the Nursing Home Regulations.

A schedule of work (inspection dates) was established for the Inspection Team so as to maximise the use of the medical resource available to the team. This schedule ensured that all nursing homes within the area would have a minimum of one full inspection within the first six months of 2005.

On the first visit of the new team it was team policy to engage proactively with the person in charge and the proprietor of the nursing homes in order to;

- introduce the new team
- develop a good working relationship
- outline the revised procedures for inspections and communications, thus ensuring a comprehensive uniform transparent inspection process, including the sending of a formal report, following each inspection, to the proprietor advising on the outcome of the inspection and issues for attention, where appropriate.

A pre-planned announced visit to each nursing home was set up (all further visits to be unannounced) and there was positive engagement by nursing home personnel in the main for the new arrangements.

The new template/checklist devised by the multi-disciplinary team was forwarded to each nursing home in early May; the start date set for introduction was 1st June 2005. The new system had widespread support as it gave the nursing homes an overview of the inspection process. It afforded the proprietor an opportunity to respond and to rectify areas that required attention.

The time allocated for the inspection of a nursing home was a minimum of one full day for a home with less than 50 beds and two days for homes 50 beds +. The team operated through individual member *tasks* to ensure efficient use of time and a comprehensive review.

A steering group to oversee the operation of the Nursing Home Inspectorate was established on 6th April 2005 and included the Principal Medical Officer.

A new complaints management policy in respect of nursing homes was devised with a central database developed in the Nursing Home Section. All complaints were logged and an acknowledgement sent to the complainant on receipt of same. It was then sent to the relevant Community Care Area HQ for investigation by the relevant personnel in the Area.

A two day training course was undertaken by _____ (September 2005) for staff who would be involved in review of complaints in relation to care at nursing homes. This training module involved setting out the framework for complaints review and the process to be followed in the review. In line with the new policy all reports are submitted to the Director of Nursing of the Inspection Team and quality assured. Thereafter the Director sends formal response to the complainant. The Director has advised that the quality of review reports had improved immeasurably.

The Director and team were concerned that the team should be enhanced with a broader multi-disciplinary input (when considered necessary) as well as senior clinicians' involvement. The Geriatricians had agreed to participate as well as to the involvement of Senior Registrars. Following consultation, a broad multi-disciplinary group saw their involvement as highly appropriate in relation to inspections and their interest and commitment to ensuring a quality of care in the services generally.

A facilitation programme was delivered by Mr. John O'Hehir, Change Management and HR Consultant, on September 1st 2005, to the Inspection Team and a multi-disciplinary group of professionals (including Consultant Geriatrician, Senior Registrar, Nurse Practice Development, Occupational Therapist, Physiotherapist, Dietician, Environmental Health Officer, Social Worker, Directors of Nursing in Public Community Units, Directors of Public Health Nursing) with follow up programme - November 10th 2005.

This development meant that a member(s), as appropriate, from the multi-disciplinary group would be available to the Inspection Team for advice and support and join the Inspection Team, as required, on inspections where their particular expertise was considered necessary.

NAHB management and management of the Mater and Beaumont Hospitals were concerned that a total system approach would be taken in responding to the Tánaiste's announcement of funding to improve the A & E Service in late 2004 and earlier proposals were submitted to ERHA - Appendix 4.

No consideration was given to those proposals by ERHA. The DOH&C and ERHA advertised publicly for intermediate care and high dependency beds. This project was handled centrally by ERHA, which included developing specifications and assessing the proposals from the private nursing homes, which involved site visits, awarding contracts and follow up of patients transferred.

It is important to highlight that:

- one home was approved by ERHA for this scheme, notwithstanding the fact that it had been *red flagged* by the NAHB Nursing Home Inspectorate Team in relation to the standards of care provided, as well as having admission of patients curtailed.

It is my understanding that a number of homes selected for this programme have not been able to meet the care requirements specified and that their contracts have ceased.

Since 2005 the DOH&C and the HSE have been very proactive in dealing with the crisis in the A & E Units and access to beds in the acute hospitals in the Eastern Region, which has been highly politicised and has been the subject of ongoing media attention, with an allocation in excess of €15m to fund: -

- 255 Beds in Private Nursing Homes
- 201 Home Care Packages

as well as €1.5m to further develop home help services. The decision by ERHA to phase out the use of contract beds in private nursing homes was rescinded.

I understand that plans are being finalised to extend this programme in 2006, as well as the fast tracking of a significant number of extra public beds, with innovative ways being considered to achieve same. These developments will go a long way in redressing the deficits in the HSE Dublin North East (North Dublin) area in relation to continuing care places for older persons as well as community supports, particularly Home Care Packages and home help.

In conclusion, it should be noted that strategic planning in relation to the phasing out of the health boards, and the planning of the HSE management structure and support systems, commenced in early 2004. A member of the Management Team was seconded to the project, whilst the CEO and other members of the Management Team also had substantial commitments to the project, as well as putting in place an effective communication process with Board staff in relation to the change agenda, etc..

PART II - EXECUTIVE SUMMARY

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The document was consistentinsight or capability to effect meaningful change.

- (i) Professor O'Neill's conclusions are incorrect, they do not reflect the active steps taken by senior management, including the appointment of the dedicated Nursing Home Inspection Team and development of the inspection templates and revised complaints procedure.
- (ii) An important aspect of the new protocols followed by the Inspection Team (from September 2004) was that the proprietor of each home would be met. This was not standard practice. This was considered a particularly important protocol in the new inspection programme as the proprietor was the person charged with statutory responsibility. The record in effecting change by the Inspection Team to other homes, which were seen to have problems similar to those experienced in Leas Cross, clearly shows how a sustained programme for change could be effected with the proprietor, however unwilling for change he was at the outset. This was the first time the proprietor of Leas Cross was challenged regarding the need for improved standards of care and additional staffing. The inspection was followed up by a formal report on the outcome and a follow up four weeks later. We cannot speculate on how the process could have developed.

Management's views in relation to the further development of the Nursing Home Inspectorate were subject to informal discussions with clinicians as opportunities presented.

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There is no record of senior management in the HSE (NA) appearing to give due weight to written concerns from senior clinicians about standards of care.

This matter is referred to later in the report - pages 41 and 48. I will deal with all three references simultaneously.

Page 15

The documentation was consistent with a deficiency in the regulatory process of the Health Board/HSE (NA)

I disagree with this statement. The NAHB took over the management of the health and social services in its administrative area in March 2000 and took on the transition of services from the EHB systems. The budgetary, staffing, and service constraints affecting the NAHB were highlighted earlier in the report, as well as the way services in the NAHB were compromised in 2002, 2003, 2004 by the service readjustment programme and its ability to meet ELS (existing level of service) as specified by the Department. Notwithstanding the service pressures, as highlighted, NAHB

management took the necessary steps and set up a dedicated Nursing Home Inspection Team.

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... and in its assessment that the proprietor and senior clinical management at Leas Cross had the insight or capability to effect meaningful change.

I disagree with those comments. As stated earlier it was not the custom to meet the proprietor during nursing home inspections - the NAHB introduced this change when the new inspection process was established.

The Director and his team had met with the proprietors on 7th/8th April 2005. In my dealings with the Director afterwards I am satisfied that he clearly understood the challenge he faced in ensuring that the necessary change/development, as identified, would be brought about by the management of Leas Cross.

The Director and his team had dealt effectively with the proprietors and senior management in other homes where matters of concern to the NAHB in relation to standard of care, facilities, and staffing had been noted. These concerns were somewhat similar to those which had presented at Leas Cross. In dealing with those homes, the Director had the ongoing support of NAHB management. This support would have been taken as a "given" in relation to Leas Cross by the Director and his team.

Page 16

In Leas Cross, the median time to death of those who died was 221.7 (7.3 months)Director of St. Ita's Hospital.

I have no record of concerns as highlighted. It is management's understanding that the patients assessed and referred to Leas Cross were the more high dependent patients in Reilly's Hill - referred to by Consultant A in her letter to the CEO "we have had a lot of turnover which has been due to patient deaths especially in those who were frail as a result of end stage dementia". - Statistics on mortality amongst the Reilly's Hill patients (St. Ita's) 2000 - 2003 show mortality rates ranging from 20% - 25% per annum.

On page 26 Professor O'Neill raises issues regarding the qualifications of the Nurse in Charge - this was a problem - this matter has and is causing problems in various nursing homes in north Dublin and possibly elsewhere.

The comments made regarding nurses with higher training in gerantological nursing are aspirational - I feel it would be a worthwhile project for the manpower experts in the HSE to carry out a study of nurse staffing in public and private nursing homes nationally to ascertain the ratio of nurses in the services with higher training in gerantological nursing.

With regard to evidence of a specific acculturation programme for overseas nurses, as indicated, it is noted that An Bord Altranais had dropped this requirement.

Page 27 - promoting FETAC training for care assistants ... - A pilot FETAC training course took place in St. Mary's Hospital in 2003. Similar training programmes took place in St. Ita's - psychiatry and intellectual disability - pilot sites. The roll out and extension of these programmes will generate a core of suitably trained care staff over time.

Page 27 - Therapy Services

The question of therapy services (professionals allied to medicine) being provided by the NAHB to any nursing home had not arisen up to handover to the HSE. In any event the staff complements (professionals allied to medicine) and posts filled in these professions were not sufficient to meet priority needs in the community with waiting lists in every service e.g. a Stroke Rehabilitation Unit developed in St. Mary's could not be commissioned as staff posts could not be assigned due to overall pressure on staff ceiling. This is a national issue relative to understandings in regard to the Nursing Home Regulations - this may very well be pursued by the HSE.

Page 28 - The provision of dysphagia and clinical nutrition services ...

The comments in relation to dysphagia and clinical nutrition service are noted - this important service issue should be reviewed by a multi-disciplinary group - clinicians and nursing, professionals allied to medicine, and representatives from patient advocates - to decide on the best way forward.

Page 34 & 35 - Overview of Inspection Teams and Team Composition

The development of the dedicated Nursing Home Inspection Team is dealt with earlier in my response.

I disagree with Professor O'Neill's comments in this section for the reasons set out.

The comment in relation to improving capacity for inspectorate teams to access multidisciplinary experts is noted: - this is the reason why I called the meeting referred to in the next paragraph - team composition. This was a very successful meeting attended by the Inspection Team, senior staff from the allied health professions, Nursing Directors - Community Units, Assistant Director of Nursing - Psychiatry of Old Age, Clinical Nurse Specialists, Director of Public Health Nursing, Senior Medical Officer, Principal Environmental Health Officer.

Those present, with one exception who expressed conflict of interest, agreed to participate in inspections as required subject, as appropriate, to clearance by their line managers. As indicated earlier a two day facilitation programme was provided by an independent Consultant. The difficulties highlighted by the SAMO present were very relevant - however, there are professional and recruitment/retention problems in this area (Brennan Report). Commitment had already been given by the Geriatricians in relation to supporting inspections as appropriate, including the assignment of Senior Registrars.

Professionals from this group, including Geriatricians and Registrars, have participated in inspections with the core team on a needs basis, as well as follow up

visits to particular nursing homes to deal with and advise on problem areas identified. The issue raised in introducing the paragraph regarding "HSE NA's intentions regarding resource provision" is not clear.

The core members of the Inspection Team were top-sliced from the existing staff complement and assigned to the team full time. The support team members "to be called on as required" to augment the core team and in this context would be released by their supervisor for the period specified.

There are no agreed minutes of the meeting; I chaired the meeting and did not arrange for minute taking - nor was there need for same as the meeting achieved its outcome with a positive commitment from those staff - professionals allied to medicine, nursing managers and specialist nurse practitioners.

Page 39

What might be termed as the final inspection report in identifying threats to appropriate patients care.

It is incorrect to refer to this as a final inspection report. It is important to put and her team's report in context.

With agreement of Mr. Aherne, the HSE NA assigned a Director of Nursing and support staff to take over the day-to-day management of the home from June 1st (incumbent Director of Nursing stepping down). The assignment of senior nurse management was made in the first instance to:

- Ensure patient safety
- Improve the level of care
- Following the recruitment of the necessary staff (as advised to Mr. Aherne) provide training and support for them.

team consisted of eight senior nurses (selected by their Directors) - (Assistant Directors of Nursing, Clinical Nurse Specialists e.g. infection control, practice development co-ordinators). The team called on occupational therapy and other supports as appropriate and had HSE NA administration support in the unit. This team covered shifts 7 x 24 and as a consequence were in a position to observe and collate the ongoing clinical and related programmes in Leas Cross - many of these were already noted by the Inspection Team's recent visits. Likewise, significant new areas of poor patient care were outlined as well as unsatisfactory skill mix in all areas of the service.

It would be quite impossible for the formal Inspection Team to build up the level of information in minute detail, as presented by team were involved over a lengthy period and were working alongside the Leas Cross staff and were in a unique position to observe practice throughout the home and compare against best practice. Furthermore neither } or any member of her team were designated as Inspectors under the Nursing Home Regulations.

Page 40 - Letter from M. Lyons regarding standard of care in Leas Cross - questions of warning of gravest import - and my reply

The NAHB had no communication, formal or informal, from “referrers” in relation to standards at Leas Cross - this raises questions in relation to the obligations of “referrers” under the Nursing Home Regulations. Records in the Board’s Nursing Home Unit show that “referrers” were referring patients to Leas Cross at that time and continued to do so until the end of May 2005.

Following his inspection of April 7th/8th of Leas Cross Private Nursing Home the Director of the Nursing Home Inspectorate apprised me of his findings and his proposed programme of follow up.

It was agreed that a sustained programme of enforcement/follow up would be undertaken on the same lines as pursued in relation to the inspection of a number of homes where the NAHB management had concerns on the standards of care and staffing overall in those homes; in addition management had received formal complaints in relation to care issues in those homes. The situation in relation to Leas Cross was similar to what had arisen in those homes.

The records show that the Director effected a substantial programme of inspection and follow up and achieved, over time, the outcomes as specified in the homes referred to. Both [redacted] and I were satisfied that the Director and his team had the capacity to deal with the challenges presenting at Leas Cross and that this would be monitored by [redacted] and myself as appropriate.

Furthermore, the ERHA team, who visited Leas Cross, were not authorised inspectors under the Nursing Homes Regulations. It is important to highlight also that an ERHA team approved a nursing home in the NAHB for the intermediate/high dependency programme notwithstanding the fact that this home was subject to review by the NAHB Inspection Team because of care issues.

The Nursing Home Regulations place specific obligations on the proprietor of a nursing home and also on the referring agencies (Appendix 5) - these obligations are independent of the obligations which the proprietor must fulfil under Company Law.

Admission to Leas Cross Private Nursing Home in the main arose from:

- Discharges (referrals) from Beaumont, Mater and to a less extent Connolly Hospitals.
- Community - following assessment and referral by Consultant Geriatrician.
- St. Ita’s Hospital and community services following assessment and referral by Consultant Psychiatrist in the Psychiatry of Old Age.
- Private admissions.

Health boards have obligations in relation to nursing home inspections.

As public funded voluntary hospitals, the Mater and Beaumont act as “agents” of the Health Board in the provision of acute hospital services - this would include assessment and discharges to nursing homes – public and private.

I am satisfied that the management and clinicians in St. Ita's fulfilled their duty of care to the patients discharged from St. Ita's and transferred to Leas Cross and other homes, in the selection, consulting with patients and their next of kin, and follow up/liaison medical and nursing services - this also included re-admission to St. Ita's for a small number of patients – Appendix 6.

Professor O'Neill's report does not adequately deal with the responsibilities of the proprietor of Leas Cross and the referring agencies.

Page 41 - Perhaps the most worrying aspect documentation to counter the perception that they failed ... into executive decisions on nursing homes.

The NAHB had a complaints and appeals service; all complaints were investigated and where there were recommendations arising from complaints, these recommendations were dealt with as far as it was practicable. The NAHB's records will show the level of complaints; the investigation process, and the outcome of these investigations and whether they relate to services in the community, residential facilities across all care groups, acute hospitals, etc..

Page 41 - Oral and written communications from mental health professionals at around the time of the transfer of patients from St. Ita's Hospital.

This matter is referred to later in the report - page 48. I will deal with all three references (i.e. Page 15, 41 and 48) simultaneously.

Page 41 - It is not immediately apparent that the HSE or the Inspection Team understood the significance of such communications....

I do not agree with this statement. The (dedicated) Nursing Home Inspection Team, as highlighted earlier, withheld its first inspection visit to Leas Cross until all complaints from patients pertinent to Leas Cross were investigated and reported on.

Page 44 - Letter regarding Alzheimer's Centre, Highfield

Agenda item meeting with Consultant A on June 1st 2005 as referred to earlier.

There was no change of policy towards Highfield. There are four units on the campus - two registered as private nursing homes and two (Highfield & Hampstead Units) designated under the Mental Treatment Acts. As a consequence patients referred to Highfield and Hampstead cannot be covered by nursing home subventions and Consultant A was so advised. However, it has been custom and practice that where Consultants express a need for a particular referral to Highfield and Hampstead, those applications are dealt with on a case by case basis. At all stages there were 3-4 patients from the NAHB in Highfield/Hampstead (4 patients – March 06).

With regard to beds for people in end-stage dementia with behavioural disturbance, it should be noted that the Area 8/St. Ita's Service and the Area 6/7 Service have their

own designated beds for patients with disturbed behaviour and their bed numbers compare favourably with the norms set out in the new policy framework - *Change* - published by the Expert Group on Mental Health.

Page 45 - In a further letter to the Medical Superintendent, St. Ita's Hospital, ... discharge to nursing home process.

Consultant A's line manager is the Clinical Director, St. Ita's Hospital/Area 8, who, with the Director of Nursing and Hospital Manager, form the Management Team of the Psychiatric Service, and who reported to me. I have no record of any communication from the Clinical Director or Management Team in relation to standards of care at Leas Cross, nor indeed did a discussion take place on this issue at any meeting I have had with the Team. I am particularly mindful of a series of meetings I had with the Clinical Director in May 2004 dealing with a complex Freedom of Information request from a relative who objected to the proposed discharge and transfer of her relative to a private nursing home as part of that particular initiative - this discharge did not take place which was in line with the policy in relation to the initiative. This was an ideal opportunity for the Clinical Director to raise issues in relation to Leas Cross if they were a matter of concern to him or the Management Team. He did not do so.

Page 48 (plus Pages 15 & 41) - Of particular concern is the lack of documentation senior clinicians in Old Age Psychiatry Leas Cross was not going to significantly alter its ways.

Professor O'Neill's conclusions are incorrect and do not reflect the actions taken by senior management which include the appointment of the dedicated Nursing Home Inspection Team and putting in place a revised complaints procedure. These developments also involved a tailor made training programme for the Inspection Team by experts from the UK and likewise for the panel of staff from whom teams to investigate complaints would be selected.

Professor O'Neill is incorrect in stating that management did not respond to written concerns expressed by senior clinicians in Old Age Psychiatry and Geriatric Medicine.

Accompanied by a senior colleague, I had a planned meeting with Consultant A and the Assistant Director of Nursing in her service, on June 1st 2004 to discuss the content of a number of letters dated: -

- 19/4/04 to [redacted] copy [redacted] (and referred to [redacted] for attn);
- 19/4/04 to [redacted]
- 30/4/04 to [redacted]
- 27/4/04 to [redacted] - copy to [redacted] , and
- letter of 21/4/05 to Mr. [redacted] and Consultant A - copy to [redacted] , and others covered a range of issues, mostly inter-related.

Important service issues were highlighted in those letters and were listed as agenda items for the meeting.

I also had a meeting with Consultant A and the Management Team at St. Ita's Hospital (Clinical Director, Director of Nursing, Hospital/Area Manager) to review

the development of the Psychiatry of Old Age Service (17th August 2004) – the meeting concerned itself in the main with the formal report presented by Consultant A.

Furthermore, I attended seven meetings with Consultant A and Beaumont management in 2004 / 2005, as well as five meetings with the Geriatricians and Consultant Psychiatrists in the Psychiatry of Old Age. It is my experience that persons attending meetings use the occasion, before or after a meeting, for an informal discussion on issues of interest or concern. No reference to the standards of care at Leas Cross was made on those occasions or on occasions when joint management meetings were held with the Mater and Beaumont Hospitals.

Consultant A commented verbally to me that Leas Cross could not provide the appropriate level of care to high dependant patients referred by her and as a consequence she reverted to referring low dependent patients, as well as patients on respite care. Consultants A & B have continuing care beds in St. Ita's and Lusk Community Unit, and dedicated beds in a number of private nursing homes - this arrangement is similar to the range of facilities available to colleagues in Area 6 and 7. This allows the Consultant to assess and refer patients to homes with care programmes designed to meet the patient's needs. Likewise, the community psychiatric teams utilise beds in certain nursing homes which provide programmes suitable to the needs of patients with specific psychiatric and social problems.

At a bed management meeting (St. Ita's - 12/9/04) - chaired by Consultant B - a senior manager from the NAHB, who attended the meeting, complimented the clinical staff on the success of their discharge programme and clarified the main issues in relation to arrangements with the private nursing homes -

- Nursing Home places subvented by Health Board are public beds in Private Nursing Homes.
- Follow up and review by Psychiatry of Old Age.
- Any problems encountered while reviewing patients to be documented and if necessary notification to Nursing Home Inspectorate.
- Beds in Private Nursing Home are not set in stone and may be moved if Psychiatry of Old Age Team encounter difficulties regarding patient needs or care.
- will support decisions of Psychiatry of Old Age Team.

I feel sure there are positive conclusions and recommendations in Professor O'Neill's report overall; I have made positive comments on some of the conclusions, where appropriate, on the sections referred to me.

APPENDICES

Proposals Adopted by NAHB and Submitted to ERHA

- Report of the Working Group on the Short to Medium Term Service Needs of Older Persons and The Young Chronic Disabled - NAHB – Working Group Report.
- Upgrading / replacing the St. Mary's complex 2001 and 2004.
- Joint submission from Beaumont Hospital and the NAHB to ERHA (5th July 01) - Rehabilitation Unit for Older Persons including A Stroke Rehabilitation Service; Day Hospital for Older Persons; Psychiatry of Old Age Day Hospital.
- Development Control Plan - St. Joseph's Hospital, Raheny - May 02 - including units for older persons.
- Development Control Plan - St. Brendan's Site, including units for older persons.
- Proposals to develop a second community unit on Claremont site using Sean Chara Unit brief and footplate - planning permission was granted.
- Development Control Plan for St. Ita's and development of services on and off site.

Developments to Improve Services for Older Persons

- Home First Programme.
- North Inner City Primary Care Programme – Liaison Service Older Persons
- Collaboration with Consultant Neurologist, Mater Hospital, including financial and administrative support in developing a register of stroke survivors in the NAHB area.
- Rapid Access Clinic, St. Mary's Hospital.
- Falls Clinic.
- Osteoporosis Clinic, St. Mary's Hospital (including DEXA Scanner).
- Semi Acute Ward, St. Mary's Hospital.
- Courier Service – General Practice/Hospitals - Bloods, etc.
- Home Care Packages Programme (1st client in 2001 – 600 in Programme x 2005).
- Day Units - Glasnevin; Cappagh Road, Finglas; and Mellows Road, Finglas.
- Phasing out Mobile Day Hospital – North Dublin and transfer and enhancement of service to Community Unit, Lusk.
- Housing with Care Developments at Hartstown, Dublin 15, and Claremont, Glasnevin. Joint projects NAHB/Fingal County Council (Dublin City Council) and Fold Housing with Care. Fifty + beds at each centre (50% frail elderly and 50% dementia). Two day centres at each location with 25 places in each centre (frail elderly and dementia) and local primary care centre linked to each area. 95% Funding from Department of the Environment and Local Government; balance funded by NAHB asset disposal including primary care centre.
- Rehabilitation Unit – 15 places – St. Joseph's Hospital, Raheny
- Two additional Consultant Led Geriatric Teams – Mater/NAHB, Beaumont/NAHB.
- Rationalisation of services to fund 2.5 Consultant posts in the Psychiatry of Old Age Area 6 & 7 / Mater / Connolly Hospitals, and Area 8, St. Ita's / Beaumont Hospitals, plus additional support staff for the Area 8 post.

Dedicated Nursing Home Inspection Team

A base in St. Mary's Hospital, integrated with the Nursing Home Section, was established. The Board management's resolve in setting up a dedicated Inspectorate is a reflection of its concerns in relation to this very important service and was the only Board in the country to so do.

In order to progress the development of the Nursing Inspection Framework meetings were held during 03 with (a) General Managers; (b) Directors of Public Health Nursing; (c) SWAHB Nursing Home Section; (d) Chief Inspector for Children's Residential Services; to establish the methodology used for inspections and measurement of standards.

Following those meetings Assistant Chief Executive (Primary Care and Community Services) established a multi-disciplinary group (on 3rd July 03) (including Director of Public Health Nursing, Principal Environmental Health Officer, Manager for Nursing Home Section, Technical Services, Area Medical Officer, Physiotherapy Manager, Social Worker, Director of Nursing – Residential Unit Older Persons) to review the current system for inspections within the NAHB and make recommendations for improvements.

Three sub-groups were set up to:

- (a) Develop a framework for registration and inspection.
- (b) Review complaints management.
- (c) Review financial management for residents' monies.

and templates were developed as follows:

- (i) *Inspection Template/Checklist* - which placed significant emphasis on standards of care of residents. The checklist in place since the development of the nursing home inspection process in 1990 placed its emphasis primarily on infrastructure with some care dimensions.
- (ii) *Template for the Notification of Deaths in Nursing Homes* and proprietors and persons in charge of nursing homes were advised of procedures to be followed.
- (iii) *Template for the Notification of Discharges from Nursing Homes* and procedures to be followed.
- (iv) The *Environmental Health Department* provided a nursing home registration inspection form relevant to their service that fulfils the information required by the Nursing Home Section for registration purposes.
- (v) A *complaints tracking system* for private nursing homes was developed with details of procedures to be followed.
- (vi) A *Template for the Financial Management of Residents' Monies* was set out.

A meeting with The Federation of Private Nursing Homes took place on 30th January 04 to consult with and gain their input to the templates and their agreement for implementation.

A Director of Nursing working in the Board's Quality Risk Unit was redeployed to develop a dedicated Inspection Service for Private Nursing Homes (2nd September 04); an Assistant Director of Public Health Nursing joined in October 04, a second Assistant in May 05 as well as administration support and a ½ time GP. From Jan 05 the Inspection Team was based in St. Mary's and was integrated fully with the Nursing Home Section.

These developments were put in place following meeting of 2nd September 04 with her senior staff.

In order to enhance the skills of the Inspectorate and other disciplines who from time to time would be requested to assist the Inspection Team, a three day training programme was organised by the Director. A company specialising in this area - Anne Davis and Association (UK) - was contracted to deliver this programme. The training programme drew from the standards applicable in the UK National Health System (NHS) (Private Nursing Homes).

During his involvement with the Quality Risk Unit, the Director of Nursing was authorised to inspect nursing homes and was involved in two high profile inspections and thereafter enforcement programmes.

The new Inspection Team at the outset reviewed the current position in relation to inspections completed. It was noted that many nursing homes had not been inspected for a considerable period of time due to staff shortages, and were not meeting the requirements of the Nursing Home Legislation.

A review meeting took place involving the Nursing Home Inspection Team and the administrative section of the Nursing Home Section in order to establish and agree an agenda for change going forward.

The purpose of this meeting was to effect an integrated approach to nursing homes in general by the Nursing Home Section and the Nursing Home Inspection Team.

This in effect meant that a single administration process was in place for both services so that administrative issues in relation to the inspection process were updated /informed: -

- person in charge
- complaints
- insurance
- fire certificates
- An Bord Altranais pin numbers -- nursing staff
- deaths

were available to the Inspection Team synchronised to the timetable for inspection.

Response to the Tánaiste's Announcement of Funding to Improve A & E Service in Late 2004

- NAHB management consulted with all service managers, GP partnerships and Geriatricians.
- Arranged a study day with an independent facilitator to brainstorm and agree key proposals to respond to priority needs as identified. The acute hospitals - Mater, Beaumont, Connolly – were represented by the CE, Director of Nursing, Chair of Medical Board, A&E Consultants, Bed Manager, Head Social Worker; the NAHB was represented by senior managers, community & residential units, GP representatives of Partnership and Assistant Chief Executives.

The package of measures agreed were costed and submitted to ERHA (joint proposal - NAHB/Mater/Beaumont – 20/12/04). The package included proposals to:

- utilise public beds more proactively with private nursing homes.
- create pathways for step down.
- GP Unit access to public nursing home (sub acute crisis).
- increase in the number of Home Care Packages as well as community staff to support and manage the packages.
- create 3 Community Geriatrician posts to provide Consultant support to the frail patients in the community programme and nursing homes - this would facilitate a timely response by Geriatricians to patients in private nursing homes, experiencing acute medical problems, as well as high dependent patients who required referral to a specialist.

The Nursing Home Regulations

The Nursing Home Regulations (93 - 96) set out the criteria for dependency levels in private nursing homes:

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.*

Likewise the assessment process is set out as follows:

- 1. A health board shall make arrangements for the carrying out of an assessment of the dependency of a person in respect of whom a nursing home subvention is being sought by a designated officer or officers of the board or make arrangements with another agency or persons for the carrying out of such assessments by a qualified person.*
- 2. A designated officer for the purposes of this schedule is a person who is a registered medical practitioner, a registered nurse, an occupational therapist or a chartered physiotherapist.*
- 3. The assessment of the person in respect of whom a nursing home subvention is sought shall include an interview by the designated officer or officers with the person and his or her nearest relatives, if any.*
- 4. The health board to which the application for a subvention has been made shall inform the person making the application of the date and time of an interview in connection with an assessment of dependency and the place in which any interview will take place.*
- 5. The assessment of dependency shall include an evaluation of the ability of the person in respect of whom a subvention has been sought to carry out the tasks of daily living and of the level of social support available to the person.*
- 6. The ability of the person in respect of whom a subvention has been sought to carry out the tasks of daily living shall be assessed on the basis of his or her:*
 - (i) degree of mobility*
 - (ii) ability to dress unaided*
 - (iii) ability to feed unaided*
 - (iv) ability to communicate*
 - (v) extent of orientation*
 - (vi) level of co-operation*
 - (vii) ability to bathe unaided*
 - (viii) quality of memory*
 - (ix) degree of continence*

7. *The designated officer or officers shall indicate either numerically or qualitatively the extent of independence or dependence of the person being assessed for each of the headings in paragraph 6.*
8. *In assessing the social support of the person being assessed, the following indicators shall be taken into account:*
 - (i) *the housing conditions of the person being assessed;*
 - (ii) *the number of persons in the household of the person being assessed;*
 - (iii) *the ability of the members of the household, if any, to care for the person being assessed;*
 - (iv) *the extent of support from the community for the person being assessed;*
 - (v) *the services which the person being assessed is receiving.*
9. *The designated officer or officers shall indicate, either numerically or qualitatively, the level of social support available to the person being assessed for each of the indicators in paragraph 8.*
10. *The assessment shall include consideration of the medical condition of the person being assessed.*

The Nursing Home Regulations specify that the person in charge of a nursing home should have three years relevant experience.

St. Ita's Bed Initiative

The clinical teams work to and are supported by the hospital management / area management team - Clinical Director, Director of Nursing, Hospital / Area Manager. In this context where issues of concern are raised at clinical meetings:

- team member engage with the line manager to seek a resolve of a particular issue(s)
- or indeed the full team with hospital / area management if appropriate. Where and when appropriate the hospital / area management team consult with
- the Programme Manager / Assistant Chief Executive
- the CEO if necessary.

In this context the Assistant Chief Executive had regular meetings with senior management teams in all services. In practice clinical teams hold formal clinical meetings - where issues of concern arise that require consultation with/input from senior management of the service, arrangements are made to have these issues discussed.

The first Psychiatry of Old Age Service was established in Area 6 & 7 in the late 80s. The ethos of the service was domiciliary assessment and home support - this was supported by day hospitals in Connolly and Mater Hospitals; 6 acute beds in St. Vincent's, Fairview; 40 beds in Connolly Hospital for patients presenting with challenging behaviour. The service had access to dedicated beds in Verville Retreat and Bloomfield Hospital. Those services were relocated to Talbot Lodge and TLC private nursing homes. Patients assessed as requiring long term care whose needs could be met in an accessible nursing home, were referred to homes as appropriate through the Nursing Home Section. All patients placed in residential care are monitored with ongoing assessments as appropriate by the Clinicians and Specialist Nurses.

In 2002 Consultant A took up duty as Consultant Psychiatrist in the Psychiatry of Old Age in St. Ita's and Beaumont Hospitals / Community Care Area 8. Consultant A immediately set about building her team and developing her service in St. Ita's, the community and Beaumont Hospital.

Phase I of the rationalisation of services for older persons at St. Ita's was achieved in the development of an acute unit at St. Ita's and re-orientating services to facilitate the development of dedicated units for patients with challenging behaviour.

The second phase of rationalisations was initiated in early 03 in order to phase out *Reilly's Hill* as a residential unit due to its unsuitability to meet patients' needs (Ref - Inspector of Mental Hospitals' Report 02).

This development was the penultimate phase in implementing Government policy (*Planning for the Future*) in relation to the development of community services and phasing down the large institutions. The final stage relates to the transfer of acute services to Beaumont Hospital and the development of customised units for older persons with challenging behaviour on the St. Joseph's campus, Raheny).

Reilly's Hill was one of the newer buildings (1940s) isolated from the main campus - consisting of 4 open plan nightingale units. The design layout did not meet the needs of high dependent frail older persons (internal access, sanitary facilities, etc.); the building had major problems with heating due to corroded pipework, and did not meet health and safety requirements.

A number of nursing homes were visited by Consultant A, the Director of Nursing and the Hospital Manager. For a variety of reasons, Leas Cross Private Nursing Home was chosen for the placement of upwards of 25 or so patients. Other homes were chosen for smaller groups.

The group transferred to Leas Cross were in general the more dependent of the cohort - were patients in end stage dementia, etc. - and were transferred in line with:

- choice of patient
- choice of family
- access families
- access clinical staff – proximity St. Ita's and Beaumont
- capacity of new nursing home for significant number of patients (25)
- assurances regarding competency and staffing

These patients in the main were not *graduates* (ageing patients who had lived for many years in St. Ita's) - rather frail patients admitted to St. Ita's from the community.

The situation was further exacerbated in relation to:

- staff ceiling overall (the service readjustment programme)
- recruitment and retention issues
- and on prioritising RPN trained nurses for acute and community services and particularly in resourcing the new teams – psychiatry of old age and rehabilitation, including Consultant A's team.

The team (Consultant A, Director of Nursing, Hospital Manager) had discussions with the proprietor and person in charge of Leas Cross and other relevant homes in relation to the dependency levels of the proposed client group, their nursing care needs, etc.. Discussions also took place at Leas Cross in relation to the provision of hoists, etc., and agreement was reached that this was a matter for Leas Cross.

Subsequently, the person in charge paid a visit to St. Ita's to meet with staff and orient herself with the patients whom St. Ita's proposed to transfer. A decision in principle was made to proceed with the transfers subject to agreeing a financial package which was later confirmed by the Group Services Manager. Consultation took place with the patients/their families/advocates. A liaison nursing service, involving senior nursing staff who had cared for the patients prior to their transfer to Leas Cross and other nursing homes involved in the programme, was put in place following the transfer of patients to those homes, including Leas Cross.

The Psychiatry of Old Age Team holds clinical meetings in Beaumont and St. Ita's where issues of concern that may arise at these meetings can be brought forward/referred to the relevant senior manager or management of St. Ita's where necessary.

Report on transfer of patients to Leas Cross; liaison and clinical follow up is also shown hereunder.

Report of Transfer of In-patients from St. Ita's Hospital to Leas Cross Nursing Home

A discharge initiative took place from St. Ita's Hospital to various nursing homes in 2003. A total of 24 long-stay patients were discharged to Leas Cross Nursing Home on a phased basis over a period of three months.

The discharge initiative was carefully planned. Each transfer was accompanied by a detailed case summary with details of any medical problems, psychiatric problems and medication. Prescriptions for medications were sent in advance and prescriptions were repeated until medical cards were issued for the patients.

Families were contacted at an early stage regarding these transfers. The approach taken by families to the discharge of their relatives was variable. Some had actively sought transfer to nursing home care for their relative. Others were opposed to the transfer. Any persons or families who requested for a person to stay in St. Ita's were accommodated. All those who requested to return to St. Ita's were also facilitated.

Following discharge, a liaison service was developed where the nursing staff from the units from where the patients had originated visited regularly to liaise with the nursing home staff to help meet the needs of the patients and to help sort out any difficulties.

The medical staff visited frequently, both regularly and on request, since the time of discharge and at this time there is a regular weekly visit from the Consultant Psychiatrist and a formal six monthly psychiatric review of patients in these beds. In addition, emergency assessments are also catered for. This would equate with the Consultant-provided psychiatric service provided to the long-stay patients at St. Ita's. The GP is first on-call to the patients.

In this way St. Ita's fulfils its duty of care.

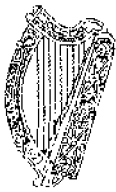
Mortality Rate - St. Ita's Hospital - 2000 - 2004

<i>Date</i>	<i>No. of Older Patients in Hospital at the end of 31st December</i>	<i>No. of Deaths</i>
2000	171	39
2001	151	30
2002	140	27
2003	81	19
2004	86	4

Mortality Rate - Community Units

Deaths in the community units were in the 20 - 25% range with the exception of Sean Chara in 04 and 05 with deaths at 9 and 5 respectively.

Response D



11 August 2006



**DEPARTMENT
OF HEALTH AND
CHILDREN**
AN ROINN
SLÁINTE AGUS LEANAÍ

Quality and Fairness
A Health System for You

To whom it may concern,

I wish to refer further to your letter of 28 June 2006 in relation to the review of the deaths at Leas Cross nursing home 2002-2005, carried out by Professor Desmond O'Neill. You attached a copy of the review, on behalf of the Health Service Executive, in order to give this Department an opportunity to respond to the sections that are relevant to it. The Secretary General, who is away on leave, asked me to write to you in regard to the Report.

1. Throughout the document, Professor O'Neill makes a number of remarks in relation to the Department which I feel are made out of context and are not backed up by any evidence in the report, a number of which I have outlined below.

1.1 In the executive summary, the Professor makes reference to
"... policy, legislation and regulations which have over many years failed to adequately articulate and address the complex needs" of older Irish people. (p 5)

This is a very broad statement, and there is no evidence presented by the Professor to back up these remarks. This statement fails to recognise the very real and positive developments in regard to services for older people, which are set out in more detail later, and such a statement gives the impression that there is a vacuum in terms of policy relating to older people.

1.2 The Professor goes on to say that
"There is scant evidence that the Department has taken cognisance of the huge concerns internationally over the quality of care of older people in long term care, or has shown a sense of urgency about the threat posed to a very vulnerable group of people." (p 52)

Again, this remark is not backed up by any evidence. Please also see paragraph 2.2. which describes the investment made in the area of elder abuse.

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1.3 The Professor comments that the 1994 health strategy, *Shaping a Healthier Future*,

“seems oblivious to the possibility of poor quality care in Irish nursing homes” (p 52)

The 1994 Health Strategy was a strategic document, designed to outline the broad, overarching priorities of the Department. It was not intended to go into great detail in relation to each of the Department's areas of work. Also, the issue of standards in nursing homes was dealt with, only a year before the Strategy was launched, by way of the Nursing Homes (Care and Welfare Regulations) 1993. Therefore, it was not considered necessary to refer again to the issue of standards specifically in the Strategy.

1.4 I am very concerned to read Professor O'Neill's comment that

“it was with some surprise that the reviewer noted a claim in the OECD overview of long-term care that Ireland has put into place national standards of care” (p 53)

The Professor is surely aware that Ireland already has in place, since 1993, national standards of care in relation to nursing homes. The Nursing Homes (Care and Welfare) Regulations 1993 set out standards that apply nationally to all private nursing homes and inspections are carried out against these regulations. Indeed, the purpose of the comment made in the OECD report was more to draw a distinction between countries who set standards nationally (such as Ireland) and those who set standards at regional level (such as Canada) rather than a distinction between countries who have developed a set of standards and those who have not.

1.5 Again, I am surprised by Professor O'Neill's comment that

“the Department of Health and Children seems to be little influenced by the world-wide developments in response to concerns over the quality of long-term care” (p 56)

There is no evidence to back up this assertion. Progress has been made in relation to a number of areas which I refer to later in this letter, including the development of a new set of standards, the provisions contained in the Health Bill 2006 and developments in the area of elder abuse. These developments have all been influenced by best-practice worldwide and clearly documented in the public arena.

2. There has been significant progress in relation to putting care of older people at the centre of health policy and service delivery and the following are examples of such progress.

2.1 Policy

It has long been the policy of this Department to assist older people to remain in their own homes and communities, in dignity and independence, for as long as possible. When this is no longer possible, there should be a comprehensive range of care options available to older people, including long-term care.

An Inter-Departmental Group of senior officials was established early last year by the Tánaiste and the Minister of Social and Family Affairs to review policy on a number of key areas, as they affect older people. The Group reported to Government, and the Government decisions on that report are reflected in the new Social Partnership agreement "*Towards 2016*". That agreement (see pages 61 and 62) describes a whole range of initiatives covering new arrangements for residential and community care for older people.

The agreement also outlines that quality residential care should be available, where community and home-based care is not appropriate, and that the level of State support for residential care should be indifferent as to whether the care is in a public or a private facility. Work is continuing on developing a new residential care scheme, whereby those in private and public facilities would be eligible for the same level of State support, thus rendering the system more equitable. The new system will propose appropriate levels of co-payment by care recipients based on a national standardised financial assessment, a principle that was also agreed by Government.

2.2 Funding

An additional €150m was allocated in the 2006 Budget toward improving services for older people and palliative care. This investment represents by far the largest ever investment in resources for these two areas. It also points toward a new focus on caring for older people in the community as a first option, in line with Government policy. This commitment to community care is proven by the fact that almost three quarters of the investment is going towards services in the community, including Home Care Packages (€55m), the home help service (€33m), day/respite care (€9m) and meals on wheels (€5m).

I would add that the issue of elder abuse, whatever form it takes, is one that the Department takes very seriously. In December 2003 the Department established the Elder Abuse National Implementation Group to oversee the implementation of the recommendations outlined in the report 'Protecting our Future.....Report of the Working Group on Elder Abuse' Funding also began in 2003 to commence implementation of the Elder Abuse Programme and, of the Budget investment package mentioned above, an additional €2 million was allocated to address elder abuse split evenly between 2006 and 2007. This level of funding will facilitate the implementation of the full range of recommendations, including staffing requirements, contained in the Report "Protecting Our Future", including the development of a research function in this area.

2.3 Subvention

As outlined previously, the subvention scheme, the purpose of which is to provide financial assistance to persons towards the cost of maintenance in a private nursing home, was introduced in 1993, and spending for the first full year of the scheme (1994) was €15m. When compared with a total spend of €140m on the scheme in 2005, the enormous growth in this scheme, and the

numbers availing of it, is very clear. In many cases, an enhanced level of subvention is paid by the HSE, over and above the maximum rate that a person would otherwise be entitled to. In cognisance of the fact that there will always be those who require residential care, an additional €20m was also allocated this year to the nursing home subvention scheme. For those who did not need to enter residential care there has been significant funding of the home help services over the years. For example, the expenditure on that programme has increased from €42m in 2000 to €142m this year.

2.4 Standards

In relation to standards, it is intended that the Health Bill 2006, the heads of which were published for consultation purposes some months ago, will establish the Health Information and Quality Authority (HIQA). The Bill will also put the Social Services Inspectorate (SSI) on a statutory basis and will contain provisions to underpin a more robust inspectorial system. It is the intention that the Chief Inspector of Social Services will be required to monitor, against standards set by HIQA, residential services provided to, among other categories of persons, older persons.

In advance of HIQA being established, a Working Group was established last year, chaired by the Department, to produce draft standards for long-term residential settings, both public and private. Members include representatives from the Department, the HSE, the SSI and the IHSAB. It is intended that these (draft) standards are standards that will apply to all residential settings - public, private and voluntary - where older people are cared for and for which registration will be required.

It is intended to have this draft standards document finalised and circulated to interested parties for consultation shortly. The intention is that HIQA, once established, will be asked to consider adopting these standards.

2.5 Legislation

In relation to legislation, the Nursing Home Subvention Scheme was introduced in 1993 on foot of the Nursing Homes (Subvention) Regulations 1993. The purpose of the Health (Nursing Homes)(Amendment) Bill 2006 is to ensure that the existing subvention scheme for private nursing home care is grounded in primary legislation and to help the HSE to implement the scheme on a standardised basis across the country. The Bill is currently on its passage through the Houses of the Oireachtas and is expected to be published in the next Dáil session.

3 Comments on specific aspects of the recommendations

3.1 Much of what I have outlined above addresses the recommendations contained in the report that relate to this Department. However, I would have the following comments to make specifically in relation to some points contained in these recommendations:

3.2 In regard to comments on training and the regulatory responsibilities of professional bodies in the medical area, you will be aware that the Medical Council is responsible for professional regulation and a new Medical Practitioners Act is to be introduced later this year. The Medical Council is broadly responsible for standards and competence of medical practitioners and also for their training standards, a function which is delegated to the professional training bodies. In this case, these would be the Royal College of Physicians of Ireland and the Irish College of General Practice. A copy of the report should, therefore, be sent to the Medical Council, the RCPI and the Irish College of General Practitioners for their observation, comments and actions as appropriate.

3.3 Rather than referring to a minimum number of nursing staff, the report should, perhaps, more appropriately refer to numbers of competent nursing and support staff. The Department and the HSE have been examining the development of appropriate systems to determine nursing and midwifery staffing levels so that systems of measuring dependency, examining the principles of skills mix and measuring work load could be tested and evaluated here.

3.4 An Bord Altranais (ABA) already gives guidance to all nurses/midwives in the context of The Code of Professional Conduct, and the Scope of Practice that every nurse should work to within the clinical environs of their practice area (for example, care of the elderly).

3.5 Professor O'Neill refers to gerontological training for international (this term has now replaced "non-national") staff. However, it is not clear what exactly is meant by the term gerontological training, and it is more appropriate to talk about continuing professional development in gerontological education.

3.6 The ABA has been supportive in relation to the development of post-registration programmes for gerontology. The first such course was approved in 1983 and now there are 12 programmes approved nationally by the ABA, with good access and geographical spread.

3.7 Regulatory bodies do not identify needs of any specialised group of clients. However, the nursing board has a code of professional conduct. Nurses have to operate within their scope of practice. The ABA is also responsible for approving the specialised training courses for gerontology nurses.

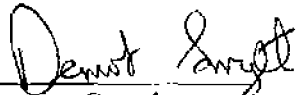
3.8 It should also be noted that each of the Nursing and Midwifery Planning and Development Units (NMPDUs) within the HSE has employed a Project Officer (total number 11) over the past two years to develop and undertake a needs analysis of staff to identify training needs. Three successful projects have been run using the philosophy of the Essence of Care.

3.9 In relation to the Director of Nursing, the competencies required are management competencies -vision, strategic direction and systems thinking, and of course a good knowledge base of the complexities required in caring for older people. These are employment issues and not the business of a regulatory body.

3.10 In regard to training for healthcare assistants a national programme of training for health care assistants was introduced on a pilot basis in Autumn 2001. In 2004 the continuation of the course was recommended following an evaluation of the pilot. To date, 1,700 staff have completed this programme with another 1,000 staff nearing completion of their training. It is intended that all health care assistants will in time receive such training with 1,000 such assistants being trained each year in the public system.

I trust that this response is informative and will be of assistance.

Yours faithfully,


Dermot Smyth
Assistant Secretary

Response E

Dear Sir

With reference to Professor O Neil's findings regarding deaths in Lea's Cross Nursing Home, I take this opportunity to make some comments.

I and the management of Lea's Cross worked alongside HSE senior personnel. We were inspected every six months by them and were given registration for the new section of the nursing home. We accepted their standards and adhered to them.

During my time dealing with the inspectorate team and received only positive responses to inspections. Any matters that they suggested were carried out as soon as was possible. If faults in care standards were found by the inspectorate team it would have been their duty to inform management at Lea's Cross, and confirm that action was taken to address any issues.

Prior to a senior inspectorate team member retiring in 2001 (approximately), I received a copy of each inspection report carried out at Lea's Cross. From that time up to March 2005 no inspection reports were forwarded to me. The inspectorate team had a duty to inform me if any misfindings were found and issue inspection reports. The inspectorate team arrived unannounced approximately every six months and inspected the following:

- Nursing Home environment
 - Interviewed residents
 - Resident attire
 - Resident Activities
 - Resident Dependencies
 - Dynamics of resident base (those mobile/bed bound/wheelchair)
 - Review of complaints
 - Hygiene
 - Each room
 - Common areas
 - Sluices
 - Laundry
 - Call Bells
 - Lighting
 - Sanitation
 - Bed Linen
-

- Kitchen (menu choice, freshness and quality of food)
- All documentation - resident charts/Nursing Kardex/Drug Charts/DDA register
- Register of admissions, discharge and deaths
- Qualifications of staff
- Rosters
- Equipment and service records
- Subventions
- Contract bed listing
- Environmental Health Inspector records
- Ground Maintenance

Lea's Cross was inspected on several times by the Environmental Health officer, and received a copy of their report after each visit.

The inspectorate team had the authority to enter a nursing home at any time, day or night to carry out an inspection, if any doubts regarding care standards in Lea's Cross were felt by the team they would have carried out inspections in the late evenings or night. None were carried at those times since approximately 1998.

With reference to Page 38 of the report "Deaths notified to the Coroner", I informed the coroner of all deaths at Lea's Cross from approximately April 2004 as requested by the HSE. If a resident was transferred from the Nursing home to a hospital, and later died, it was not the responsibility of Lea's Cross management to inform the coroner. Indeed quite often the hospitals did not inform me of deaths, the family's would.

Your Sincerely

Response F

28/08/06 updated 25/10/06 Senior Management HSE (NA) response to the draft report prepared by Professor O'Neill regarding Leas Cross Nursing Home.

I have considered the contents of the draft Report furnished to X by XXX on behalf of the Health Service Executive.

It is clear from the findings that the standards of care in Leas Cross private nursing home were not appropriate and I regret the impact this had on residents.

I support the recommendations in learning from Leas Cross including consistent national regulation and oversight systems that focus on quality of care. In addition I feel the rapid growth in the private nursing home sector needs to be matched with further investment in core community posts and the recruitment of additional dedicated specialist geriatric teams/quality liaison posts that could share expertise, back up and support services including upskilling and A and E avoidance . This could ensure a continuum of care to residents in private nursing homes and enhance linkages between home or hospital settings by effecting real change in day to day interactions with private nursing homes.

I note that in the first paragraph of his Executive Summary, Professor O'Neill states that *"There is no record of Senior Management HSE (NA) appearing to give due weight to written concerns by senior clinicians about standards of care"*. I cannot agree with this assessment of the role played by Senior Management in this document with regard to Leas Cross. Unfortunately Professor O'Neill did not interview any members of staff or any senior management of HSE and therefore he cannot be aware of the many discussions and regular meetings which took place between the senior management of HSE and clinicians. It appears therefore that the contents of his Report can only be based on documents and correspondence.

Concerns and the HSE (NA) response

I have reviewed the letters sent by XXXX which purportedly relate to Leas Cross. In fact having read these letters again there is very little in the way of reference to Leas Cross. There were a number of nursing homes under review at that time. The letters referred to are the:-

19th of April 2004

19th of April 2004

27th of April 2004

30th of April 2004

Whilst Professor O'Neill may have access to these letters, he does not appear to have access to the response by senior management and to that end I enclose the Agenda for a meeting held on the 1st of June 2004 in response to these letters and of which X attended. The meeting had been originally scheduled for the 25th of May 2004, however, a member of HSE was not available and therefore the meeting was postponed until the 1st of June. I attach the Agenda in response to the four letters which were interrelated and of which senior management felt convening a special meeting gave due weight. The minutes of the meeting include my handwritten notes. The Agenda reflects the concerns raised in correspondence, However, Leas Cross was not raised in the meeting. Therefore, contrary to the impression given by Professor O'Neill in his Report, there was ample opportunity to raise concerns formally or more importantly agree corrective actions regarding Leas Cross.

Meetings between HSE (NA) and Medical staff

Available on request:-

6th of December 2001

7th of February 2002

13th of March 2002

2nd of April 2003

29th of January 2003

12th of November 2003

19th of May 2004

7th of July 2004

22nd of September 2004

3rd of November 2004

24th of February 2005

13th of April 2005

25th of May 2005

As can be seen from the minutes of the meeting, those meetings were attended by XXXX and XXXX and NAHB senior management. Those meetings were held on a regular basis and there is no record of Leas Cross been raised . In addition there were a number of further meetings with the XXXX and XXXX management and XXXX, again , I can not locate a record of formal concerns specifically raised relating to Leas Cross from X files.

Further in the Report, Professor O'Neill states with regard to the complaint made by the family of XXXX *"A letter from senior HSE (NA) management to the family does not seem to recognise that the care and the case represented a catastrophic lapse of service provision that was unlikely to represent an isolated incident, or one that would represent a culture of poor care that would be very resistant to change"*. I refer to a copy of X letter to the XXXX and X would draw Professor O'Neill's attention to the second page where at the time X sent that letter X listed the parties to whom this letter had been copied. They include XXXX and XXXX.

I am sure Professor O'Neill is aware the complaints raised by the XXXX family were assigned to XXXX and XXX for investigation in line with existing practice. XXXX coordinated from the newly established Corporate Governance unit. I am unaware of recommendations from the review including whether an appeal was lodged by the family. The response was drafted through the complaints XXXX with assistance from XXXX .It is worth noting that none of the parties copied in this letter, advised that this incident required further investigation or as revealing a standard of care which was unlikely to represent an isolated incident. Certainly if they did, their concerns were not communicated to X as a non clinical manager I would have valued and been guided by their input.

Further meetings

I further enclose a copy Agenda of a meeting held on the 12th of September 2004. Present were XXXX. The minutes of that meeting state that X attended that meeting and clarified issues relating to nursing homes in general. X refer to the following minutes and X clarification is EXPLICIT.

4. *"Beds in Private Nursing Homes are not set in stone and may be moved if XXXX encounter difficulties regarding patient needs or care"*.

5, "X will support decisions of Psychiatry of Old Age Team".

It is clear from the minutes of that meeting that members of XXXX were supported by XXXX and that if there were problems in care that patients could be moved and would be moved by *Senior Management HSE (NA)*.

Also in that meeting it was confirmed that a new inspectorate and complaints system was in the process of being established under the remit of corporate governance from the Northern Area Health Board. Clearly this was a new development and was designed to help and improve the inspections of nursing homes. I refer to a letter to X from X dated the 22nd of April 2005 where X raised concerns regarding the X family where X requested the transfer of X to an alternative nursing home. X notes on that letter confirm that X agreed verbally to the move of that patient which was actioned by X.

Again on the April 26th⁶⁵ letter (incorrectly quoted as 6th April in the Draft Report) X support the decisions of X to reduce beds at Leas Cross. The withdrawal of 6 beds and transfer of funding from Leas Cross is the first stage and integral to the commencement of the enforcement process.

Finally, X would submit that in preparing his report, Professor O'Neill has solely relied on documentary evidence and correspondence *to hand*. **Contact was not made by Professor O'Neill with X to establish X response in** drawing conclusions regarding standards of care applied by the Northern Area Health Board management. Unfortunately this review therefore takes no account of representations which may have been made during meetings or during telephone conversations or during regular contact and meetings with members of the XXXX. In those circumstances, X feel that his report does not accurately reflect the *good working* relationship between the XXXX and the Northern Area Health Board management.

②

16/06/04 MINUTES
AGREED CAP DEV SITE

①

10/06/04 NACT
MTJ

AT BEAU

" NAMB REV COST STAFF
" IN COS TO COST

LOPY

10/06/04 MTS Agenda

Finings POSTS B/T

+ BAC + Money ASSOC WITH
fuc this yr.

Management Team Meeting with

1st June 2004.

NACT MTJ?

Agenda 27-3

DEV of DAY HOSP SERVICES Agenda

• MTS Every 2W

→ Augus

- 1. Long Stay Care - Public and Private placement. ✓
- Eligibility and Entitlement debate. ✓
- New Subvention System anomalies. ✓
- Ring fenced delayed discharge initiatives. ✓
- Bed Management System. ✓
- Hospital Group policy change. Moved 2 ✓

• ENA SEP MTS.

2. Monitoring of Nursing Homes - Inspection process.

Review Group. ✓

- Complaints. ✓
- Appropriate Provision. ✓
- Quality of care. ✓
- Service Level agreements. ✓

50 / f Euro
50 MH/Deen

? Aios + Appri

AB NO'S IN NH getting pp

STAN of CARE DN - A UK - NH -

3. 2005 - Discussion.

CENCUS INC + DENMON JAN 05

4. Future Development of Services - Day Hospital Location.

- Posts 7 Postong Agreed / B New Agreed to S.
- Funding. 1 to 1.2 B/E

Office Space. - O.F. Sec Supp Mtg - Swans Locing.

5. Beaumont Meeting 10th June 2004 actions required.

- Joint Submission of position paper, NAHB / Beaumont.

6. Another Business.

ENA ISSUES! SPACE?

REHAS FOR BEAU CONVA... BEAU CONV... REUSE REV POST
BEAU CONV... ENA cu.

OFFICE SPACE

MINUTES BED COMMITTEE MEETING - 12th September 2004

Present: [REDACTED]

Apologies: [REDACTED]

[REDACTED] - Sick Leave

[REDACTED] - Annual Leave

Mass for Deceased Patients & Relatives:

Bed Staff Association, [REDACTED] Hospital, holding mass on Saturday 6th November 2004 at 3.00pm in [REDACTED] Hospital. [REDACTED] to furnish names of deceased patients to association for inclusion on list of invitations.

Waiting List:

[REDACTED] - Subvention form completed - awaiting bed. Difficulties with subvention may not qualify for enhanced subvention.

[REDACTED] - Subvention - Letter sent to family from subvention office.

[REDACTED] - Subvention form filled. May not qualify due to financial status.

Beds:

One bed in [REDACTED] following death [REDACTED]

[REDACTED] vacancies at present.

Follow Up Regarding 55 Graduate Patients In Nursing Homes:

Six monthly medical review dates to be decided over the next two months [REDACTED] to co-ordinate.

Nursing Reviews - Ongoing every six weeks to three months.

In-service Training for General Nurses in Hospital School of Nursing, also offered four places to Nursing Homes.

Two places to [REDACTED] Nursing Home.

Two places to [REDACTED] Nursing Home.

Commencing 5th October 2004 for one day each week for five weeks.

Ms. [REDACTED] attended meeting and clarified issues relating to Nursing Homes;

1. Nursing Home places subvented by Health Board are public beds in Private Nursing Homes.
2. Follow up and review by [REDACTED].
3. Any problems encountered while reviewing patients to be documented and if necessary notification to Nursing Home Inspectorate.
4. Beds in Private Nursing Home are not set in stone and may be moved if [REDACTED] encounter difficulties regarding patient needs or care.
5. [REDACTED] will support decisions of [REDACTED].

[REDACTED] complemented the efficiency of the Psychiatry of Old Age Team in their continued follow up & review of patients in Nursing Homes and the efficient and timely completion of subvention forms which was more evident here than in the General Acute Hospitals.

New Developments:

[REDACTED] informed the committee that a new inspectorate would be established under the Remit of Corporate Governance from the Northern Area Health Board.

The new team consists of:

1. [REDACTED]
2. Three public Health Nurses.

[REDACTED] enquired as to why there was no input from [REDACTED] especially when discharge initiatives from [REDACTED] and other [REDACTED] in the Northern Area Health Board occurred in 2003 and the possibility of future initiatives involving both General and Psychiatric Hospitals. Graduate patients from Psychiatric Hospitals are often difficult to place and appropriate assessment may facilitate suitable accommodation according to patient specific needs, so it would be important to have an input from [REDACTED] will notify Team of comments.

Meeting ended at 3.30 pm.

Next Meeting 26th October 2004.

28/08/06 updated 25/10/06 Senior Management HSE (NA) response to the draft report prepared by Professor O'Neill regarding Leas Cross Nursing Home.

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copy

cc
Agreed AT BEAU
NAHB REV COST STAFF
1 M-COS TO COST

1113

ATTY

10:00 AM
Management Team Meeting with
2 Finings Posts B/T
+ GAC + Money Assoc with
fuc this yr.

1st June 2004

Agenda
2:00

Next Mtg?

Dev of DAY Hosp Servs Agenda

Mtg Every 2 Wks
→ Aug

- 1. Long Stay Care - Public and Private placement. ✓
- Eligibility and Entitlement debate. ✓
- New Subvention System anomalies. ✓
- Ring fenced delayed discharge initiatives. ✓
- Bed Management System. ✓

ENA SEP MTG

Hospital Group policy change. Nov 02 ✓

2. Monitoring of Nursing Homes - Inspection process.

50 / 400
50 NA / 1000

Review Group. ✓

- Complaints. ✓
- Appropriate Provision. ✓
- Quality of care. ✓
- Service Level agreements. ✓

? Ainst Appri

Stand of Care DN? A Vh-
A NOT IN NH getting PO

3. 2005 - Discussion

4. Future Development of Services - Day Hospital Location.

- Posts & Postings Agreed / 9 Now Agreed to S.
- Funding 2 to 2.27 E

Office Space - O.F. Sec Swan Mtg Swans Locality. ✓

5. Beaumont Meeting 10th June 2004 actions required

- Joint Submission of position paper, NAHB / Beaumont

6. Another Business.

ENA Issues? SPACE?
RETTAS FOR BEAU CONUR... USE REV POST
BEAU CONUR... ENA out.
FUNDING CAPITAL ON ? ENA out.
CONUR... ENA out.

OFFICE SPACE

Mass for Deceased Patients & Relatives:

Hospital Staff Association, Hospital, holding mass on Saturday 6th November 2004 at 3.00pm in
Hospital to furnish names of deceased patients to association for inclusion on list of invitations.

Waiting List:

Subvention form completed - awaiting bed. Difficulties with subvention may not qualify for enhanced subvention.

Subvention - Letter sent to family from subvention office.

Subvention form filled. May not qualify due to financial status.

Beds:

One bed in following death

vacancies at present.

Follow Up Regarding SS Graduate Patients In Nursing Homes:

Six monthly medical review dates to be decided over the next two months

co-ordinate.

Nursing Reviews - Ongoing every six weeks to three months.

In-service Training for General Nurses in Hospital School of Nursing, also offered four places to Nursing Homes.

Two places to Nursing Home.

Two places to Nursing Home.

Commencing 5th October 2004 for one day each week for five weeks.

attended meeting and clarified issues relating to Nursing Homes;

1. Nursing Home places subvented by Health Board are public beds in Private Nursing Homes.
2. Follow up and review by
3. Any problems encountered while reviewing patients to be documented and if necessary notification to Nursing Home Inspectorate.
4. Beds in Private Nursing Home are not set in stone and may be moved if encounter difficulties regarding patient needs or care.
5. will support decisions of

complemented the efficiency of the Psychiatry of Old Age Team in their continued follow up and review of patients in Nursing Homes and the efficient and timely completion of subvention forms which was more evident here than in the General Acute Hospitals.

New Developments:

informed the committee that a new inspectorate would be established under the Remit of Corporate Governance from the Northern Area Health Board.

The new team consists of

- 1.
2. Three public Health Nurses.

enquired as to why there was no input from especially when discharge initiatives from and other is in the Northern Area Health Board occurred in 2003 and the possibility of future initiatives involving both General and Psychiatric Hospitals. Graduate patients from Psychiatric Hospitals are often difficult to place and appropriate assessment may facilitate suitable accommodation according to patient specific needs, so it would be important to have an input from will notify Team of comments.

Meeting ended at 3.30 pm.

Next Meeting 26th October 2004.

Response G

18th August 2006

Re: Professor O'Neill's Report on Review of Deaths at Leas Cross Nursing Home

The following has been prepared in response to letter received from
dated July 17th 2006, inviting any comments or observations on enclosed extract
from the report - pages 42 to 46. I have not met with Mr O'Neill in respect of the preparation
of his report nor have I received copies of all documentation to which he refers.

Comment on Extract of Report provided

The only reference to my role is in the second paragraph on page 43. This is in relation to
the letter of January 9th 2004 which was circulated to me as Clinical Director, not as stated
Clinical Manager of St. Ita's Hospital.

While there is no further reference to me, I was familiar with the concerns that arose through
discussion with,

The background to the original plan for
the transfer of long stay patients from St. Ita's Hospital, was to transfer patients who
required long term nursing care, but who did not need to be resident in a specialist
psychiatric setting. This was in keeping with the recommendations of the Inspector of Mental
Hospitals. All patients considered suitable for transfer were carefully assessed by the
Consultant lead teams in Old Age Psychiatry and patient's families were consulted in the
process. The nursing homes to which patients were discharged had been selected by the
Health Board, and Matrons of these nursing homes had visited St. Ita's Hospital to ensure
that they would be in a position to provide appropriate ongoing care for any patients
transferred.

In respect of the concerns outlined in the excerpt provided, I supported the actions taken by
in their effort to ensure that appropriate standards of care were
provided for patients in nursing homes.

Finally I reserve the right to make a fuller reply on this matter as appropriate in the future.

Clinical Director

Response H

Private and Confidential

Re: Leas Cross Nursing Home

A needs assessment was completed on all long stay patients in St. Ita's in 2002. This found that the majority of patients in the long stay wards did not have severe levels of psychiatric disability.

Moreover the Inspector of Mental Hospital in his annual reports consistently criticised St Ita's Hospital for continuing to keep long stay patients without such needs. The buildings in which these patients were cared for were also criticised as being unsuitable for the care of elderly patients. Similarly National Policy documents such as Planning for the Future (1984) along with other reports proposed that community treatment for elderly patients should be the desired option and actively discouraged the use of psychiatric hospitals for treatment unless necessary. This in essence was the basis for the clinical and administrative decision to seek alternative placements for these patients.

Prior to 2003 discharges had already been taking place on an individual and group basis. For example ten patients were discharged to nursing homes in 2001 and ten discharges took place to Lusk Community Unit in 2002.

In 2003 a decision was taken by the Health Service Executive, Northern Area to decommission Reilly's Hill, an 80 bed complex primarily because of the unsuitability of the building as an elderly care facility and the rapidly deteriorating conditions of the buildings.

A project team was established in September 2003 by St. Ita's Hospital to facilitate the smooth transfer of patients to nursing homes and other units within the St. Ita's complex. This group consisted of Senior Nursing, Medical, Administration and Materials Management staff. The first group of patients were discharged to nursing homes, selected by the Health Service Executive, Northern Area, in September 2003. In respect of Leas Cross, the Director of Nursing of Leas Cross was invited to St. Ita's Hospital to assess and discuss with staff the patients listed for transfer. This occurred on the 14th September 2003 and the Director of Nursing satisfied herself as to the selection and suitability

of the patients for Leas Cross and undertook to provide the appropriate level of nursing care.

Following extensive consultation with patients, relatives and staff, the first discharge occurred on the 17th September 2003. In view of the fact that the discharge initiative involved up to 60 patients to five nursing homes Creavlee, Clontarf, Bedford, Ratoath and Leas Cross the Consultant Psychiatrist for Old Age Psychiatry requested the Director of Nursing, St. Ita's Hospital to assign additional staff.

The Director of Nursing subsequently established a liaison nursing psychiatric service between St. Ita's Hospital and the nursing homes to advise and support nursing home staff on the psychiatric nursing needs of patients who were discharged from St. Ita's. This was specifically an advisory/liaisonary service and it would have been the responsibility of the nursing home staff to indicate any difficulties they may have and to seek help from the St. Ita's staff providing the support. Additionally access by telephone was also offered to nursing homes to consult staff in St. Ita's on matters relating to the psychiatric care of patients from St. Ita's. The staff providing the service consisted of senior Clinical Nurse Managers, Assistant Directors of Nursing and Staff Nurses who were familiar to the discharged patients. From the inception of the service on the 18th October 2003 to February 2004 nineteen visits were carried out, eleven of which were to Leas Cross Nursing Home. It should be noted that the largest number of discharges (24) were to Leas Cross Nursing Home.

In January 2004 two Assistant Directors of Nursing from the Psychiatry of Old Age Service corresponded with all the nursing homes concerned including Leas Cross to reaffirm St. Ita's Service willingness to maintain contact and support for the continuing care of these patients and to request that any changes or events occurring to these patients should be communicated to St. Ita's Service as soon as possible.

In July 2004 a meeting was held in St. Ita's Hospital to discuss progress and any concerns that needed to be addressed.

This meeting was attended by the Director of Nursing, Consultant Psychiatrist of Old Age and the Assistant Director of Nursing. It was agreed that a more formal nursing/medical review system was required to assist in the continuation of proper standards of medical and nursing care. This commenced in August 2004 and applied to all nursing homes which involved discharged St. Ita's patients.

In respect of page 45 paragraph two,

"These issues were discussed as with both the Director of Nursing and St Ita's Hospital and with the Director of Public Health Nursing following a meeting in Leas Cross"

It is not understood from this section of the report whether the Director of Nursing, St. Ita's was supposed to have attended a meeting in Leas Cross, in which case if that is the imputation, it can be stated that the Director of Nursing, St. Ita's Hospital did not attend any such meeting in Leas Cross and it can also be stated that if a meeting in Leas Cross took place which was attended by others, the deliberations of that meeting were not discussed with the Director of Nursing St. Ita's Hospital.

In relation to the final paragraph (last page, copied document):

"A report from the Director of Nursing St. Ita's Hospital to the 'Chief Officer' of the HSE (NA) (24/5/2005) on the transfer of patients from St. Ita's Hospital to Leas Cross did not make any reference to the concerns expressed over care in Leas Cross."

The Chief Officer, Health Service Executive, Northern Area requested a report from the Director of Nursing on the mechanisms that were put in place to facilitate the discharge initiative from St. Ita's Hospital to Leas Cross. The report of the Director of Nursing clearly outlines that process. The Director of Nursing was not requested to formulate a progress report on the patients discharged from St. Ita's Hospital to Leas Cross in which case this should properly be sought from the Consultant Psychiatrist in charge of the Psychiatry of Old Age team.

Nursing management responded to all concerns in a professional, proactive and expeditious manner. The discharge initiative and the subsequent follow-up was properly resourced from a nursing perspective.

This was reinforced by a newly developed Community Psychiatry of Old Age team consisting of Consultant Psychiatrist, Assistant Director of Nursing, two Community Nurses and a Social Worker.

All of the nursing homes involved in the discharge programme including Leas Cross gave an undertaking to provide standards of nursing care commensurate with the needs of the patients. Extensive support and guidance was made available by St Ita's Hospital for that purpose. It should be noted that it is not the responsibility of the Director of

Nursing St Ita's Hospital to inspect the standards of care in the nursing homes or to direct or manage staffing levels, skill mix and training of staff.

The report in my view is ambiguous in relation to Directors of Nursing and could lead to potential confusion as to which Director of Nursing Prof. O Neill is referring to.

Your correspondence on the 17th July 2006 refers to me as being a member of the Nursing Home Inspection Team. I can state I was not a member of any nursing home inspection team.

I have commented on the sections in the report relating to me as Director of Nursing, St. Ita's Hospital. This is not a fully comprehensive response and I am reserving the right to supplement my response on any issue in the report or issues arising from the report. I would be agreeable to comment further if so required.

It should be noted that Professor O Neill did not furnish me with any documentation or reports or indeed did not request that I meet with him to clarify any issue, at any time, during his investigation.

Director of Nursing
St Ita's Mental Health Service

20/10/06
