Response A

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INDEPENDENT INSPECTION REPORT ON CLOSURE OF LEAS CROSS NURSING HOME

LEAS CROSS
SWORDS
CO DUBLIN
IRELAND

COMMISSION BY REGISTERED PROPRIETORS
MR & MRS JOHN J. AHERNE

Quote
In an Other Issue with *Prime Time* Reporting

The Justice Minister Michael Mc Dowell accused *Prime Time* of trying to set him up with an accusatorial style of programme in which a pretence at balance is made by merely affording someone the opportunity to contradict as best he or she can a previously unseen film package. He said this amounted to a sham claim of objectivity by ambush. When this happened to Leas Cross Nursing Home, the Justice System did not help the proprietors Mr and Mrs Aherne nor did the Health Service Executive Northern Area.

Leas Cross Nursing Home and Retirement Complex

Leas Cross Nursing Home and Retirement Complex is a state of the art facility set on five acres of landscaped gardens with ample private parking. The building is a modern purpose built residence within 2 miles of Swords village and 8 miles from Dublin city centre.
The home was approved by the Northern Area Health Board to provide accommodation and nursing care for 111 persons in 43 single rooms 34 twin bedded rooms.

Registered proprietor Mr. & Mrs. John Aherne
Person in charge
Registration date 1-June 04 to 31-May 07

Recommended by

Signed 2nd February 2005

Recommendation approved by:

Signed 2nd February 2005

History of Management of Care
In Leas Cross Nursing Home
Registered and approved by Eastern Health Board as persons in charge between June 1998 to June 1999

New Registration Authority
1st June 2004 to 31st May 2007
Northern Area Health Board

Registered and approved person in charge

had been in post since 10th November 2004 as assistant matron. She was approved by the Health Board as the person in charge from mid May 2005.

had only been in the post two months prior to the *Prime Time Investigates* documentary on the standards of nursing home care in Ireland. Leas Cross employed Mr. Cahill Gallagher as a Care Assistant (the undercover/covert reporter).

Quality of Environment

Building Design

The majority of bedrooms are situated on the ground floor, comprising of single and double rooms, all passed by Building Control Standards, Fire Regulations and Registration Standards. In terms of access, rooms located on the first and mezzanine floor have lift access. In the new extension, the majority of rooms have full en-suite facilities. All rooms have TV and telephone facilities.

The building design and layout helps staff to provide good care, privacy, dignity, and individuality.

The building is of a high standard and everyone is assured of a sense of dignity and privacy from the design and location of toilets and bathrooms.

Interior design

The design of the interior eliminates any large institutional features. Rooms are shared only by choice and this remains the policy and practice of the home. **Residents are able to adapt their private space to their own needs and maintain control over it.** Maintenance and upkeep of the interior is kept to a very high standard. The appearance and condition of the general areas are well maintained and looked after.

Monitoring and inspections are regularly carried out and recorded and action is quickly taken to correct any defects.

Building Appearance - Internal

Measures have been taken to ensure the home is attractive. All areas of the building are well maintained and in good condition creating an attractive appearance. The building appears comfortable. It is suitably designed and fitted out for its purpose. Residents are able to personalise their own rooms as evidenced through personal pictures, items of furniture, etc.

Creative management and use of space has been utilised to create a pleasant environment.

Facilities and Adaptations
There is an impressive range of useful and usable facilities and aids adapted to individual needs. Residents have a choice of activities to enjoy.

There is 2 qualified activities therapists employed full time and facilities are available to stimulate and encourage residents to pursue activities.

Meeting Environmental Health Requirements
Aim
To ensure that the home is kept clean and free from the risks of illnesses and disease caused by lack of hygiene, also to ensure that basic conditions of heating, lighting and ventilation are to the standards required.

Quality of Environment
High standards of heating, ventilation and lighting are clearly in evidence throughout the home.

Health Hazards
There are contracts in place with outside contracting companies to deal with waste disposal arrangements.
Regular monitoring and inspection ensures that high standards are kept at all times.

Exterior Conditions
Conditions of drains, outhouses, bins and bin areas are maintained to a high standard.

Maintenance Management System
All repairs are attended to immediately and there is a planned programme for dealing with general upkeep.

Food Hygiene

Aim

To ensure that all aspects of the supply and handling of food conforms to the current requirements and regulations.

Supply and Ordering of Provisions

There is clear evidence that food suppliers and nursing home staff are meeting the food hygiene standards required of them.

Freshness of Provisions

Fish, meat, milk, bread and vegetables are supplied fresh daily. Other provisions are bought as necessary.

Food Storage

All arrangement for food storage meets the required standards.

Food Handling and Preparation

High standards are maintained in all aspects of food handling / preparation and regular monitoring and inspections are in place.

Food Hygiene Problems

There have been **no** outbreaks of diarrhoea or similar symptoms of food related illness during the last year.

Fire Prevention and Procedures

Aim

To ensure that risks of fire are minimised by following the required procedures and recommendations

Smoking Policy

The policy on smoking respects the rights of the residents to smoke, but clearly minimises fire risks and hazards. There is new residents' smoking room for those who wish to smoke.

Adherence to Fire Regulations
Monitoring and supervision arrangements are in place. A contract is in place with Professional Fire Protection Ltd. – whom provide on site training and education and carry out bi-annual inspections of all fire fighting equipment.

Fire Drills
Regulations are strictly adhered to and procedures are in place to ensure the safety of the residents and staff.

Recording
Records are kept up to date generally but lapses do occur from time to time.

Safety of the Environment
Aim
To ensure that people are not likely to sustain personal injury as a result of failure to conform to basic Health And Safety.

Use of Protective Clothing / Equipment
There are clear policies and practices in place regarding the wearing of protective clothing, thereby minimising risks.

Medical Equipment
Medical equipment is of a high standard. All necessary equipment is in place to ensure emergencies can be dealt with effectively.

Staff Training
All staff have participated in safety training, which is reinforced by regular monitoring and supervision.

Record Keeping
Records are kept up to date, but they could be improved.

Mood and Atmosphere

Aim

To be able to live in a warm, comfortable, safe and secure environment with efforts made to manage and reduce stress.

Sense and Smell

Every effort was made to keep the air fresh and pleasant. There were no lingering smells and the living areas remain fresh.

Residents

Residents were generally relaxed, content and welcoming and individual difficulties were sympathetically dealt with.

Quality of Staff

Selection and Recruitment

There are criteria in place for selecting staff but this needs to be utilised more often.

Job Descriptions and Documentation

Each member of staff is given all written information required. Documentation is regularly revised and updated.

Equal Opportunities

There is a written equal opportunities policy in place and there is a clear commitment to making it work.

Conditions of Employment

These are clearly up to date and well documented.

Grievances and Disciplinary Procedures

There are procedures and ample evidence to show that they are duly followed and correctly acted upon.

Commitment to Good Practice

Aim

To ensure that through good staff management and professional leadership all staff are committed to the goals of good practice, and are supported to achieve these through effective supervision and training.

When commenced work at the home in November 2005, she introduced a team working system with staff nurses in charge of each team. The teams were colour coded: one yellow, one red and one blue. The residents were positively encouraged by staff to help and motivate themselves. Efforts were increased to listen and talk to residents and relatives.

Assessment of Training Needs

was in the process of developing a training needs analysis for each member of nursing and care staff. She also set up appraisals for all staff.

Team Development

Teamwork issues are addressed routinely. It was accepted that all staff needed to improve their teamwork. Steps had been taken to improve this situation.

Stress Levels of Staff

At the time of my visit, the majority of staff appeared to be under severe stress. I met with all members of staff, both as a group and on an individual basis. Staff expressed their dissatisfaction while working with the HSE Seconded Director of They felt was the only hands on nurse that worked well with them.

Most staff had worked at the home for over two years and other members were employed by the home since its opening in 1998. The majority of staff had experienced several inspections by the HSE Inspectorate.

Quality of Care

Written Contracts of Care
Agreements with residents and their next of kin provide detailed information about their entitlements, backed up verbally as needed.

Choice of Food and Drink
There is always a choice of menu, snacks and drinks freely available and individual preferences are always met.

Mode of address
All residents are asked how they would like to be addressed and staff are trained and supervised accordingly.

Choice of Clothing
All residents including the most frail, disabled and confused are treated as being capable of choice and helped in their decision, if required.

Personal Care
Routines are adapted and organised around the individual's needs and preferences.

Religious Needs
There is a commitment to identify religious needs and to ensure they are met.

Financial Control
Residents whom are considered capable of managing their own finances are encouraged to do so.

Health Care
Choice of GP is discussed. If capable, residents may be responsible for their medication, unless evidently at risk. Otherwise nursing staff will take charge of medication.

Management of Care Practices

Aim
To ensure through effective management that high standards of care practice are maintained throughout the home

Emergencies and Crises
The policies and procedures are clearly understood and acted upon. Staff training is given in first aid.

Sudden Discharge and Death
The importance and sensitivity of this subject is understood by all staff. Sensitive procedures and practices are evident.

Complaints
Management policy and procedure ensures a consistent approach to all complaints.

Daily Monitoring and Supervision
Management were in the process of increasing the number of supervisory staff within the nursing home.

Admission
Enquiries for admission into the home are dealt with by the Matron. Admission arrangements for new residents are handled by the nurse in charge. / highlighted this area as one requiring review. The introduction of a more formal admission procedure was discussed and was due to be implemented shortly.

Reviews
Reviews are undertaken and meet current standards and there is a system to ensure standards are always maintained.

Care Plans
Nursing care plans for each resident was under review or has been updated.

Procedures for Assessment, Admission, Care Planning and Reviews

Aim

To ensure that the home is, as far as possible, able to meet the needs of the prospective or actual residents and continues to do so

Assessment

There are no formal methods to match a prospective resident's needs to what can be provided for him/her. There needs to be a tightening of this area. The complex needs of people suffering with psychological disturbance requires well organized, multi-disciplinary and multi-agency approaches with communication between all professionals and organizations.

Personal Care Routines and Practices

Personal care is provided on the basis of an individual care plan and new care plans are in the process of development.

Care Planning and Reviews

Assessment of needs should involve a multidisciplinary team with the full involvement of the client / family.

Use of Outside Facilities

There is evidence of residents taking part in field trips, such as art classes and library visits.

Visiting Arrangements and Times

Visitors are welcome at all times.

Involvement of Relatives and Friends

Part of the care planning is to assess and identify how relatives and friends could help to identify the resident's preferences.

Staff Approaches to Signs of Distress

Staff recognise when residents are upset or distressed and are able to react in a kind and sympathetic manner.

Attitudes to Challenging Behaviour
Challenging behaviour is accepted as predictable and assessments / plans are made according to need.

Opportunities for Self – Expression
Residents are given opportunities to express feelings that are not considered threatening or disturbing to themselves, fellow residents or staff.

Self Care
Residents are supervised and encouraged to be as active as possible.

Possessions
Rooms have lockable cupboards for safe keeping valuables.

Locking of Doors
Doors may be locked for security reasons (e.g. at night time) but residents are free to come and go.

Use of Bedrooms
Residents ultimately decide when to stay or leave their own rooms.

Restraints on Freedom of Movement
Safety devices are highly individualised and only used for that purpose. Residents whom use safety devices such as Buxton chairs have been assessed as needing that device and are monitored constantly.

Staff Control
Residents are free to move around the home and private gardens. Movements are monitored and supervised by staff.

Use of Medication
Medication which effectively controls and restrains behaviour is prescribed by the doctor only. This area is stringently controlled.

Safeguarding of Privacy
Staff are trained and expected to knock on doors, but still enter after doing so with or without a reply.

Dignity and Respect
Toilet and bathroom doors are kept shut and if required only the care staff are in attendance.

Private Discussions
Private meetings may take place in the office or similar meeting rooms.

Confidentiality
Personal information is restricted to senior staff members.

Use of Case Records
Access to this area/information is restricted to authorised medical nursing staff.

Institutional Practice
Routines are individualised and built around the resident's needs and preferences.

Flexibility of Meal Times
Residents know they can always obtain food and drink outside set meal times without being a nuisance.

Feed Back From Relatives
Feelings of dissatisfaction and anger by both relatives and residents at the closure of Leas Cross. The residents felt their security and stability were threatened. They were told if they did not agree to move to alternative accommodation the HSE would stop their payments to the home. Many residents/families were very stressed at the disruption caused. The majority of residents/families pointed out that they had no complaints with the home's standard of care and were all very happy.

The people who complained about the home on *Prime Time Investigates* had not lived there for a number of years. No families that were present in the home had made any complaints on the programme.

It should be noted that RTE's covert reporter failed to get permission from a number of the residents' whom appeared on the Prime Time programme to be filmed. As these residents would have been covered under the Mental Health Act, Mr. John Aherne had to take RTÉ to the High Court in an effort to protect the privacy and anonymity of the residents.

Quality of Management

Recording Procedures and Systems
Aim
To ensure that all required recording is up-to-date and to the required standard..

Quality of Methods Used
Methods for record keeping are coherent, consistent and clearly usable.

Up to Date and Good Order of Records
Improvement could still be made to ensure that all records are up-to-date.

Care records
Individual records are generally and consistently of a good quality, sensitive and usable.

Supervision and Training
All staff members are provided with training, which is supported through supervision, and on-going training.

Administration of Drugs and Medicines
Aim

To develop systems for dispensing of drugs and medicines that (A) are sensitive to the rights and needs of the residents in receipt of such medicines and (B) to ensure that all unnecessary risks are eliminated

Storage of Drugs
All of the required recommendations are met and the risks of accidents or mistakes occurring have been minimised.

Security and Access
Sound and well-used procedures exist for the security of cabinet and lockable trolleys and their contents. All medicines are clearly labelled and all unused medicines are returned to the pharmacy and are then recorded and receipted.

Dispensing of Drugs and Medicines
Only authorised staff ever dispense medicines and policies and procedures are always followed.

Records
Individual records are kept and are in good order.

Monitoring and Inspection
Informal checks are made but more regular formal monitoring could be developed and a record of these checks kept.

Policies and Procedures
Aim
To ensure that there are written guidelines relevant to all matters concerning the home which indicate the standards to be achieved. These should be brought and kept up-to-date.

Policies and Procedures
There are written policies and procedures in place. However, some aspects are not comprehensive and require improvement.

Complaints Procedures
Complaints are supported by good record keeping and evidence of actions taken.

Review and Updating
At the time of my visit all policies and procedures were under review.

Monitoring and review
Aim
To provide a system of procedures to ensure that the home maintains and improves its standards.

Monitoring
At the time of my visit, Some aspects are monitoring were inconsistent. A more regular monitoring system needs to be implemented.

Staff Supervision
Supervision arrangements apply to some staff but need to be developed so that everyone is adequately supervised.

Management Reviews
Regular management reviews take place and findings are acted upon immediately.

Use of Inspection Reports
Since 1999, there is no evidence of 6-monthly inspection reports from the HSE Northern Area, with the exception of one report dating back to 2003. When reports were received (i.e. Up to 1999), recommendations were acted upon immediately.

Management Approach
Aim
To develop an approach to management and management style that produces the quality of care and standards required to run a residential and nursing complex.

Management Systems
There are schedules in place but they need to be followed more consistently and reviewed regularly.

Quality Assurance
Leas Cross is an ISO-quality assured nursing home. It received this accreditation in November 2003 and has since passed an annual audit from EQA (the licensing body) in November 2004.

Staff Rotas
Rotas are planned well in advance and contingency plans ensure that difficulties in finding cover rarely arise.

Management Style
In most areas the management can be said to be both effective and efficient.

Information
There is an efficient, reliable information system whereby people are informed of all-important changes quickly.

Relations with Purchasers
All potential purchasers have been made fully aware of what the home has to offer.

Relations with Inspectors
The home has consulted with the inspection team on a wide range of statutory development issues. Until recent events, the HSE Inspectorate has had no significant issues with Leas Cross, despite their statutory bi-annual inspections and their continuous contact with the Matron.

Approach to Complaints
Complaints are seen as integral to the development of the service and are always treated seriously and positively.

My Comments (Ms. Rita Craig)

The management problems started when agreed to a block booking from St Ita's Hospital. This contract commenced with clients arriving between the 17th and 26th September 2003. The contract was for 24 beds. St. Ita's Hospital was closing wards and the residents whom were discharged to Leas Cross had complex mental and medical care needs.

The assessments for discharge to Leas Cross were carried out by Consultant Psychiatrist and

The patients began to arrive in Leas Cross three weeks after assessment. Five residents needed hospitalisation and were sent to Beaumont Hospital. The hospital sent them back to Leas Cross after a short time.

There were 64 admissions for respite care during the period between 18th November 2004 to 14th June 2005. Of this group, there were five residents who died, five needed long term care, there was one hospital transfer and fifty-three discharges.
It would be extremely difficult for any nursing home to cope with this amount of admissions, during the most severe months of the year. Leas Cross was being used like an extension of St Ita's Hospitals and Beaumont Hospital. Clearly this was Leas Cross' most difficult management time. It would have been impossible for any nursing home to cope with the levels of mental, medical and nursing care needs of so many respite clients.

Though the clients requiring respite care had almost all being discharged by the time the HSE seconded team arrived, it was evident this team could not cope with the needs of the long-term clients. However, problems were sorted within the first two

weeks of their arrival, but from my observations this was largely due to the efforts of the home's own staff and management.

I note the HSE Team was made up as follows:

* 6 Mental Health Managers
* 2 Hospital / Medical / Managers
* 1 Public Health Nursing Home Manager

Public Nursing Homes are not registered.

80 % of Leas Cross residents had Mental Health Needs.

There needed to be a mental health care needs manager in place and registered mental health nurses. The HSE Inspectorate never made this recommendation.

There was also a need to locate high dependency residents in one or two nursing wings of the Home in order to provide the highest standard of nursing care. This too was not recommended by the HSE Inspectorate. In my view the HSE need to accept responsibility for the problems with issues of Leas Cross nursing home because if they don't acknowledge their mistakes, they will happen time and time again.

Deaths in Leas Cross Nursing Home from September 2003 to December 2003.

The death of 7 St Itas transfers occurred within one month of being discharged from St Ita's Hospital to the Nursing Home. Quite clearly these people should never have been discharged from St. Itas as they required mental health care and medical care.

HSE Moved Residents from Leas Cross – Summer 2005

It appears that one of the reasons the HSE moved all residents from Leas Cross was an active effort to divert attention away from the HSE's error of ring-fencing 24 beds at Leas Cross in 2003 to assist the closure of wards in St. Itas and to care for mental health patients elsewhere.

The HSE gave the management of Leas Cross an impossible task of recruiting an additional 20 registered nurses immediately. It is my opinion that there may have been a requirement for an additional 1 or 2 RGNs but I believe what was fundamentally required was Mental Health qualified nurses/manager

Clients in the Home had various degrees of mental health problems such as:

- Chronic Paranoia schizophrenia
- Alzheimer's disease in various stages
- Psychosomatic disorders
- Alcoholic dementia
- Aggressive outbursts
- Chronic paranoia
- Depression
- Long history of psychiatric problems
- People with behavioural difficulties
- People with schizophrenia

List of inspectors/HSE professionals involved with the Management of the Nursing Home

The findings of Rita Craig

I find the HSE failed in their duty of care to:

- **Residents and families**
- **The proprietors of Leas Cross**
- **The registered person in charge of the Nursing Home**

Leas Cross Nursing Home and Retirement Complex was the victim of the HSE Inspectorate team's failures.

Signed: R M Craig

Date: 28-10-05

INDEPENDENT REPORT
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Medical Review of Morbid Case Studies - Leas Cross Nursing Home – 13/9/2005

As part of an ongoing investigation into Leas Cross Nursing Home the Health Board Of Ireland have requested some random case studies of those patients who have died whilst either being in Leas Cross Nursing Home or after referral to local hospitals where they subsequently died. At this moment in time no reason was given for the review of these cases but presumably the Health Board is looking into whether there is any contributory negligence to these cases that can attach any blame to Leas Cross nursing Home and the care given to the patients.

Of the 92 cases that subsequently died I was able to review a third. The Leas Cross records were given to me and no-one from Leas Cross made any attempt to influence which ones I looked at in any way. Of the 92 cases the 30 that were reviewed by myself were picked out at random. The ages of those cases reviewed ranged from 65 to 96. The majority of the cases were in their 80's and early 90's.

An interesting point to note is that all the patients who were admitted to Leas Cross Nursing home and who subsequently died were in a poor state of health. As a routine standard Nursing Home one would expect Leas Cross to accept patients who suffered from a degree of dementia, relatively modest physical illness, who needed general care. Of the cases investigated all had serious medical conditions that were either pre-terminal or terminal.

Of all the cases reviewed there was no evidence in any of the cases of contributory negligence from Leas Cross Nursing Home. Unfortunately, the hospitals did not appear to have sent any post mortem reports (if any post mortem was carried out) or any summary of the patients stay in hospital. The only evidence of any report from the hospitals was a request for a return to Leas Cross Nursing Home if they had been admitted for a short period of time. Where the request for a return to Leas Cross has been put in the notes it is interesting to note that many of the patients entered the hospital from Leas Cross without pressure sores but returned with pressure sores.

A possible criticism of Leas Cross Nursing Home is the fact that many of the cases they agreed to accept from hospitals in the area did in fact require high dependency nursing and many of them required 24 hour nursing care. It appears that these patients were placed in different parts of the Nursing Home without having a wing dedicated to intensive and high maintenance nursing.

The Nursing Home was constructed in such a way to facilitate this event, but unfortunately such organisation did not take place. These patients were in fact admitted into beds that were contracted to the Health Board and in all honesty it looks like these pre-terminal and terminal patients were "dumped" on to Leas Cross in order to free up acute beds in the hospitals.

Whilst this is a normal procedure I think that Leas Cross should have been informed of the more severe medical state of the patients so that they could have a chance to assess them and to decide where they could best place them.

Below are examples of some of the deaths taken at random from the records, each with a very brief summary.

1. Male aged 74.
Admitted in April 2004. Whilst at Leas Cross had gastritis, had a gastrointestinal bleed, due to the anaemia developed a bronchial pneumonia, deteriorated. Was admitted in good time to the hospital but died of bronchial pneumonia. One assumes bronchial pneumonia but as no Death Certificate is forthcoming one has to assume that that is what the patient died off as that is what they were admitted for.

2.Male aged 82.
Had a variety of medical problems. Anaemia, colitis, a left basal pneumonia, bladder diverticulum and had a mitral valve replacement. Whilst in Leas Cross he came on well then developed a cough, this developed into a left basal pneumonia – was cared for but deteriorated and died at Leas Cross in peace.

3. Female aged 65.
Had bowel and lung cancer in March 2004. Had a laparotomy and colectomy was referred to Leas Cross for terminal care. Was very well cared for but deteriorated and died. The level of care was backed up by a very nice letter from the relatives intimating how good the care was for their relative whilst in Leas Cross.

4. Female aged 82.

Fairly advanced Alzheimer's disease, hypertension. Who on admission from hospital was dehydrated. A week after admission she developed a chest infection, was treated with antibiotics, nebulisers and oxygen – 2 days later was seen by GP for Leas Cross was admitted to hospital where the patient died - presumably of bronchial pneumonia. Again the Nursing Home has not been informed as to the cause of death.

This is a classical case where if the patient has died of bronchial pneumonia and this is found at post mortem it is useful feedback for the Nursing Home to understand more about the care of these patients and to see whether they could improve upon the care that had been given. In this incidence however, looking through the notes, the level of care was entirely satisfactory.

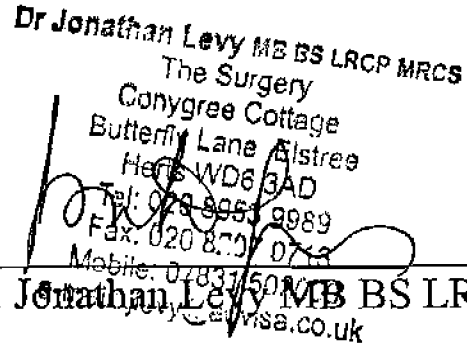
5.Male aged 90.

Admitted to the Home with dementia, angina, who was blind with a fractured left hip, which had been repaired previously. The patient developed an acute chest infection, was treated in the standard way with nursing support, oxygen, nebulisers and TLC. Deteriorated was referred to hospital where he died.

These cases clearly show as an example, and all the other cases reviewed were similar, that many of the patients were admitted either with a physical problem that is probably pre-terminal or terminal as previously stated, or have a fair degree of dementia but also have co-morbid conditions that inevitably will contribute to their demise.

Throughout my review of these cases it is quite clear that the standard of nursing care at Leas Cross Nursing Home was entirely adequate. None of the cases reviewed showed any contributory negligence found on the part of Leas Cross.
If the owners and staff of Leas Cross Nursing Home had been given the opportunity to sit down to review their nursing care and their case loads with the Health Board I have no doubt that recommendations would be made to create different areas of nursing dependency depending on the severity and needs of the patients. The Home was built in such a way that any of the wings could be converted into caring for dementia, severe dementia, general nursing care and high dependency nursing care. In that way all the appropriate skills from the staff could have been allocated to different wings. However, as has been already said in this Report the general standard of nursing care was excellent.

In summary of the 92 people who have died since Leas Cross II was opened – either at the Nursing Home or in a local hospital - I could find no evidence of contributory negligence to those deaths and all the patients were properly cared for in a warm, caring environment in a building that was state of the art.

Signed: 

Dr. Jonathan Levy MB BS LRCP MRCS

Date: 28-10-05

Response B

Purpose of the paper: Response to extracts from Prof. O Neil's report on Leas Cross review

1.1 Opening Statement

It is my deepest regret that a number of patients at Leas Cross were injured during their residency in the nursing home and that our board was unable to have in place sufficient robust oversight systems that might have identified and resolved the deficiencies in care that we now know existed.

1.2 Introductory comments,

- I was rather surprised to receive, at this late stage in the review process, a communication by way of extract pages from Prof. O'Neill's report.
- I would have expected at the very least to have been afforded a discussion with the author and a full copy of the report.
- I have only received extract pages and excerpts from pages 5,18,16,24,25,26,28,34-48 and no copies of the written documents on which Prof. O'Neill based his findings I am therefore unable to comment comprehensively
- My comments consequently are confined to the statements shown in the extracts for the period of my tenure from March 2000 to May 2004 and relate to my role and to the environment prevailing in our board at that time.
- Officer A will deal with specific issues raised in the report relating to operational matters, I formally delegated to Officer A responsibility and authority for day to day operations for older persons and a wide range of other services in March 2000. Responsibility for the inspectorate was delegated to Officer B in late 2003 when I put together the initial centralised inspectorate team.

General Comment

- The report extracts, unusually, make no reference to the prevailing environment in which services to older persons were provided in the period to which the report relates.
- Neither is there any reference to the Governance and Regulatory & Accountability framework within which the public Health Services and our Board operated or to the economic conditions prevailing.
- The report does not cover the extent and effort of all of our Board's staff in our task of providing services at the time (2002-2004) which has been widely acknowledged and publicly reported on as one of the most challenging and pressurised times in the history of the health service. The position in the Northern Area Board reflected more than most Boards the stretched situation in relation to all services provided but in particular in providing services for older persons. Significant salient features pertaining to our Board's catchment area at the time can be characterised as follows

- Population 2002 486,305 by September 2005 expected to be 600,000
- Rapid development notably in Fingal County Council area of Swords, and the villages and hinterland in the north county. Fingal County Council's house building programme of 7,000 houses in 2003 and 7,700 in 2004 represents 10% of the national average build.
- Of the designated areas identified by Government criteria for rapid expansion and investment and development out of a total population of 165,000, 6 designated areas of social depravation were identified in our Board's catchment area. These had a related population of 60,000. It is an established fact that the higher the levels of social depravation the higher the associated demand on health and social care services.
- There are 3 large scale acute hospitals and a number of specialist hospitals in the area but correspondingly the Northern Area Board community and primary care services by comparison were remarkably underdeveloped, for example the national rate of GP's to patient ratios 1:1,600. In the Northern Area Board the ratio was 1:2,500 out of a total complement of 28.5 area medical officers, for our board 16 posts were vacant.
- The weekly waiting lists for long stay places averaged 400 per week.
- Following the introduction of a new funding policy by the department of Health and Children refers to as "Existing levels of service" funding which carried through the years 2003& 2004 had the impact of reducing our net allocation by 6% and the capping of recruitment and resulted in a reduction in overall employee numbers by 193 (wte's) in 2003 and 130 in 2004.
- Beside staff ceiling constraints, nationally and locally at that time were difficulties in recruiting specialist staff particularly nursing and paramedical grades due to lack of availability in national manpower supply. At one stage in 2003 for example our Board had 120 recruitment competitions in ongoing progress.

Endeavouring to put in place services and recruit staff during this time of unique circumstances and constrained resources was both disappointing and frustrating for all of us.

1.4 Format of my response

In respect of those matters above my response is set out below in two parts. **Part I** will relate to my role and the regulatory and accountability aspects of my remit and to the environment prevailing during the period March 2000 – April 2004. In **Part II** I will comment on a number of matters relating to the following findings in particular in Prof O'Neill's report,

> Pg5 "senior management .... appears not to give due weight to written comments by clinicians"

Pg28 "HSE need to clarify if therapy services are provided in the package"

Pg34 "The Health Board's responsibility to set standards of care"

Pg35 "The resource intentions of the Northern Area Board in setting up the inspectorate is not clear"

Pg36 "Mortality rates"

Pg41 "Complaints by relatives"

Pg41 "Communication one way"

Pg43/44 "Concerns by clinicians"

Pg46 "Consultant A's assertion of repeated transmissions by correspondence to various levels"

Pg48 "Inspectorate setup without clear instructions"

Part I

1.0 Governance Framework.

The enabling legislation –
The Health (Eastern Regional Health Authority) Act 1999 Sections 4 to 15 sets out the Governance and Accountability framework and nature of the Accountability relationship between the Authority and the Area Health Boards in the region. Part II of the Act sets down the Functions and Membership framework for the Area Boards, Section 17 deals with the role and function of the Area Chief Executives.
Other enabling legislation particular to the role of the Chief Executive is set out in the Health Acts 1970 – 1996 the role generally relates to the appointment of staff, financial accountability and management, service provision and development issues, eligibility and other matters. The 1996 Act set down other legislative requirements relating to, for example:

Sec 5 – The determination by Minister of Net Expenditure limits for a health board;

Sec 6 – Adoption of a service plan (A service contractual agreement in the case of the ERHA and Area Health Boards);

Sec 8 – Amounts of indebtedness of a Health Board;

Sec 11 – Accounts of a Health Board;

Sec 13 – Directions to a Health Board;

Sec 15 – Annual report of a Health Board;

The Acts also sets out the role of the Board of the ERHA and that of the Boards of the Area Health Board.

1.1 The nature of the relationship between the ERHA and the Area Boards.

Accountability

This section relates briefly to the legislation governing the setting of priorities and the management of expenditure in the health system. The ERHA is governed in this regard primarily by two pieces of legislation, the No. 32/1996: HEALTH (AMENDMENT) (NO.3) ACT, 1996 and The Health (Eastern Regional Health Authority) Act, 1999. The main provisions of these acts as they affect delivery of services and use of resources are summarised below.

In summary under this legislation the ERHA is required to "have regard to resources available" and also have regard to the "policy and objectives of the Government". The ERHA is a health board and as such must comply with these requirements. The ERHA and the area boards had for the duration since 2002 sought to manage the tension between limited resource availability and the objectives of the Government and the service demands from various care groups who were often in competition with each other for similar services. The objectives of the Government are set out in the letter of determination to the ERHA each year. The major objectives of Government as expressed in the letter of determination relate to the development of services. As in 2002 and 2003 the Service Plan showed a high priority on progressing service developments in respect of which the Department of Health and Children made funding available and taking into account the excess demand for services. Complying with the objective of Government terms has been a major challenge given the level of growth. The monitoring processes of the Department of Health and Children for expenditure and service delivery explicitly include tracking the application of new resources to the named service developments specified in the allocations. The effect of this was that where funding amounts were ear marked in the letter of allocation for named services the funding could not be diverted or transferred for application against other services. This level of control by the ERHA and the Department of Health reduced this type of management flexibility which was previously at the discretion of CEO's. This overall heavy focus on new resources has been commented on in a number of national reports. The reports recommend a shift to a global resource and management approach.

Area Health Boards are independent corporate entities but derive their delegated authority from the ERHA. They are not health boards in "legislative terms". The Area Health Boards must comply with the provisions of the 1996 Act by delegated order from the Regional Chief Executive of the ERHA. In

compliance with the Act and any deficit arising for whatever purpose is treated as a first charge in accordance with S.10 of the 1996 Act in the next year.

The 36 voluntary agencies (including the DATS Hospitals) funded by the ERHA are not bound by the 1996 Act, The basis of arrangement for the provision of service is Section 10 of the ERHA Act 1999. This section refers to an "arrangement" as the basis for buying service and providing resource. The ERHA enters into "arrangements" that include recognition of the resource constraint. The Area Health Boards under the 1999 Act can also make similar arrangements for the delivery of services by voluntary organisation within the resources available.

Other service and expenditure provisions are set out in the Health Act (Eastern Regional Health Authority) Act 1999 in sections 14 – 18 and in the first and second schedules of the Act

Oversight by ERHA

The ERHA in its oversight remit held monthly meetings with all providers from whom they commission services which includes all 3 Area Health Boards and Acute Hospitals in the Eastern Region – and who are also the principal service providers. In addition formal written reports were submitted to the ERHA prior to these meetings. These reports were in the format set out be the Department of Health and Children referred to as the IMR's i.e. the Integrated Management Report. These reports were sent by the Northern Area Board on the 18th of every month and dealt with the financial, staffing and service detail. These reports were also accompanied by a narrative report from me on the financial and service position relating to the month and the cumulative position to date and further projections based on current trends.

The ongoing pressure for demand for Older persons places was the main focus of those meetings.

2.0 Prevailing environment commencing 2002.

This brief note sets out some of the context for the management of the responsibility of the ERHA and the Area Boards during the year commencing 2002. The organisations were in their second full year of operation during 2002 and were gradually moving to build up staff and capability in key areas.

2002 was an election year and also the year of the NICE referendum. The economy was slowing as the rate of tax growth declined, the special savings scheme hit gross tax returns and funds available to Government, and the health systems allocation was tightening. Public values and expectation are not reflected in the accountability requirements of health legislation except in the vague notion of not increasing taxation. In the normal course of events there is friction in terms of maintaining the balance between expectation and resource limits.

2002 was very much a year of two halves where in the first half of the year all the messages from the political system were positive and growth orientated while in the second half of the year constraint and control were dominant. This change of political sentiment year and the ensuing economic reality came as a sharp shock to the health system which slowed growth rates from mid 2002 to 2004. The deficit at the end of 2002 represented the last vestiges of hope in the face of harsh realities to come.

The ERHA did receive additional money in 2002 but at a much reduced level when compared with 2001. Some agencies including our Boards members had difficulty in accepting this prospect. The Authority saw additional revenues received fall from an additional €270m in 2001 to an additional €118m in 2002. This represents a very major shift in experience from the previous three years, And yet for the first half of 2002 the message to the system and the public was reasonably upbeat. In the latter part of 2002 the real impact of budgetary constraint became clearer and the message from central Government hardened and this position continued into 2003 and 2004. The service impacts of these Government fiscal measures were reflected in our Board's capacity and capability to meet patients and other clients growing needs.

3.0 Factors influencing growth in the East 2002 – 2004

Demand for health and social services in the Eastern Region was and still is outstripping supply and a major challenge to the health system in the East is to grow efficiency and delivery capacity in acute services, intellectual disability services, childcare, mental health and primary care and older persons services to meet that demand. The health service faces a number of challenges in delivering effectively while also focusing on the development of cost consciousness.

These challenges include the following:

-A move to rights based access to health care while operating within a financial constraint.

-Significantly ear-marked funding in the letter of determination while the Authority and Health Boards are required to break even overall

-Growing range of legal requirements relating to health and safety, quality and risk management

-The need for substantial investment in information systems

-The need for substantial investment developing standards/protocol quality framework

-The impact of legislative change in the EU directives example clinical waste management, junor hospital doctors working time directive, etc

-Demographic change

-New treatments, technologies

-Public private mix

-Change in Supplementary funding arrangements

Bearing in mind the changing needs above the ERHA and the Area Boards were also concerned that the movement from a "No Policy Change" funding basis to an "Existing level of services" policy change from 2003/2004 would have a significant impact on services as turned out to be the case.

4.0 Resumé of detailed proposals made by the health boards for sustaining investment during the period in question.

I have summarised below salient points from a number of reports submitted to the ERHA during the periods in question. A list of these reports is set out in appendix 1

Overall Position

The ERHA and the Area Board's position was that there was a requirement for a sustained programme to address all facets of service including older persons through transferred investment and improvements. This was the dominant theme in my reports to the ERHA for the period 2002 -2004. The dominant theme in our monthly meetings with the ERHA centred around the following core matters which I am summarising for the purpose of brevity.

- Access to Emergency Services

In 2004 an average 135 patients per week wait over 6 hours for admission through A&E Departments compared to an average of 74 per week in 2002
Over 30% of attendees in some hospitals are re-attendees

- Change in population.

Changing demographics in the region was contributing to the increased needs and change in demand for acute and primary care and older services. These had 4 main features

- Significant population growth
- An aging population profile
- Increase in diverse ethnic minority groups
- Consequences of entrenched social deprivation

The increase in population in the Northern Area Board between the last two census is the equivalent of the total population of certain counties in other parts of the country. All these factors added to the increasing challenges that our services were seeking to address within the finite allocated budget.

- Population Age over 65

In 2002 there were 136,329 people (9. 7% of the total population) over the age of 65 in the region, an increase of 8.8% over the corresponding figure from the 1996 census. There had been a particularly significant increase in the numbers of people aged 75 and over. It is acknowledged that people in the older age groups generally have the highest level of needs in relation to health and social care services. Hospitals experienced an increase in the number of older persons being admitted to hospital through A&E. (over 2000 more older persons were admitted through the A&E in 2003 compared same period in 2002.) While older persons account for approx. 20% of A&E attenders they make up over 50% of A&E admissions and their average length of stay in the acute hospital tends to be longer.

An associated emerging feature of the acute sector was the issue of existing beds being occupied by patients who had completed the acute phase of their treatment and who were waiting access to respite, long term and other community services. This had the impact of removing many of the beds which would accommodate those waiting for admission in Emergency Departments. Across the region at anyone time over **350** acute beds were occupied by older persons and over **60** beds occupied by young chronic sick awaiting transfer to a more appropriate care setting. While the delayed discharge funding targeted initiatives were successful in reducing these numbers from the peak position in Quarter 3 2003 (450 older persons and 80 YCS) the availability of a range of post acute facilities had not kept pace with demand.

- Underdevelopment of Community Facilities

There were a number of factors contributing to the situation including the historic under provision and underdevelopment of community facilities in the Eastern region relative to the rest of the country. In 2003 a comprehensive review was undertaken to assess the level of health resources available to persons living in the Eastern region relative to the national population and other Health Boards. The review concluded that the ERHA was under-resourced given the need of the region and the current level of resources used to deliver health and social services in Ireland. The analysis confirmed that all other Health Boards employ more persons in the non-acute sector than the ERHA. There were relatively fewer staff (e.g. public health nurses, home helps, etc) available to undertake the normal community and primary care duties in the East. This lead to a shortage of community services, an accumulation of problems leading to care crises and presentation at Emergency Departments and blockages in the rest of the system e.g. the discharge of older persons from acute to community care services in the East as mentioned above.

- Employment Ceiling Constraint

The employment of additional staff is integral to the implementation of many of the solutions to the current situation. There were limits to the potential to achieve real results without flexibility in the current constraining approach to the employment ceiling. This has been the subject of comment by the C&AG in recent reports.

5.0
Systems Wide Proposed Approach to the Resolution of the situation

While initiatives both regionally and locally did go some way towards alleviating the pressure both in acute and community services they only provided a partial solution to what was recognised as a system wide problem. Analysis of the prevailing network of health service provision within the region indicated that weaknesses in different parts of community, acute and extended care provision were having a cumulative impact in visibly increasing the demands on A&E departments while also limiting access by these departments to the necessary supports from other parts of the system. The key in addressing the situation was seen as a whole systems approach which would address the needs of people on a timely basis in the most appropriate setting, and ensure that there is a smooth flow of patients through the acute system and that patient care is provided in the setting most appropriate to the individual care needs of patients. To achieve this four key areas that needed to be addressed in tandem were recommended as follows:
1. Primary/Community initiatives and admission avoidance;
2. A&E initiatives intended to fast track decision making and stream patients through A&E on a timely basis;
3. Improved response by hospitals to emergency admissions through enhanced capacity, internal efficiency and deployment of resources
4. Improving flow out of hospitals ~

Details of the initiatives proposed and sent to the ERHA under each of the above headings deserve mention as in these proposals are incorporated many of the consultants' concerns referred to in Prof O'Neill's report. Among the proposals also included the following;

(I) Enhanced facilities for older persons

These initiatives centred on the following areas:
1) Enhanced respite facilities -including where appropriate direct admission to extended / long term care facilities from community / home;
2) Rehabilitation services, including where appropriate, direct access to rehabilitation services from community;
3) Day Hospital facilities;
4) Development of Falls Clinics throughout the region. Development of a service designed to minimise current unacceptably high level of acute admissions arising from falls;
5) Further Development of an Osteoporosis Clinic Service.

(II) Access to diagnostic services

It was recognised that poor access to diagnostics services for General Practitioners severely impacted on attendances to the Emergency Departments. In the absence of community-based diagnostics the GP should be able to access hospital based diagnostic and therapeutic facilities for their patient through the provision of locally agreed protocols. This would reduce unnecessary referral and waiting times for the service user. The process of communication and co-ordination also needed to be addressed to facilitate effective integration.

(III) Additional provision of public extended / long term care facilities

The primary requirement was the provision of sufficient appropriate extended/long term care placements. Beds ideally should be within a hospital's own catchment area and/or close to a patient's residence. This should enable appropriate annual/monthly placement projections to be identified and a degree of synergy to develop between the hospital and extended/long term care facility. It was recognised that substantial additional funding would be required so that the existing area health board extended care facilities would resume normal operations. The Pilot PPP Community Nursing Units (CNUs) Project, which was announced by the Minister for Health in 2004 and for which a decision was awaited from the Department of Finance to proceed to the next stage this would provide for an additional 450 beds over nine sites in the region. *The primary focus was in the provision of additional places for highly dependent patients, which were very often difficult to place within the private nursing home sector.*

These 50 bed units proposed would include along with *rehabilitative day facilities*, a dedicated *number of rehabilitative beds* in each unit. The provision of these rehabilitative beds was seen as a critical aspect of the Pilot Project not only in terms of supporting other initiatives in the region of maintaining people in their own home, but also in providing patients with approximately 8 weeks appropriate treatment to get them back home which would otherwise necessitate considerably longer stays in Acute hospitals. Thus elderly patients who need this short period in intensive of physiotherapy and or occupational therapy could be admitted directly from the community and discharged back home without needing to enter the Acute system.
While the PPP Pilot Project was being pursued as outlined above, there were a number of other developments identified which would provide a speedy response in addressing the need for additional elderly capacity across a spectrum of different dependants and requirements. Against a backdrop of nationally acknowledged deficits in this area it was argued that advantage should be taken of these opportunities, particularly if progress on PPPs was delayed for example:

FOLD, St. Clare's Claremount. -This was a proposal in which a Housing Association, FOLD can provide 56 residential places 50 % of which are targeted for patients suffering from dementia. As this development can avail of housing grants from the Department of the Environment the net exchequer capital funding requirement is £2.4m. This facility would be developed in 12 - 18 months *(it should be noted* approval was given by the Department of Health and Children in 2004).

(IV) Access to Other Extended Care Services

In the years in question there were insufficient available placements to meet the demands being generating within the acute sector. Issues regarding eligibility for long term care, limitations in community services and the reliance unique to the East on *private nursing homes* also restricted the range of options for discharge of patients to appropriate settings.

Not withstanding these difficulties substantial numbers of patients were successfully discharged from acute hospitals in the period under the delayed discharge scheme. Since September of 2002 478 discharges have been funded under this initiative with 300 over 65s funded for private nursing home care, 105 home care packages were put in place for older people and 73 packages involving both nursing homes and home support funded for young chronic sick patients.

The ongoing *requirements for placements from the major hospitals each month were estimated at approximately 120.* In order to assist in bringing core service provision up to meet this level it was proposed to extend and develop the delayed discharge initiative supported by closer monitoring and review of patients. The initiative would again span nursing home, home care and young chronic sick services. In developing the initiative it was proposed to use existing geriatricians and the *additional consultant's appointments together with other Professionals* to ensure that each patient discharged to an alternative setting would be reviewed after an agreed interval to ensure the appropriateness of the care and the, appropriate utilisation of all resources. In addition, where there were clinical or social indications that a patient might, following a period in extended care, be suitable for return home these patients would be targeted at a limited number of nursing homes selected to work in cooperation with hospital and health board staff to achieve, where appropriate, their discharge following convalescence and suitable arrangements at home being secured.

(V) Monitoring and Management

In implementing the delayed discharge initiative a detailed administrative monitoring system was put in place at each hospital and area health board level in the region. Detailed consideration was given by the ERHA to implementing an enhanced system that would span clinical and administrative uses using a Canadian approach that was currently being piloted in England and Northern Ireland. Roll out of this software would be part of an overall integrated change programme between the acute and community sectors. It

would encompass patients awaiting placement in hospitals, the community, those in public extended care, private nursing homes and availing of home care packages. Work had been completed in the Northern Area board on a bed management system which would position the organisation to take an early initiative in this area in association with acute hospitals, nursing homes and the ERHA.

*Projected r*esources and costs associated with the above
All reports submitted by me to the ERHA on service needs/developments were costed for example.
To address the need to reduce the number of delayed discharges in the region an additional 200 placements were needed. It was estimated that the regionally this would cost approximately £7 million in a full/year. In addition, a further additional 200 placements were needed to be put in place over the months of October, November and December 2004(further full year cost of €7 million) in order to meet the excess need for placement over and above the 2004 funding available. Sustaining such investment in 2004 and 2005 would allow medium term initiatives (e.g. the development of PPPs) to come into play in the later period together with an expected turnover in the additional discharges funded which would allow these funds to be re-applied to new patients presenting. Additional resources would be targeted at nursing home places, home care and young chronic sick.
In summary it was recognised the level of funding i.e. capital, revenue and staff needed for that level of investment was indeed very substantial.

(VI) Intermediate Care Services

It was recommended that:-

- Opportunities to develop rapid response services so, as to avoid hospital admission and facilitate early discharge for older people should be explored and developed.
- District Care Units should be enhanced with staff appointed solely to those posts. Its role in providing rehabilitation services should be paramount, with pre discharge decision regarding acceptance and immediate response assured.
- Rapid Access Clinic-the aim of this service was to provide a hospital based review service for older patients who are too unwell to await a routine outpatient appointment. This new service currently established by the Northern Area Board in St Mary's Hospital with 110 referrals in the first quarter of 2004, 26 directly from A&E. This service has shown the benefit of preventative initiatives to relieve the pressure on A&E centres.
- Outreach services, develop crisis outreach teams comprising nursing staff who will act as a crossover between the community services and specific older peoples units where crisis beds will be located. Nurses will work conjointly with GPs to resolve crises and if a GP is not available outside hours/weekends, the nurse may effect direct admission so as to obviate a crisis.

- *Crisis intervention centre-these* beds within specialist older persons units would be the third element of this service. They would accept referrals directly by the geriatricians directly from A&E and -also direct referrals by GPs or nurse practitioners in line with protocols and through the rapid access clinics.
- *Slan Abhaile/HomeFirst/]oint Initiatives-* The expansion of these services on a multi-disciplinary basis would enable the delivery of more complex care for older people in the community.
- Convalescence Beds -A number of additional convalescence beds could be made available to each of the major hospitals along the lines of the successful initiative undertaken by St James Hospital. It is proposed that provision a total of 20 beds to be accessed on a protocol- driven basis for a period of 8 to 10 weeks.

The summary above indicates the level of analysis and proposals developed at all levels and to the challenges in providing service for older persons and the need for a complete systems approach. The paragraphs above chronicles the concerns and proposals which were a regular feature of our reports (written and oral) to the ERHA. They were of equal concern to all providers and front line staff. My role in this regard was to analyse need, prepare service and business reports on the service progress/difficulties, report and make proposals for additional resources for service developments/ improvements and to manage,reengineer and prioritise existing services to meet patient/clients needs within the resources allocated These are the mechanisms through which the system of influencing Government policy in relation to health matters works. The Department and the Minister and the Government mindful of the exchequer situation year on year are however the final arbitrators in regard to the decision to providing additional budgetary resources.

The proposal above and others were included in the Tánistes announcement of a €70m funding package in December 2004. The Northern Area Board's €16m in addition to base funding for 2004 for older persons is testament to the scale of the deficits that existed in the years 2002 -2004.

Part II

Set out below are my observations relating to specific issues raised in the report. Officer A in his reply will respond to the other particular operational matters raised.

Pg 5 Senior Management appearing not to give due weight to written comments by clinicians about standards of care

As signalled in Prof O'Neill's report high quality and standards require adequate support resources to implement. However much as we desired to achieve those standards of excellence our ability to do this was impacted on

by the prevailing environmental macro and micro factors outlined above. I disagree with the reports conclusion in that it ignores totally the prevailing environment at the time and the efforts and representation, costings, initiatives and analysis by me and my staff, as set out at I above, seeking an application of resources to meet the crucial service levels which our staff were struggling to meet on a daily basis all of which did not generate in the years in question either for the Area Boards and the ERHA the response for an adequate level of resources.
The level of budget allocation in 2005 and 2006 bears testimony towards reflecting the magnitude of the deficit that existed for elderly services during the time from March 2000 to May 2004.

Pg 28 "HSE need to clarify if therapy services are provided in the package"

Services to be covered by Subvention are set out in section 16.2 and 16.4 of the nursing homes regulations.

Pg 34 "Setting standards of care"

On start up, for the reason set out above, it was not possible due to staff ceiling limits to appoint to the inspectorate the numbers of staff and skill sets required. An interim solution was to create a panel of senior nursing managers, nurse practitioners, geriatricians, senior registrars in general medicine, occupational therapists and physiotherapists to augment the core team. To identify and recruit the team members from an already overstretched staff compliment took time and effort and had to be done in consultation with professional heads and local management and unions as in some cases it incorporated changes in work practices. The shortcomings in the inspectorate (staff mix and specialist skills mix) is acknowledged. That is not the fault of the inspectorate team. Their desire to operate to the **highest ideal standards** as described in the extract report was the wish of the team but as I have stated above the development of good standards and protocols is only possible when the underlying supports are made available.

Prof O'Neill would have probably been aware of the early experiences of all acute hospitals nationally. When the Irish Hospitals Accreditation Board assessed protocols and standards in the acute hospitals and none met the standards (with segmental exceptions) and 4 years later to the best of my knowledge only one hospital has been awarded full accreditation.
I agree with Prof O'Neill of the need for services in all residential centres to be of high standards. Parallels may be drawn with other services: for example children's services have an independent children's inspectorate so also do mental health and intellectual disabilities services. The latter have an independent inspectorate and mental health tribunals.

In good governance terms it is a conflict of interest for Health Boards (now HSE) to be both commissioners and overseers of services for older persons. Oversight must be independent of the HSE to be fully effective and an inspectorate backed with legislative authority similar to those of the mental

health commission/inspectorate should be the immediate governance priority. This oversight must also be considered in the context of the responsibility of Nursing Home owners, as Directors, and employers under company law and other relevant legislation. There is also an onus on such entities to run their business in accordance with best prevailing governance, practice and ethical standards.

Standards of Care

- The policy of the Northern Area Board reflected the national policy in relation to buying services from the private sector. The Health Act 1970 permits such arrangements.
- There has traditionally existed a high level of trust between voluntary and private sector carers as the latter group in their own right have statutory and legal obligations under separate enabling legislation and regulations to be adhered to.
- The main thrust of all our efforts was in expanding the bed supply for older persons to meet the demands for discharge from acute hospitals. These pressures here being manifested by the situation in the A&E departments. The level of effort and focus by the Northern Area Board on quality/inspection initiatives was not by necessity of similar intensity because of the other prevailing challenges experienced and as described above in the period 2003/2004 in particular.

Pg 35 "Establishment of Inspectorate and resource intentions not clear"

In response to the backlog building up locally in community care areas outstanding inspections combined with growth and nursing home places culminated in my decision in 2003 to establish a single unified Nursing Inspectorate Unit to address the situation.

To ensure that the greatest degree of independence to the new inspectorate, I assigned the team to work under the direction of Officer B. An independent National external Nursing Home Inspectorate would of course have been the optimum preference.

Pg48 "Inspectorate set up without clear instructions"

The role of the inspectorate is clearly set out in the 1993 Nursing Homes regulations.

As an integral component and team development planning Officer B set up a multidisciplinary team which included 2 Directors of Public Health Nursing (one a director of older persons, services), Environment Health Officer, Public Health Medical Doctor, Social Worker, Physiotherapist, and a technical services manager.

First task was to review the current system of inspections. 3 sub groups were tasked this

The out put from this group included the following

1) An inspection template – with emphasis placed on the standards of care
2) Template for the notification for the register of Deaths for residents in Nursing Homes
3) Template for the notification of Discharges from Nursing Homes
4) A template (revised) for registration notification purposes
5) A complaints tracking system for Nursing Homes
6) A template for Nursing Homes Providers relating to the financial management of residential persons monies

In Jan 2004 Officer B convened a catchment wide meeting with the Federation of Private Nursing Home proprietors to discuss the impact of introducing the new templates.
From existing resources in 2003/2004 it was not possible to build an inspectorate team to the desired standard and my alternative was to grow the inspectorate incrementally as quickly as resources would allow.

Understanding of role

In Sept 2004 Officer B held a workshop meeting with senior staff and staff of the inspectorate to map out a realistic agenda of work for the inspectorate, while being mindful of the deficits of the inspectorate. The following developments were put into place after this meeting.

a) I authorised the redeployment of an Assistant Director of Nursing from our own Board's risk unit to the inspectorate team. From the records I noted that a second assistant director, ½ time GP and administrative support were added to the team.
b) Advertisement for staff for the inspectorate were place on 19 September 2004.
c) The Director of Public Health Nursing proactively visited the College of Nursing in Cork to encourage student applicants to apply for Public Health Nursing posts in the Northern Area Board.
d) A schedule for 1st and 2nd round inspections was drawn up.
e) Training days for the Inspection team was approved.
f) A 3 day training programme was commissioned from a UK company with expertise in this area. To enhance the skills of the inspectorate team and those of other nominated disciplines who would augment the inspectorate skills as required. The training programme was based and drawn from the standards applicable in the UK National Health and Private Nursing Homes. It should be noted that no such standard existed either nationally or Health Board wide at this time.
g) The review of the inspectorate showed that due to staff/workload pressures at the Community Care levels a backlog of nursing home inspections had grown and the 1st task of the fledgling inspectorate was to address this issue.
h) A database for the inspectorate was set up

Note:
Currently no national standards for residential long stay care places exist. I note from records that in the latter half of 2005 a National Group was set up by the HSE to draw up a standards for all Homes – Public and Private to be incorporated into a national standard.

Pg41 "Complaints by relatives"

For a number of years there has been a formal system of complaint and appeals in operation in the Northern Area Board which allows for verbal, face to face, telephone or written complaints from a complainant or an authorised person. Complainants also have the right of appeal to the ERHA, the DOHC and to the Minister of Health and Children and were informed of their right of appeal to the ombudsman. Other protections are offered under the Freedom of Information Act. A dedicated unit under the management of a Director of Complaints and Appeals was established by me in 2000 to log, process and investigate and respond to all complaints received.
All complaints made are investigated and reported on.

Pg16"Mortality"

I am not in agreement with the basis for comparisons of death in Leas Cross used by Prof. O'Neil as those for all hospitals as they do not reflect mortality trends for similar cohorts of mental health patients deaths in the population. A more appropriate comparator for statistical purposes would be to compare mortality rate at St Brendan's, St Ita's and those in other similar long stay psychiatric institutions.

Pg 43/44 "Concerns by consultants regarding quality of care in Nursing Homes"

Our Board's policy has always been that where patients who were discharged from St Ita's to either our own community residences or to private nursing homes and who did not settle in or were unable to be managed in their new residence, have always been readmitted back to St Itas' without difficulty. At no time in question have barriers ever placed on consultants at St Ita's or elsewhere relating to this readmission policy and I am concerned that if such were the consultants concerns about the care provided at Leas Cross that they did not readmit the patients back to St Ita's without question as has always been the norm.

Pg46 "Consultant A's assertion of repeated transmissions by correspondence to various levels"

The consultant in question addressed one letter to me in April 2004. The consultant stated that the purpose of the correspondence related to the new long stay bed distribution system. The deputising officer at that time in his note on the letter indicates that the matter would be addressed at his next meeting with her and the team.

In relation to other letters to which she refers, I note that most were sent to staff junior in rank to the consultant and most were members of her team I am surprised that she did not direct this correspondence to her Clinical Director as her direct report which would be the normal procedure and with whom I met frequently and to whom I had given my contact numbers for outside of working hours

NB.
At no stage during my tenure was the **quality of care** relating to patients in Leas Cross mentioned or reported to me personally nor did I have any specific knowledge in that regard in relation to any individual patients care.

Other concerns of the consultants relating to subvention, access to and availability of long stay places and staffing and overall quality matters were already identified and included in our regular reports to the ERHA and for which I had consistently requested for the resources to enable our own Board to address the deficits in service and to which I have referred Section 5 Part 1 above.

Pg 41 "Communication One Way"

To reach conclusions from a number of letters circulated mostly within the consultant's own team and written over a fairly close period with a whole paragraph given over to a letter that was not sent to anyone, and to cite these micro examples as an indicator of the status of and level of communication between senior management and the consultants is both inaccurate and biased. There were regular meetings with the consultants both as a group and with the local teams as the records will show and officer A will deal with the matter of communication in greater detail in his reply.

Concluding comment

In my years working in the Health Services the pressures on all staff during this period were intense and unremitting arising from;

a) Institutional changes i.e. the establishment of a Regional Health Authority and 3 new Area Health Boards in the period 2000/2001 and the abolition of these institutions in mid 2004 and the establishment of the new Health Services Executive is an unprecedented level of organisational change for any organisation to experience. This combined with the issues below
b) The budget and staff ceiling constraints
c) Recruitment difficulties and lack of availability of nursing and paramedical manpower grades nationally
d) Population growth in the northern area
e) An inadequate quality infrastructure in the underlying community services
f) A deficit in community management and information systems, of any note, combined with a skeleton inspectorate and overburdened staff at every level, all converging in the period between 2003 and 2004 regrettably all contributed

to the creation of the high risk environment and for situations such as those at Leas Cross to arise.
g) As s supply for older persons and the level of effort and focus by the Northern Area Board on quality initiatives, was not by necessity of similar intensity because of a high a level of trust in the boards relationships with nursing home providers and the other prevailing challenges as described above in the period 2003/2004.

Appendix 1

List of Northern Area Reports

- Service provider agreement reports 2002 - 2004
- Yearly Reports on services for older persons
- Report on the working group on the short to medium term service needs of older persons and the young chronic disabled – NAHB – Working group
- Upgrading/replacing the St Mary's Hospital 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 Services; Day Hospital for Older Persons; Psychiatry of Old Age Day Hospital
- Development Control Plan – St Joseph's Hospital, Raheny – May 02 – including units for persons
- Development control plan – St Brendan's site, including units for older persons
- Proposal 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
- Annual reports 2002 to 2004
- Sustaining progress reports 2003/2004