Bord Altranais agus Cnáimhseachais na hÉireann
Nursing and Midwifery Board of Ireland

Findings and Decisions
following
Fitness to Practise Committee Inquiries
Nurses Act, 1985

Name: Hayley Rosemary Holmes; **PIN:** 130268
Findings of the Fitness to Practise Committee: Professional misconduct

Allegations proven against Ms Hayley Holmes:
That you, being a registered nurse, while Key Senior Manager and/or Assistant Director of Nursing and/or Deputy Person in Charge of Nursing Home X:

Resident Care

Failed to ensure that any or any adequate and/or appropriate care was afforded to one or more of the residents of Nursing Home X in that you:

- On one or more occasions, between in or around 2009 and on or around 11 May 2011, directed one or more staff, to wake up one or more residents between approximately 04.00hrs and approximately 07.30hrs for the purpose of administering medication and/or for the purpose of feeding and/or for the purpose of dressing and/or for the purpose of washing when you knew or ought to have known that this was not appropriate;

- On one or more occasions, between in or around 2009 and on or around 11 May 2011, failed to respond appropriately and/or at all when you knew or ought to have known that one or more night staff woke up one or more residents between approximately 04.00hrs and approximately 07.30hrs for the purpose of administering medication and/or for the purpose of feeding and/or for the purpose of dressing and/or for the purpose of washing;

- On one or more occasions, between in or around 2009 and on or around 21 July 2011, knew or ought to have known that an all-in-one sleeping suit was used for one or more residents when you knew or ought to have known that the use of all-in-one sleeping suits had not been adequately assessed and/or was not appropriate;

- On one or more of the following unidentified dates, before and between on or around 22 March 2011 and on or around 21 July 2011, failed to ensure that residents' skin and/or wounds were cared for adequately or at all, when:

    - Medication was not administered to Ms A resident, ("Ms A") on one or more occasions prior to her pressure sore being dressed;

    - Ms A was not referred to a tissue viability nurse and/or a specialist wound care nurse in a timely manner when her pressure sore deteriorated;

    - Ms A's care plan did not reflect the advice given by her General Practitioner that her dressings were to be changed every three days;

    - On one or more occasions, Ms A was allowed to sit in a chair in the day-room for more than two hours when this was likely to contribute to the deterioration of her pressure sore and/or cause Ms A discomfort and/or pain;

- On one or more of the following unidentified dates, before and between on or around 22 March 2011 and on or around 21 July 2011, failed to ensure that the nutritional needs of one or more of the residents were managed and/or monitored adequately and/or at all, to include when:

    - Ms B, resident, was not referred to a dietician in a timely manner, when you knew or ought to have known that her weight had deteriorated or decreased;

    - You failed to refer Ms A to a dietician and/or failed to discuss Ms A's nutritional needs with a dietician from on or around 28 February 2011 onwards, when you knew or ought to have known that her weight had deteriorated or decreased since on or around 5 February 2011;

- You failed to ensure that Ms A's Malnutrition Universal Screening Tool (MUST) was updated on a monthly basis between on or around August 2009 and on or around December 2010 and between on or around February 2011 and on or around June 2011;

- On one or more unidentified dates, before and between on or around 22 March 2011 and on or around 21 July 2011:

  - Failed to implement and/or manage any or any adequate risk management strategy regarding falls and/or accidents in respect of one or more residents who were at risk of falls;

  - Failed to manage adequately or at all the falls risk of Mr C, resident, and/or failed to respond adequately or at all to concerns raised with you by Ms D about Mr C's falls risk;

- On one or more unidentified dates between 2009 and on or around 21 July 2011, failed to ensure safe medication management practices in Nursing Home X, to include one or more of the following:

  - A failure to investigate adequately or at all and/or take appropriate action(s) in response to one or more medication errors;

  - A failure to ensure appropriate staff training in medication management;

Health Information and Quality Authority Reports and/or Immediate Action Plans

Between on or around 5 April 2011 and on or around 21 July 2011, failed to take appropriate action to implement one or more of the recommendations contained in one or more of the following Health Information and Quality Authority **("HIQA")** Reports and/or Immediate Action Plans:

- 5 April 2011;
- 12 May 2011;
- 15 June 2011;
- 1 July 2011;
- 6 July 2011;

- 14 July 2011;

On one or more occasions between on or around 5 April 2011 and on or around 21 July 2011, failed to engage properly and/or appropriately with one or more HIQA inspectors;

Discharge of Residents

On or before 20 July 2011 and/or 21 July 2011, failed to ensure that the arrangements for the discharge of one or more residents was carried out in a planned and/or safe manner, when you:

- Failed to contact Dr I, General Practitioner to one or more of the residents, to discuss the arrangements and/or the plan of care and/or the clinical requirements for the transfer of one or more of the residents;

- Failed to ensure that any or any adequate discharge plan was in place for one or more of the residents;

- Informed the Wards of Court Office that the discharge of Ms M, resident, was for approximately three weeks to facilitate the carrying out of emergency construction works when you knew or ought to have known that this was not the case;

- Knew or ought to have known that arrangements were in place for Ms A to be transported by wheelchair taxi when you knew or ought to have known that this mode of transport was not suitable and/or appropriate.

Sanction: Pursuant to Section 39(1)(a) of the Nurses Act, 1985, Ms Hayley Holmes' registration was **erased** from the Register of Nurses and Midwives.
The decision to erase Ms Hayley Holmes' name from the Register of Nurses and Midwives was confirmed by the High Court on 15 November 2021.