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: Miriam Geraldine F. Holmes; **PIN:** 36664
Findings of the Fitness to Practise Committee: Professional misconduct

Allegations proven against Ms Miriam Holmes:

That you, being a registered nurse, while Person in Charge and/or the Registered Provider 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 2007 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 2007 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 any or any adequate systems were in place for management of pressure sores and/or wounds when:

- Medication was not administered to Ms A, resident, 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 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 and/or failed to ensure that any or any adequate system for monitoring weight and/or food intake and/or fluid intake was in place, 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, staff nurse, 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;

Resident Finances

Between on or around March 2010 and on or around 31 May 2011, on one or more occasions, failed to ensure that one or more of the subvention funds paid to Nursing Home X by the Health Service Executive in respect of Mr E, resident, were reimbursed to Ms F, niece of Mr E, on Mr E's behalf;

Policy Implementation

Between on or around 22 March 2011 and on or around 22 July 2011, failed to ensure that any or any adequate **policies** and/or procedures were in place and/or implemented, to include one or more of the following:

- Risk Management Policy;
- End-of-Life Care Policy;
- Restraint Policy;
- Prevention, Detection and Reporting of Incidents of Abuse Policy;
- Consent Policy;

Fire Safety

Between in or around May 2011 and on or around 22 July 2011:

- Failed to complete a fire safety assessment in respect of Nursing Home X, as ordered by Fire Authority G, and/or failed to provide Fire Authority G with a fire safety assessment;
- Failed to provide any or any adequate Certification to Fire Authority G for one or more of the following systems:
    - the Fire Detection and Alarm System;
    - the Emergency Lighting System;

Premises

Failed to ensure the premises at Nursing Home X was suitable and/or appropriate for the safety and/or care of residents, to include one or more of the following:

- A failure to have thermostatic controls on the hot water taps and/or the hot water systems when you knew or ought to have known that these controls were required;
- A failure to ensure that some or all of the external grounds of X Nursing Home were safe and/or secure;
- A failure to ensure that there was sufficient space at the dining table and/or dining area for one or more of the residents;

- The use of metal serrated wall guards and/or wall protections on one or more corridors and/or on one or more bedroom walls when you knew or ought to have known that this was inappropriate and/or unsafe;

Staff

Before and between on or around 22 March 2011 and on or around 21 July 2011, failed to ensure on one or more occasions that staffing levels of nurses and/or care assistants were adequate;

Employed or arranged for one or more staff members to be employed when you knew or ought to have known that one or more of the following documents had not been obtained in respect of one or more of those staff members:

- Evidence of satisfactory Garda Vetting;

- Evidence of satisfactory physical or mental fitness;

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;

Management of Nursing Home X

On or before 9 June 2011, in advance of going on leave from Nursing Home X, failed to ensure that appropriate arrangements were in place for the management of X Nursing Home in one or more of the following respects, when you:

- Appointed Ms P, as the Person in Charge in circumstances where you knew or ought to have known that she was not appropriately briefed for and/or supported in this role;

- Failed to ensure that any and/or any adequate funds were available to manage the day-to-day running of Nursing Home X;

- Failed to ensure that one or more suppliers to Nursing Home X were paid and/or failed to take any or any adequate steps to ensure that arrangements were in place for the payment of one or more suppliers;

Discharge of Residents

On or around 10 July 2011, failed to ensure that Mr H resident was discharged in a planned and/or safe manner, when you failed to ensure that an appropriate discharge plan and/or care package and/or any or any adequate supports and/or support services had been put in place and/or had been activated in advance of Mr H's discharge;

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 one or more staff members and/or one or more of the residents and/or their families and/or their next of kin that the discharge was temporary or words to that effect, 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;

Hotel J

On or around 21 July 2011 and/or around 22 July 2011, had in your possession at Hotel J the Personal Public Service ("PPS") cards of one or more of the following residents, when you knew or ought to have known that this was inappropriate:

- Mr C;

- Ms A;

- Ms L;

- Ms M;

- Ms N;

On or around 21 July 2011 and/or 22 July 2011, had in your possession at Hotel J, one or more of the following medications prescribed for one or more of the following residents when you knew or ought to have known that this was not appropriate:

- Lexapro for Mr H;

- Nuelin SA and/or Nuelin SR for Mr H;

- Protium for Ms O;

- Laxose for Ms M;

Left one or more of the items referred to in allegation above at Hotel J, when you knew or ought to have known that on or more of the items were sensitive and/or confidential;

Left one or more of the items referred to in allegation above at Hotel J, when you knew or ought to have known that the one or more of the medications should be stored responsibly.

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