Lydia Buckley

From: [redacted]
Sent: Monday 17 June 2019 11:23
To: Sean Lynch
Subject: Re: FOI - Unsolicited information records

Hi Sean,

Can I just confirm when I can expect a decision on this FOI?

Kind regards,

--
[redacted]
Reporter
TheJournal.ie

Please note my direct line number has changed:

[redacted]

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On Mon, 10 Jun 2019 at 15:59, Sean Lynch <slynch@hiqa.ie> wrote:

Hi Hayley,

Thanks for amending the dates. I can confirm that there will be no fee with the new dates.

Kind regards,

Sean

From: [redacted]
Sent: 07 June 2019 13:41
To: Sean Lynch
Subject: Re: FOI - Unsolicited information records

Hi Sean,

Your recommended dates are fine to amend it to. Can I just confirm that there would be no fee with the new dates?

Kind regards,

On Fri 7 Jun 2019 at 13:16, Sean Lynch <slynch@hiqa.ie> wrote:

> Hi [redacted]
>
> Thank you for your Freedom of Information request.
>
> As the request is quite large, I would appreciate if you could amend it to the unsolicited information received in 2019, that is, from 1 January 2019 to 4 June 2019. There may be a charge involve for the longer period.
>
> Kind regards,
>
> Sean
>
> Sean Lynch
>
> Publications and Social Media Officer
>
> **Health Information and Quality Authority**
>
> George's Court
>
> George's Lane
>
> Dublin 7
>
> D07 E98Y

Phone: 01 8147486

Email: slynch@hiqa.ie

Web: www.hiqa.ie

From: [redacted]
Sent: 04 June 2019 09:23
To: FOI
Subject: FOI - Unsolicited information records

Dear Hiqa,

In accordance with Section 11 of the Freedom of Information Act 2014, I wish to request the following records which I believe to be held by Hiqa:

- All information in Hiqa's possession in relation to unsolicited information received by Hiqa between the dates of 1 November 2018 and 4 June 2019 in relation to older people, disability services and children's services.

I wish to obtain digital copies of the records. If you need to clarify anything in this request, please contact me

via email.

Please confirm that this request has been received.

I look forward to hearing from you in the time period prescribed.

Kind regards,

--

[redacted]

Reporter

TheJournal.ie

Please note my direct line number has changed:

[redacted]

[redacted]

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Hayley Halpin

Reporter

TheJournal.ie

Please note my direct line number has changed:

e: hayley@thejournal.ie

t: **01 255 1333**

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Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Private & Confidential

[redacted]

18 June 2019

Our Ref. FOIR 027 019

Re: – Acknowledgement of FOI request

Dear [redacted]

I refer to the following request which you have made under the Freedom of Information Act 2014 for records held by the Health Information and Quality Authority:

> All information in Hiqa's possession in relation to unsolicited information received by Hiqa between the dates of 1 November 2018 and 4 June 2019 in relation to older people, disability services and children's services.

Your request was received by this, the Health Information and Quality Authority, on 4 June 2019, and was subsequently amended to the following request:

> All information in Hiqa's possession in relation to unsolicited information received by Hiqa between the dates of 1 January 2019 to 4 June 2019 in relation to older people, disability services and children's services.

I will be the Freedom of Information Administrator handling your request, if you have any queries in relation to your request you can contact me by telephone on 01 814 7486 or by email at foi@hiqa.ie.

A final decision on your request would normally be sent to you within 4 weeks. A week is defined in the Act to mean 5 consecutive weekdays, excluding Saturdays, Sundays and public holidays. This means that you can expect a decision letter to be issued from the Health Information and Quality Authority not later than 2 July 2019.

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Fax: +353 (0) 1 814 7499

e-mail: info@hiqa.ie **www.hiqa.ie**

There are some limited situations under the FOI Act which could mean that the period for a final decision may be longer than the normal four weeks. If this occurs in the case of your request, I will promptly advise you in writing. Should our final decision not reach you on time, please feel free to call me to discuss any problems that may have arisen.

If you have not heard from us once the allotted time has expired, you are automatically entitled to appeal to the Health Information and Quality Authority for a review of the matter. This review proceeds on the legal basis that the initial request is considered to be refused once the specified time for responding to it has expired. The review is a full and new examination of the matter carried out by another member of staff of the Health Information and Quality Authority.

In the event that you need to make such an appeal, you can do so by writing to FOI Unit, Health Information and Quality Authority, Dublin Regional Office, Georges Court, George's Lane, Smithfield, Dublin 7, D07 E98Y or alternatively by sending an e-mail to foi@hiqa.ie.

You should state that you are appealing because an initial decision was not sent to you within the time permitted. In that event, you would normally have 4 weeks (after the initial decision should have been sent to you) in which to make the appeal. The Health Information and Quality Authority will, however, allow the appeal to be made late in appropriate circumstances. Please note that a fee of €30 applies for an appeal. Payment should be made by way of electronic transfer. Please contact the FOI Office for further details.

Publication

This Authority will publish a log of all non-personal Freedom of Information requests received in 2019 on its website.

Yours sincerely,

Sean Lynch
Freedom of Information Administrator

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Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Private & Confidential

[redacted]

1 July 2019

Our Ref. FOIR 027 019

Re: – Freedom of Information request – Decision to part grant

Dear [redacted]

I refer to the following request which you have made under the Freedom of Information Act 2014 for records held by the Health Information and Quality Authority:

> All information in Hiqa's possession in relation to unsolicited information received by Hiqa between the dates of 1 November 2018 and 4 June 2019 in relation to older people, disability services and children's services.

Your request was received by this, the Health Information and Quality Authority, on 4 June 2019, and was subsequently amended to the following request:

> All information in Hiqa's possession in relation to unsolicited information received by Hiqa between the dates of 1 January 2019 to 4 June 2019 in relation to older people, disability services and children's services.

Your request was received by this, the Health Information and Quality Authority, on 15 May 2019, and was subsequently amended to the above request. The Authority has made a final decision today 1 July 2019 to part grant your request. If you have any queries regarding this correspondence you can contact me by telephone at 01 814 7488.

The purpose of this letter is to explain that decision. This explanation has the following parts:

1. a schedule of all of the records covered by your request;
2. access arrangements
3. findings, particulars and reasons for decisions to deny access in parts
4. a statement of how you can appeal this decision should you wish to do so.

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e-mail: info@hiqa.ie **www.hiqa.ie**

This letter addresses each of these parts in turn.

1. Schedule of records

A schedule is attached. It shows the documents that the Authority considers relevant to your request. It also gives you a summary and overview of the decision as a

whole. The schedule describes each document, and indicates whether the document is released in full, released with deletions or not released. The schedule refers to the sections of the FOI Act which apply to prevent release.

2. Access arrangements

You have requested access to the records by email and I consider it an appropriate form of access in this case. The records described as released will now be made available to you in a redacted format attached to this email letter.

3. Findings, particulars and reasons for decisions to deny access in part

Reasons for decisions to deny access in part:

Section 35 – Information obtained in confidence

(1) Subject to this section, a head shall refuse to grant an FOI request if—
(a) the record concerned contains information given to an FOI body, in confidence and on the understanding that it would be treated by it as confidential (including such information as aforesaid that a person was required by law, or could have been required by the body pursuant to law, to give to the body) and, in the opinion of the head, its disclosure would be likely to prejudice the giving to the body of further similar information from the same person or other persons and it is of importance to the body that such further similar information as aforesaid should continue to be given to the body,

The decision maker contends that the records concerned contain information given to the Authority in confidence and on the understanding that it would be treated as such, its disclosure would be likely to prejudice the giving to the Authority of further similar information from the same person or other persons. It is of importance to the Authority that such further similar information as aforesaid should continue to be given.

There are no discernible or particular public interest grounds leaning in favour of a release in this specific case. The decision maker has decided to release a redacted version of the records in this request so that all possible identifiable information is removed.

Section 37 - Personal Information

In relation to all records identified in the schedule, each contains matters where access to the records would involve disclosure of personal / identifiable information within the meaning of Section 37 of the FOI Act. Where appropriate the Authority has sought to the largest extent possible to redact personal or identifiable information so as to part grant records identified.

Section 37(1) provides as follows:
Subject to this section, a head shall refuse to grant an FOI request if, in the opinion of the head, access to the record concerned would involve the disclosure of personal information (including personal information relating to a deceased individual).

Section 37(5) provides that a head may grant the request if the:
"public interest that the request should be granted outweighing the public interest that the right to privacy of the individual to whom the information relates should be upheld."

Grounds for Decision to Part Grant Request

The records contain the name(s) of individual(s) and or other personal identifiable data and for this reason the Authority is of the view that the exemption applies and the records will be redacted in order not to disclose the personal identifiable information of third parties.

Public Interest Consideration

The Authority accepts that Section 37(1) is subject to Section 37(5) which provides that access to a record may be granted in specified circumstances where the public interest would, on balance, be better served by granting than by refusing to grant the request.

Section 42(M) — Restrictions of Act

Section 42(M) provides as follows:

42. This Act does not apply to—
(m) a record relating to information whose disclosure could reasonably be expected to reveal, or lead to the revelation of—

> *(i) the identity of a person who has provided information in confidence in relation to the enforcement or administration of the law to an FOI body, or where such information is otherwise in its possession, or*
>
> *(ii) any other source of such information provided in confidence to an FOI body, or where such information is otherwise in its possession.*

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Grounds for Decision to Refuse Request

This section states that the Act does not apply to a record that may reveal the identity of a source of confidential information. The information contained in the relevant records was received in confidence and could reveal the source of the information; therefore, the Act does not apply to these records.

4. Rights of appeal

You may appeal this decision. Please note that a fee applies for an appeal, with the exception of an appeal against the imposition of a €30 fee. In the event that you need to make such an appeal you can do so by writing to the Freedom of Information Unit, Health Information and Quality Authority, George's Court, George's Lane, Dublin 7 or by email to foi@hiqa.ie. Payment should be made by way of electronic transfer. Please contact the FOI Office for further details.

You should make an appeal within 4 weeks (20 working days), from the date of this notification. However, the making of a late appeal may be permitted in appropriate circumstances. The appeal will involve a complete consideration of the matter by a more senior member of the staff of the Authority.

Please note this Authority will publish a log of all Freedom of Information Requests received in 2019 on its website.

Yours sincerely,

Sean Lynch
Freedom of Information Administrator

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HIQA - Freedom of Information
Schedule of Records: Summary of Decision Making

Health Information and Quality Authority
An tUdarás Um Fhaisnéis agus Cáilíocht Sláinte

FOI Request Reference FOIR 027 019

FOI Received 04 06 2019

Decision Maker David Lowbridge

Decision due no later than 02 07 2019

Rec. No	Brief description and date of record	File Ref	No. of pages	Third Party involvement Y/N	Decision: Grant/Part Grant/Refuse	Basis of Refusal: Section of Act	Reason for Decision	Public Interest Considerations (for and against release)	Record Edited/ Identify Deletions
[redacted]									
2	Copy of URIS received for DCOP between 01/01/19 to 04/06/19	FOIR 027 019 DCOP_Redacted	6	N	Part Grant	Section 35 and Section 37	Information received in confidence and Personal Information		Redaction of personal indentifiable information
[redacted]									

(1)

Reference	Date Of Receipt	Concern Detail
URI-0017903	30/05/19	1. Tusla gave advice from an incontinence advisor to the school in relation to the administration of movicol which the family are saying was bad advice. 2. Parents are unhappy with how Tusla managed the information the school gave them. [redacted]
URI-0017882	27/05/19	Allegations of sexual abuse made against CP in [redacted] regarding [redacted] Allegations were made by the maternal grandparents. CP contacted Garda and Tusla [redacted] in relation to these allegations, no charges were made and Tusla's investigation now closed. CP feels [redacted] was treated very unfairly by the social workers and this has left an impact on [redacted] mental well-being.
URI-0017880	26/05/19	Concern in relation to false allegations made by service provider.
URI-0017875	23/05/19	CP [redacted] was one of [redacted] victims of historical sexual abuse. According to CP the Barr Judgment assures any alleged perpetrator is afforded two days to revert with a response to any allegation. The issues were brought to the attention of Tusla [redacted] and the alleged victims were interviewed and an investigation was undertaken [redacted] However, there were delays in the due process and eventually CP was informed the file was missing. There was a lot of misinformation regarding the issue of the Barr Judgment process. CP is following up on the erroneous process applied and the lack of good practise and clarity. CP has engaged with the Minister for Children, Ombudsman's office for children and other public agencies. CP would like to engage with a senior person to further discuss as CP believes Tusla is not fit for purpose
URI-0017854	17/05/19	CP has concerns relating to [redacted] children in foster care.
URI-0017852	16/05/19	Concerns relating to the investigation of child sexual abuse.
URI-0017836	10/05/19	There were allegations about an incident that occurred months ago and as a result there is high supervision when meeting the children. The children went unsupervised to a flats complex [redacted] this is a cause for alarm as there was mention of child sexual abuse against the parent of CP's ex-partner who lives there. The sexual abuse has been reported to the relevant authorities.
URI-0017834	10/05/19	CP has issues that are impacting on the well-being of children and vulnerable adults.
URI-0017827	08/05/19	CP initially suffered a mental breakdown and the child was placed in voluntary care. [redacted], the child was placed in the care of the other parent. There has been no contact with CP and no access to the child. CP was initially told more suitable accommodation was required to ensure the return of the child. CP moved to [redacted] to ensure a bigger house and is not feeling isolated and has no access to the child and also no contact or support from the Social Worker. CP was advised there is a hearing to arrange the father gets full custody.
URI-0017816	03/05/19	Child has attempted to take their own life [redacted] now. They have been assessed by the Psychiatrist and are involved with CAMS. The child has been removed from the family home and lives with [redacted]. The child's parent is frantic and cannot get support that is needed to help support the child. TUSLA will not communicate or provide any support. CP has left numerous messages but gets no reply with social worker. Child

		made another attempt on their own life [redacted] after been discharged from hospital where they had been [redacted]
URI-0017782	25/04/19	Concerns relating to CP's [redacted] children in foster care. Concerns surrounding alcohol abuse within the foster home. CP does not believe that their concerns are been taken seriously by social workers.
URI-0017777	24/04/19	Poor professional communication between CP and Social Workers.
URI-0017776	23/04/19	CP is an advocate for Service User. Concern relates to foster carer having more power than parent. Parent's concern not being listened to in relation to access to children. Parent has limited access to children in care. Lack of professional communication between social workers and parent.
URI-0017763	15/04/19	CP's child is in long term care and CP's visiting has been cancelled on a number of occasions. CP has tried to contact the relevant social worker but has been unsuccessful. CP wishes to have sight of the child's records while in care.
URI-0017754	12/04/19	CP's child is in foster care and CP has access. There is a process where a urine sample for the child is provided before and after the court. The child will be [redacted] in [redacted] and CP takes the child into the female toilet. The Access worker is insisting on accompanying CP when CP takes the child into the toilet. CP believes there is no dignity, respect or privacy for the child or CP.
URI-0017738	10/04/19	There are [redacted] children, [redacted] The [redacted] are in the care of CP who is the [redacted] is in the care of [redacted]. There is a social worker who is forcing the children to go into residential care and the court has declared if the children are happy and safe where they are there is no need for the social worker to encourage them to leave their present care. However, the social worker and Tusla are putting pressure on the children to change and go into residential care.
URI-0017714	04/04/19	CP's child is in the care of CP's former partner. There are care issues and lack of support from Tusla.
URI-0017693	02/04/19	CP has issues with social workers and the local Garda and there was issues relating to a child receiving bruising.
URI-0017675	29/03/19	Issues relating to management and social workers.
URI-0017659	26/03/19	Concern relating to access to child
URI-0017630	14/03/19	Issues relating to custody of children.
URI-0017629	13/03/19	Parent enticed CP's [redacted] to sign some bank cheques to steal money from [redacted]
URI-0017612	08/03/19	Poor Communication from Service Provider Letter sent by concerns that UROI is not within the remit of HIQA and CP was referred to Tusla complaints and the Ombudsman. [redacted]
URI-0017608	07/03/19	Concerns relating to leadership, governance and management of Social Workers.
URI-0017598	04/03/19	The family are currently receiving a service from the [redacted] Child Protection and Welfare social work department. CP is not satisfied about how the case is being managed and there is an important meeting about the case scheduled for [redacted].CP was advised about HIQA's remit and that if CP wished to provide further information it would be held on file to inform our monitoring of the service area. CP was also advised about the formal Tusla complaints procedure. CP decided not to provide further information at this time, choosing instead to await the outcome of the upcoming meeting regarding CP's child.

URI-0017597	04/03/19	The child's [redacted] were taking care of the [redacted] child and then CP took over the care of the [redacted] child when the [redacted] marriage ended. There are other siblings and they stayed with CP for a few days. There are ongoing issues with Tusla and social workers who are sourcing alternative accommodation but the child refuses to go to any residential care centre. The child has suffered a lot of trauma due to family issues and there is a court hearing to ensure the child is transferred to a residential care setting.
URI-0017522	12/02/19	Lack of appropriate care for child.
URI-0017476	04/02/19	Issues relating to discrimination and access to children
URI-0017468	31/01/19	Service issues.

(2)

FOIR027 019

Reference	Date Of Receipt	Concern Detail
URI-0017909	04/06/19	CP received an anonymous letter stating the resident suffered physical and sexual assault by another resident. When staff reported the incident to the CNM and the assistant DON, they were instructed the resident suffers from dementia and would not be aware of the incident. Staff were then instructed not to record the incident. CP alerted the local Gardaí and both the Gardaí and CP went to the nursing home and engaged with management. CP was assured an investigation would be undertaken. CP had to bring the resident to a local assault unit for tests to confirm the assault took place and this has upset CP albeit the resident is not aware of the violation of the resident's person. There has been no contact by the provider to update CP or to provide assurances of safeguarding. [redacted]
URI-0017908	04/06/19	[redacted]
URI-0017901	30/05/19	Concerns relating to resident not being encouraged to eat or drink. Resident is losing a lot of weight and is dehydrated. Poor personal hygiene procedures. NH has requested that family put resident into another NH. No care plan in place for resident.
URI-0017899	30/05/19	Poor hygiene conditions. While [redacted] was informed of an incident where a resident absconded from nursing home and stated that this is widely known in the locality. Another resident who is now deceased was ill and management at nursing home delayed in calling an ambulance. Residents are left in soiled incontinence wear for long periods of time. The majority of residents [redacted] in the nursing home.
URI-0017900	29/05/19	Concerns relating to resident's physical and psychological well-being.
URI-0017886	28/05/19	Concern relates to abusive language towards staff. Residents and staff being mistreated.
URI-0017881	27/05/19	Concerns relating to inadequate and safe nursing care.

URI-0017883	27/05/19	Concerns relating to unrequested hair cut for relative. Door of medicine room is often open.
URI-0017874	23/05/19	Resident is [redacted]. Resident asked for a [redacted] staff member to assist with personal hygiene but this was refused. There was lack of care and medical reviews were not carried out in a timely fashion to ensure antibiotics were prescribed for [redacted] There was an outbreak [redacted] and after deep cleaning and laundry of clothes; the resident's personal belongings were misplaced. Resident was dressed in other resident's clothes. The bathroom is cluttered with medical aids and is impossible to use.
URI-0017872	23/05/19	Notice of discharge was issued to resident. Care issues were alerted to the PIC regarding diet. The lift is not operational causing inconvenience to staff and residents who are accommodated on the first floor.
URI-0017871	22/05/19	CP relative was in the centre for [redacted] Resident had dementia and [redacted]. Resident was screaming in pain and no relief or support was given to the resident. Resident was eventually transferred to hospital and was diagnosed at EOL with [redacted] CP believes the provider failed in their duty of care to alleviate the distress caused by pain suffered by the resident.
URI-0017870	22/05/19	While there was a wonderful caring nurse on duty on the night of the incident, CP firmly believes there is not enough staff to cater for the needs of all the residents. The resident had dementia and on the night did not settle; staff brought the resident to the common room and the nurse was with the resident. Unfortunately, there was another incident and the nurse went to help the other resident. During the nurse's absence, CP's relative fell and sustained injuries requiring transfer to hospital. [redacted]
URI-0017869	22/05/19	There is regular disruption to the peace and routine of the local residents. There is screaming from residents with dementia that is rather upsetting neighbours and ambulances use the siren when approaching the nursing home regardless of the time be it late or very early hours.
URI-0017859	20/05/19	Lack of professionalism, communication and lack of dignity or respect.
URI-0017851	16/05/19	CP found relative to be cold, hungry, soiled and upset when they visited. Relative discouraged from making further complaints for fear of being barred and affecting [redacted] care Communication breakdown between CP and management of nursing home.
URI-0017850	16/05/19	Concern relating to fire & safety. Please also refer to URI-[redacted] which relates to previous concerns from CP.
URI-0017847	15/05/19	Lack of care, support and empathy.
URI-0017846	15/05/19	Family raised concerns with the nursing home and were advised a report was sent to HIQA. Family wish to engage with HIQA to further discuss the issues. Please see incoming email in the document folder. A request was made for further details of the concerns raised and on receipt of same it will be uploaded to this UROI and the relevant person will be alerted. As far as I can ascertain there are no notifications that refer to any issues of care.
URI-0017845	14/05/19	Resident has dementia and is a falls risk. Family noticed resident appeared to be in pain and on examination the family noticed there was bruising on the resident's arm. There was no explanation from staff regarding the bruising and no doctor was requested to review the resident. CP noticed the resident slumped on the chair and after alerting staff, an ambulance was called and the resident was transferred to hospital. Resident's life expectancy is reduced due to the injuries and the resultant trauma.

URI-0017826	08/05/19	Resident is in the centre [redacted] and during that time, has suffered serious head injuries and a fractured hip. These injuries were sustained [redacted]. [redacted] the resident caught the fingers in the fire door and another resident closed the door [redacted] The resident suffered unexplained bruising on the face. CP and the family had a meeting with the nursing home provider and requested certain safeguarding measures but these were refused and the family were advised this was due to HIQA. There is a blind spot on a corridor where residents wander and are not visible to staff and are at risk of safeguarding and falls. CP and the family suggested a CCTV that could be monitored at the nurses' station but this was refused due to HIQA. There is not enough staff available to provide the necessary care for all the residents.
URI-0017824	08/05/19	Issues relate to residents receiving early breakfast and they are dressed and left on their bed until later.
URI-0017822	07/05/19	Nursing Home reluctant to contact a GP when residents are ill. Concerns from residents not taken seriously by Service Provider.
URI-0017817	07/05/19	Staff not trained in care of dementia Residents. Lack of empathy for Residents. Chemical restraint and bedrail restraints used on a daily basis. Relative excessively sedated.
URI-0017815	03/05/19	Relative visited centre to find resident sitting in their bedroom very upset and crying. Resident has Dementia but could not communicate what was wrong. Relative lifted the residents clothing to find bruising on their arm. Staff was called for; they advised it must be a sprain. The Relative requested that the resident be brought to hospital. Staff asked the relative to drive the resident themselves to hospital. On admission the resident. was diagnosed [redacted] They were operated on that evening. Family were informed the incident was un-witnessed. Family want to know how the resident managed to get back up on the chair in their bedroom [redacted].
URI-0017813	03/05/19	CP is concerned regarding staffing levels especially at night time. Staff are constantly rushed off their feet and have informed CP that they need more staff. CP has witnessed call bells ring constantly without being answered because staff are attending to residents who need constant monitoring. Some staff are excellent but cannot continue trying to cope with staffing levels. Concerns have been raised by other resident's relatives but outcomes have been dismissive. during the day is not as bad but something needs to be done after 8pm. One staff member now stays on until 9pm but staff are still not coping with the demand of some residents for the large number that resides there.
URI-0017811	03/05/19	Resident is immobile and requires assistance with hoist when getting in/ out of bed. An incident occurred causing bruising and cuts I to the residents face [redacted] The resident was put to bed [redacted]. CP was informed the injury happened between [redacted]. Resident is placed in a low- low bed and cannot get out without assistance. CP requested an investigation to what happened. At a meeting CP was informed they have no explanation how incident occurred. CP is not satisfied with the response and attitude of Provide and PIC. CP wants to know how these injuries occurred.
URI-0017809	02/05/19	Floor surface of relative's room is very slippery and resident has had [redacted] falls to date. hand rail of some sort from her bed to the toilet and her bed to the door.
URI-0017805	02/05/19	CP has concerns relating to lack of supervision in the day room. Residents do not have access to fluids. Drinks are left on a trolley at the top of the room and residents do not receive assistance in taking fluids.

URI-0017804	02/05/19	Concern relating to a resident who was naked from the waist down entering relative's room and standing at the head of the bed. Another resident previously entered relative's room and urinated all around it. Lack of supervision. Concerns not been taken seriously by the service provider.
URI-0017800	01/05/19	Resident has [redacted] and is permanently left in bed with no stimulation or engagement by staff. Resident appears to be deteriorating physically and emotionally and there is no encouragement by staff and the resident is never taken to the day room. CP made enquiries of staff as to the reason why the resident is left in bed and was advised they were treating pressure sores on the resident.
URI-0017798	01/05/19	There is not enough staff to provide the necessary care for the residents. Due to staff shortages, residents who require 2:1 care are not receiving it. Staff are requested to do extra work after working 80 hours per week. Residents are left in personal hygiene pads that are soaking wet and soiled. Catheter bags are not emptied in a timely manner and this causes residents discomfort and is an infection risk.
URI-0017793	29/04/19	Resident was admitted on [redacted] and has capacity but requires assistance with toileting. The centre is not conducive to the residents' mental wellbeing. The resident was transferred from the bedroom to the day room in a wheelchair that requires cleaning and was an infection risk. There were dirty cups, table and cupboards in the visitors' room. The public bathroom was filthy. There was no toilet cover or bin in the resident's bathroom. The bedclothes were not fit for purpose and CP had to purchase new bedclothes for the resident's bed. The floor in the shower is not properly installed and water can seep underneath the floor covering. The water jug was filthy both on the inside and outside. The call bell was not answered in a timely fashion and the resident waited almost one hour to receive assistance to use the toilet. The floor area is not properly cleaned and the furniture throughout the centre and particularly in the resident's room is chipped and is an infection risk.
URI-0017792	29/04/19	Resident suffered a scald; resident complained to the HCA who continued to use very hot water. While assisting resident with a jumper the HCA was inappropriately touching the resident. The resident is never brought out on a trip.
URI-0017791	29/04/19	There was lack of staff impacting on the care, safety and wellbeing of the residents. Staff did not notice the deterioration in the resident's health. Resident was transferred to the local hospital and passed away. Records were incorrect and a DNR was referenced to the resident who died and was incorrect as it referred to the resident's [redacted] who is also resident in the centre.
URI-0017789	26/04/19	Concern in relation to closure of Nursing Home.
URI-0017783	25/04/19	Lack of care appropriate to Resident's needs. Significant failings in how a complaint was managed.
URI-0017780	24/04/19	Concerns relating to Financial abuse and poor professional communication between Provider and CP.
URI-0017775	23/04/19	Resident banged their head and family were not informed. When another relative visited they noticed the bruising and also that the resident was in soiled, wet clothing in the activity room. The following day when relative visited again they noticed blood on the bandages used to cover [redacted] ulcer and discovered that the blood was not from ulcer but from a fresh cut. When relative touched resident's arm to try hold her whilst investigating the fresh cut they were in pain. Resident transferred to [redacted] hospital and tests confirmed that they had two fractured bones in their arm and a lot of bruising under their arms. Staff

		cannot give an explanation as to how these injuries occurred. Resident is currently in the [redacted] hospital.
URI-0017771	22/04/19	Poor Standards of Hygiene Overcrowding in rooms
URI-0017773	19/04/19	Resident has had significant bruising on a number of occasions. Medical attention was not received by resident until 3 days after a fall.
URI-0017767	17/04/19	Resident receives no assistance and the call bell is not answered. Resident has to phone the nurses station to get assistance.
URI-0017762	15/04/19	CP spent some time receiving respite care in the centre, following transfer from hospital. The staff were professional, helpful, friendly and supportive to CP during the respite period. CP's room was very clean and comfortable and CP was afforded dignity, respect and privacy during the respite care.
URI-0017751	12/04/19	Resident was [redacted] years of age on admission to the centre. There was lack of equipment and treatment to provide pressure relief. There was no hand soap in a public toilet. There were no gloves available for use during personal care provision.
URI-0017750	11/04/19	Issues relating to change of management and the systems in the centre.
URI-0017749	11/04/19	Resident has renal and heart health problems. Resident is sometimes taken to the sitting room, beside the nurse's station, to sleep on an armchair as there is not enough staff to check the resident in the bedroom. The breakfast tray was not removed from the room until 7.30 in the evening. There is a malodour from the resident's bed. A staff member dressed the bed using the wet sheets and CP requested the bed to be washed and a new set of clean bedclothes. Food is often served cold. The GP assigned to the centre reviews residents on the assigned days and outside these days staff are reluctant to alert the GP or a doctor on call when residents appear to be ill. The resident's prescription is often not fully dispensed and staff does not try to source the missing medication from another chemist. The resident is left without the medication until the chemist gets a new supply.
URI-0017748	11/04/19	Issues relate to general care, medication management, equipment and professional communication along with correct medical records.
URI-0017745	10/04/19	These events happened in [redacted]. Resident suffered a fall sustaining a [redacted] Two days later CP was informed the resident fell as a result of an assault by another resident with challenging behaviour.
URI-0017743	10/04/19	[redacted] organised a GP to review resident's wellbeing and capacity. [redacted] distributed the report following the GP's review to the family. CP has serious reservations regarding the following: - The Centre has no control over a GP entering the centre and drafting a report. The Centre stated it was none of their business when a resident's relative brought in another GP. The GP arrived on a Sunday to do the assessment.
URI-0017742	10/04/19	Resident suffered a number of assaults by another resident who has challenging behaviour. Resident received [redacted] after an assault and was very unsteady following the assault. CP tried to engage with the management but the resident's [redacted] is CP's sibling and is of a different opinion regarding the care the resident is receiving and has confirmed satisfaction with the service provided.

URI-0017740	10/04/19	There was lack of appropriate care to meet the needs of the resident. CP brought the resident home rand discovered the resident had be given medication that was prescribed for another resident.

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Reference	Date Of Receipt	Concern Detail
URI-0017876	23/05/19	CP is aware of a recent unannounced inspection and wishes to review the relevant report to ascertain if the report reflects what CP has witnessed in the service. Historically, CP had considerable issues around [redacted] for the resident but he did not mention any of these issues during today's call.
URI-0017830	09/05/19	Resident died [redacted]. There were care issues prior to HIQA's regulatory remit [redacted] and up to the resident's death [redacted] The family requested a second opinion and choice of GP and this was declined. There were many issues and following on from complaints made, there were meetings and the outcome of the meetings was not satisfactory.
URI-0017820	07/05/19	Poor quality of care and staff shortages.
URI-0017806	02/05/19	CP has concerns relating to his [redacted] and a previous safeguarding officer. CP believes that the previous safeguarding officer made sexual advances towards [redacted]. Trend of communication failure between management and CP over the years. Breakdown in communication between the current PIC and CP.
URI-0017770	17/04/19	CP is in the house neighbouring another house that accommodates another service user who has 'challenging behaviour' The other resident screams during the night and early morning and disturbs CP's sleep. There appears to be ongoing issues between the two residents. Although CP brought his concerns to the attention of the various key workers and PIC, no action has been taken.
URI-0017764	15/04/19	There are no activities in the centre. The last HIQA report mentioned day centres but the residents do not attend them. The [redacted] of the centre has resigned and there is an atmosphere of apathy among the staff CP met and engaged with.
URI-0017760	15/04/19	Resident was admitted to the centre [redacted] The [redacted] were advised that a programme would be in place to progress the resident's lifestyle and behaviour. However, there is no programme in place and the resident's behaviour and appearance has deteriorated. The resident's fees are in deplorable condition with the nails curling around the toes and the big toes are infected. Cream was prescribed by the GP for the resident's [redacted] but this has not been applied. There is no encouragement given to the resident and personal hygiene is ignored. The resident's diet is not conducive to a good healthy one and the resident is sometimes given four ice-creams to eat in the one day with no regard to over-eating. The resident's parents have engaged with the staff to reach a resolution but this is not forthcoming.
URI-0017758	15/04/19	CP was informed of an incident that involved the resident and had to be reported. CP engaged with the PIC and was not happy with the outcome. CP believes the incident involved two residents. CP's [redacted] was having dinner at [redacted]. A glass of orange was taken from the resident. The glass was brought into the kitchen and the orange emptied and the glass was dropped on the floor. After the breakage, CP's [redacted] feet were placed on the other resident's foot. Although CP has not seen the incident report, CP disagrees with the content and believes it will not reflect the factual events.

URI-0017756	12/04/19	Issues relate to the provision of respite care and the reduction in the days allocated.
URI-0017739	10/04/19	CP changed from the assigned GP for the service to a private GP. CP is capable of self-medicating using the kardex structure. The private GP will not complete the kardex for CP to enable CP to tick the kardex when self-medicating. CP was advised to speak with the key worker and social worker in an effort to resolve the issue.
URI-0017728	09/04/19	Issues relating to resident's Positive Behavioural Support Plan
URI-0017718	05/04/19	CP's [redacted] was injured in a peer to peer incident that took place [redacted]
URI-0017712	04/04/19	Resident suffered a fall and CP was not notified. There were different accounts on how the accident happened. The resident had [redacted] following the incident. Resident was provided with a prescription for pain relief but it was not filled.
URI-0017708	04/04/19	The capacity in the centre is outside HIQA's recommendation. There are [redacted] residents; [redacted] male and [redacted] female. There is one [redacted] resident aged [redacted] and there is a safety issue around a child resident with adult male residents. There are no personal alarms for staff caring for residents with challenging behaviour.
URI-0017707	04/04/19	Centre has a policy that care assistant can accompany resident to the A&E of the local hospital but they are now allowed to accompany the resident in the A&E. The resident has a lot of health problems and has been admitted to the hospital on occasion. The resident was provided accommodation in a [redacted] room but did not know the other patient and this caused the resident stress as the patient is familiar with the care assistants in the residential centre.
URI-0017689	01/04/19	Resident developed [redacted] and following treatment was accommodated next door to the original place of accommodation. The resident wishes to return to the original accommodation next door but staff are insisting on the resident staying in the current place as they consider the resident to be unwell and requiring 24/7 care.
URI-0017683	01/04/19	Service is not compliant with standards. There is no follow up regarding falls.
URI-0017682	01/04/19	Resident left the centre for over two hours unsupervised. Notification of incident was not issued to resident's sibling.
URI-0017681	29/03/19	Safeguarding concern. The service user made an enquiry to NAS about a [redacted] interference in the Service User's financial affairs.
URI-0017679	29/03/19	Resident is [redacted] and displays challenging behaviour. There is 2:1 and sometimes 3:1 care provided due to the challenging behaviour. Currently the resident is accommodated downstairs; however, the provider has advised the resident will be moved upstairs and the rest of the house will be used for respite care. CP did not know respite care could be provided along with residential care and is fearful for the resident due to the challenging behaviour.
URI-0017667	27/03/19	Staff member inebriated while on duty.
URI-0017634	19/03/19	Resident has been in residency for over [redacted]. There are ongoing preparations to transfer the resident to alternative accommodation. The resident uses [redacted] and has suffered falls. The resident's family have been advised as the incidents are falls it is not a safeguarding issue. Resident's family have received no information relating to the compatibility tests for the resident and there is no communication or clarity regarding the coordination of the transfer of residents.

URI-0017632	19/03/19	CP's adult child was refused respite care on the grounds that there was high dependency and that there was no nurse to provide the necessary care. The centre is not wheelchair accessible
URI-0017633	15/03/19	CP has concerns as witnessed their relative being physically restrained by two staff members. Relative has challenging behaviour but CP states that behaviour has become more problematic owing to stress. Concerns also relating to constant staff changes.
URI-0017627	13/03/19	Resident had treatment for [redacted] and unfortunately, [redacted] The resident suffers falls and is at further risk from falls. CP is not notified when the resident falls. The consultant in the hospital recommended that every effort be made to ensure the resident did not suffer falls. There are no safeguarding measures in place for the resident.
URI-0017609	07/03/19	Concerns relating to breeches of confidentiality and data protection.
URI-0017603	06/03/19	Resident was assaulted by a staff member [redacted]. The resident received 1:1 care and is non-verbal. There was an internal investigation and the Garda were involved. The DPP decided there was no case to answer. The investigation and allied checks took six months to complete. CP has been advised the staff member is returning to work and will be assigned as the 1:1 care provided to the resident.
URI-0017602	06/03/19	CP's [redacted] is resident in the centre and has suffered physical and verbal abuse. CP brought these issues to the attention of the management and had a meeting to further discuss. However, the resident is still at risk. Management was dismissive of CP's concerns and fears.
URI-0017601	06/03/19	[redacted]) disclosed that following receipt of correspondence from the authority seeking confirmation that residents were registered with and availing of national screening programmes, that residents were being taken to appointments such as cervical checks without prior knowledge or informed consent. [redacted] stated that concerns raised to the provider by staff in relation to residents rights were ignored, and that the priority is to ensure that they are complete for when records are checked by the authority. Concern is that residents are subject to invasive procedures without adequate knowledge, preparation or consent.
URI-0017600	05/03/19	Resident is at risk as there are no safeguarding measures in place. There is another resident with challenging behaviour who is liable to assault the resident. CP has engaged with the PIC and other staff members and has received no reassurances regarding the future safety of the resident.
URI-0017590	01/03/19	CP refers to an inspection report relating to findings of safeguarding. CP believes the findings may refer to the resident.
URI-0017589	01/03/19	Resident appeared to be unwell and no appointment was made for a GP review.
URI-0017586	28/02/19	CP refers to an inspection report relating to findings of safeguarding. CP believes the findings may refer to the resident.
URI-0017579	27/02/19	Resident is non-verbal and has minimum mobility and has been in care [redacted]. The service provided is excellent and very professional. There is no assistance for the resident to visit siblings who are old and unable to travel to visit the resident. There is an expectation that staff should accompany and assist the resident abroad to visit some of the siblings and also to travel for overnight stays to other parts of the country.
URI-0017568	25/02/19	Staff Shortage.

URI-0017559	21/02/19	CP is concerned with the severe reduction in care staff which will put their relative at risk.
URI-0017556	20/02/19	Provider has installed an entrance gate with a code panel. CP has not received the details of the code to ensure CP can enter the centre and this is causing anxiety about the wellbeing of the resident. The gate is large and constructed of steel coloured black and is approximately 5 feet high. The resident is unable to look out and will not see any visitors as they arrive. Neighbours have asked CP if the resident might be dangerous when the gate was installed. CP believes the code to the gate should be provided.
URI-0017544	18/02/19	CP was advised the resident is moving to an apartment and CP is anxious as CP believes the resident is not capable of independent living. There is a historical incident of a sexual attack that CP believes impacted on the resident's ongoing wellbeing. CP engaged with the resident's carer who confirmed the resident is capable of taking medication and other personal actions such as using an ATM. The carer advised CP the resident has lost weight and is aware of eating appropriately. The resident can attend to personal hygiene. The resident was previously threatened by staff regarding challenging behaviour.
URI-0017528	13/02/19	There is lack of management and the PIC is covering other centres resulting in lack of continuity of care. One resident took [redacted] from the fridge and was eating them.
URI-0017516	11/02/19	CP's relative shares the accommodation with [redacted] others and is in the centre [redacted]. Another resident entered the bedroom and was lying on top of CP's relative until staff removed this resident from the room. A few days while CP's relative was in the communal sitting room the other resident who was undressed [redacted] in front of CP's relative. Agreement was reached that the resident with challenging behaviour would be moved to another centre. However, a transfer would take time to organise and in the meantime, there would be safeguarding arrangements put in place. A staff member would be provide 1:1 care and alarms would be installed to alert staff. Senior management stated there would be three unannounced visits by them to ensure these arrangements were adhered to by all concerned. There were some unexpected circumstances due to family bereavement and hospital visits and the arrangements to transfer the resident were left in abeyance. However after a time lapse, the transfer did not take place. CP was informed that the management allowed the resident remain in the centre. Staff advised CP the alarms were removed as the resident was behaving well. However, the challenging behaviour continues to frighten and sometimes CP's relative is hit by the resident. CP made a further formal complaint and was advised that the best solution was to transfer CP's relative to another centre. CP is not happy with this suggestion as CP's relative has been resident for over [redacted] and gets on well with the other residents.
URI-0017498	08/02/19	Resident has limited communication. Resident had unexplained bruising, and, while the issue was investigated, the result was inconclusive. Staff fail in their duty of care towards the resident and CP noted a staff member lying on a bed watching TV while the resident [redacted] There is lack of appropriate information provided during staff changeover. There is lack of proper communication between the centre and CP regarding the ongoing care of the resident.
URI-0017497	07/02/19	Resident is suffering verbal abuse from a staff member and is feeling upset as it is ongoing with threats that the resident will be forced to leave the centre.
URI-	05/02/19	Death of resident, loss of keys and verbal abuse.

0017486		
URI-0017472	01/02/19	Allegation of historical sexual abuse.
URI-0017466	31/01/19	There are issues of safeguarding for the resident.
URI-0017464	31/01/19	Staff member was drinking while on duty.
URI-0017450	29/01/19	Restrictive practices in place for young person living in apartment.
URI-0017427	22/01/19	Resident is aged [redacted] and has a care plan that includes various activities to promote the resident's well-being. The care plan is not adhered to and the resident was taken to meet Santa regardless of age and the outing was in place of swimming. Staff are not receptive to CP engaging with the resident and when appointments are made, staff ensure the resident is taken out to avoid meeting CP.
URI-0017422	21/01/19	CP has voiced a suggestion regarding the limited space in the house but staff will not accede to the suggestion. Space is limited so the conservatory at the back of the house would provide extra airy space for all the residents to enjoy. However, the conservatory is used for laundry purposes.
URI-0017418	21/01/19	No assistance when resident used bathroom. Resident fell and sustained injuries. No record made relating to fall.