



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 Ann Maria Gillooly; PIN: 48096**

**Findings of the Fitness to Practise Committee: Professional misconduct**

**Allegations proven:**

That you, being a registered psychiatric nurse and Person in Charge and/or Director of Nursing and/or in control of Nursing Home X, between on or about July 2009 and on or about April 2010:

- Failed to **manage** and/or ensure the Nursing Home was managed in a safe and/or appropriate manner and/or in a manner consistent with the provision of safe and/or appropriate care to residents in one or more of the following respects:
  - Failed to ensure that one or more of the following **records** were maintained adequately, and/or at all:
    - Care Plans for Residents (*as regards the adequacy of the records maintained*);
    - Accounts of Residents' Personal Property and Possessions; and
    - Directory of Residents;
- You failed to ensure in a timely manner, and/or at all, that any or all of the following were suitable for the care of elderly residents with varying levels of dependency:

- The staffing levels;
- Failed to ensure that one or more of the **residents** in the Nursing Home received the appropriate standard of care in respect of one or more of the following, when:
  - You failed to arrange any and/or any adequate supervision of one or more of the following residents who you knew or ought to have known that they were at a high risk of fall(s):
    - Mr A who fell on or around 07 July 2009;
    - Mr B who fell on one or more occasions on or around 07 November 2009;
    - Ms C who fell on or around 11 November 2009;
  - You failed to maintain the privacy and/or dignity of one or more of the residents of the Nursing Home in respect of one or more of the following:
    - The use of a communal supply of toiletries and cloth towels;
    - The failure to ensure that bathroom doors locked;
  - You failed to ensure the proper management of residents' nutrition to include the failure to introduce a formal system of communication in relation to residents' dietary requirements and/or special dietary needs;
- Failed to ensure the appropriate recruitment and/or management of **staff** when:
  - You failed to communicate with staff by:
    - Failing to hold any and/or any adequate number of staff meetings on a sufficiently regular basis and/or at all;
    - Failing to maintain any or any adequate minutes of staff meetings;
    - Failing to holding any or any adequate staff training appraisals;

- You failed to manage adequately and/or at all the staff members that were on duty when you required the care assistants who were working on night duty to carry out domestic chores and/or cleaning, negatively impacting on the care staff's ability to supervise and/or care for the residents.

**Sanction:** Pursuant to Section 39(1) of the Nurses Act, 1985, Ms Gillooly's name was erased from the Register of nurses and midwives. The decision to erase Ms Gillooly's name was confirmed by the High Court on 18<sup>th</sup> April 2016.