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: Ms Grace Marie Kelly; PIN: 43752
Finding of the Fitness to Practise Committee: Professional misconduct

Allegations proven:

That you, being a registered nurse, while employed at Nursing Home A ("the Nursing Home") as Person in Charge from on or around 12 March 2012 to on or around 27 April 2012:

- Failed to ensure safe and appropriate care was provided to one or more of the residents in the Nursing Home by staff under your management in the Nursing Home in respect of one or more of the following:
    - A failure to ensure adequate staffing levels of nurses and/or care assistants to include:
        - On or around 14 April 2012, when you knew or ought to have known that no nurse was on duty in the Nursing Home from approximately 10.00am until approximately 02.00pm;
        - On or around 21 April 2012, when you knew or ought to have known that an unqualified and/or untrained member of staff was providing care and/or supervising residents;
    - The failure to maintain any or any adequate nursing documentation to include one or more of the following:
        - Care plans;
        - Current and/or appropriate nursing records;
        - An audit of falls;
        - Falls assessments and/or reassessments;
        - Risk assessments;
        - Wound care folder;

        - Pain assessment records;
        - Assessments in relation to the use of restraints;
        - Audits of accidents and/or incidents;

    - The failure to adopt and/or implement any, or any adequate, policies and/or procedures in respect of one or more of the following:

        - Medication Management Policy

- You failed to ensure safe medication management practices in the Nursing Home and in particular, following the Health Information and Quality Authority ("HIQA") inspection on or around 14 March 2012 and the HIQA report dated 14 March 2012, to include one or more of the following:

    - A failure to ensure that the controlled drug press was locked on or around 20 and/or 21 April 2012;
    - A failure to ensure any or any adequate handover or briefing to agency nursing staff;
    - A failure to ensure that any or any adequate medication administration records were kept;
    - A failure to investigate one or more medication errors noted in the Controlled Drugs Register;
    - A failure to arrange a medical review of one or more of the residents' medications;
    - A failure to ensure that the Controlled Drugs Register was maintained in accordance with good medication practice;
    - A failure to provide any or any adequate system to reduce the number of medication errors;
    - A failure to ensure the safe and/or proper transcribing of the residents' prescription / medication order;

- You failed to ensure that any or any adequate care was afforded to one or more of the residents of the Nursing Home and in particular, following the HIQA inspection on or around 14 March 2012 and the HIQA report dated 14 March 2012, to include;

    - A failure to ensure that the hygiene needs of one or more of the residents was addressed adequately and or at all;
    - A failure to ensure that, where required, residents were provided with appropriate assistance at meal times;
    - A failure to manage adequately or at all the nutritional needs of one of more of the residents to include managing the residents' weight loss and/or recording the residents' weight loss;
    - A failure to ensure that one or more of the resident's skin and/or wounds were cared for adequately or at all;
    - A failure to arrange and/or ensure any and/or any adequate access to allied health professionals;

- A failure to ensure that the residents had any or adequate access to call bells;
- A failure to conduct any or any adequate dependency assessments;

- Failed to ensure that safe and appropriate care was delivered to one or more of the residents in the Nursing Home arising from the HIQA inspection on 14 or around March 2012 and the HIQA report dated 14 March 2012, you:

    - Failed to progress adequately or at all one or more of the issues identified by HIQA at the inspection on or around 14 March 2012 and/or as set out by HIQA in an Action Plan following the said inspection when you knew or ought to have known was required;

    - On or around 20 and/or 21 April 2012, told one or more of the HIQA Inspectors that you had reviewed and/or individualised the residents' care plans when you knew or ought to have known that this was not the case;

    - On or around 20 and/or 21 April 2012, told one or more of the HIQA Inspectors that you were of the opinion there was adequate staffing levels and/or supervision of staff and/or residents when you knew or ought to have known that this was not the case.

Sanction: Pursuant to Section 41(1) of the Nurses Act, 1985, Ms Kelly was **censured** in relation to her professional conduct and pursuant to Section 40(1) of the Act, a **Condition** was attached to the retention of Ms Kelly's name in the Register of Nurses and Midwives. The decision to attach a condition to the retention of Ms Kelly's name in the Register of Nurses and Midwives was confirmed by the High Court on 3rd April 2017.