## Lydia Buckley

**From:** [redacted]
**Sent:** Wednesday 30 October 2019 15:06
**To:** Sean Lynch
**Subject:** RE: Freedom of Information request

That's fine Sean, thanks

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**From:** Sean Lynch [mailto:slynch@hiqa.ie]
**Sent:** 30 October 2019 15:04
**To:** [redacted]
**Subject:** RE: Freedom of Information request

**External Sender**

Dear [redacted],

Further to our phone conversation, I would appreciate if you could confirm that you will amend the request to the following:

- A copy of all concerns received by Hiqa since 15 May 2019 in relation to public and private nursing homes.

I can supply the concerns for the period 1 January 2017 to 15 May 2019 by giving you previously released FOI requests.

Just to note that HIQA refers to the information received by the public about nursing homes as concerns rather that complaints, hence the slight change in wording in the request.

Kind regards,

Sean



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**From:** [redacted]
**Sent:** 21 October 2019 15:20

**To:** FOI
**Subject:** Freedom of Information request

Hello,

I am requesting the following under the Freedom of Information Act 2014:

- A copy of all complaints received by Hiqa since 2017 in relation to public and private nursing homes.

I would like to receive this electronically.

Kind regards,

[redacted]
*Irish Daily Mail*

*Embassy House, Herbert Park Lane, Ballsbridge, Dublin 4*

[redacted]

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

**Private & Confidential**

[redacted]

1 November 2019

**Our Ref. FOIR 051 019**

**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:

> A copy of all concerns received by Hiqa since 15 May 2019 in relation to public and private nursing homes.

Your request was received by this, the Health Information and Quality Authority, on 21 October 2019 and was subsequently amended to the above request. 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 18 November 2019.

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

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decision not reach you on time, please feel free to call me to discuss any problems that may have arisen.

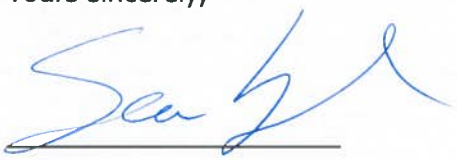
If you have not heard from us once the allotted time has expired, you are automatically entitled to appeal to the Health Information and Quality Authority for a review of the matter. This review proceeds on the legal basis that the initial request is considered to be refused once the specified time for 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]

18 November 2019

**Our Ref. FOIR 051 019**

**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:

> A copy of all concerns received by Hiqa since 15 May 2019 in relation to public and private nursing homes.

Your request was received by this, the Health Information and Quality Authority, on 21 October 2019 and was subsequently amended to the above request. The Authority has made a final decision today 18 November 2019 to part grant your request. If you have any queries regarding this correspondence you can contact me by telephone at 01 814 7486.

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.

This letter addresses each of these parts in turn.

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## 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 the 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 that you receive access the records electronically. I consider email an appropriate form of access in this case. The records described as part granted 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 the 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,*

Grounds for Decision to Part Grant Request

The decision maker is of the view that this exemption applies to certain information contained in the records requested. This is because the records concerned contain information given to the Authority in confidence, and on the understanding that it would be treated as such, and the disclosure of this information 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, which may inform its regulatory activities, should continue to be given.

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Public interest consideration

The Authority accepts that Section 35(1) is subject to Section 35(3) 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.

There are no discernible or particular public interest grounds leaning in favour of a release of the information in question. The public interest in preserving the right of privacy is a strong public interest in favour of not releasing the record. Accordingly, the decision maker has decided that the public interest is better served by refusing access to the information and redacted from the records any information given in confidence and any details which would identify the person who provided this information.

## Section 37 - Personal Information

In relation to the records identified in the schedule, they contain 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 personal identifiable data about service users and others 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. The decision maker believes that the right to privacy of third parties outweighs the public interest of transparency in how public bodies operate. Therefore, on this occasion, we believe the public interest favours non-disclosure of personal identifiable information.

## 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 tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

**FOI Request Reference** **FOIR 051 019**

**FOI Received**

**Decision Maker** **Shane Grogan**

**Decision due no later than**

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| 1 | List of URI's | FOIR 051 019 PART 1. | 2 | N | Part Grant | Section 37 - Personal Information and Section 35 Information received in confidence | Full disclosure of the document could lead to the identification of an individual | The public interest that unrestricted access should be granted does not outweigh the right to privacy of the individual | Personal identifiable information redacted |
| 2 | List of URI's | FOIR 051 019 PART 2 | 36 | N | Part Grant | Section 37 - Personal Information and Section 35 Information received in confidence | Full disclosure of the document could lead to the identification of an individual | The public interest that unrestricted access should be granted does not outweigh the right to privacy of the individual | Personal identifiable information redacted |
| 3 | List of URI's | FOIR 051 019 PART 3 | 5 | N | Part Grant | Section 37 - Personal Information and Section 35 Information received in confidence | Full disclosure of the document could lead to the identification of an individual | The public interest that unrestricted access should be granted does not outweigh the right to privacy of the individual | Personal identifiable information redacted |
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FOIR 052 _DCOP

| Reference | Date Of Receipt | Concern Detail |
|---|---|---|
| URI-0018470 | 30/10/19 | Resident suffers with Dementia; they have problems settling at night time and have a tendency to wander about. They recently wandered into another resident's room and started to throw cushions at them. The Residents family complained. The PIC of the centre rang CP stating [redacted] didn't know what to do with the resident and was sending them to the A&E. The resident refused to get in the ambulance; they finally went in the 3rd ambulance that arrived. The resident was assessed by the Psychiatrist and their medication was changed. The Psychiatrist was happy that the Resident was fit to return to the nursing home. The PIC in the centre refused to take the resident back. After several conversations with the bed manager the resident returned back to the home. CP verbally received a months' notice to find a new centre. CP is upset with the lack of patience, care and understanding afforded to the resident who suffers with this illness. The PIC's solution was to discharge the resident to A&E and let it become their problem. |
| URI-0018463 | 29/10/19 | Resident absconded from building, staff unaware. 3rd absconding instances in six months, wrist alarm placed on resident, alarm goes off at reception. Last 2 instances no one on reception. Entrance in and out is a sensor and is not manned, easy for resident to walk in and out as no supervision |
| URI-0018457 | 25/10/19 | CP concerned about quality of care, incorrect information been given regarding HIQA feedback forms and overcrowding in the nursing home |
| URI-0018446 | 23/10/19 | Resident suffers with Dementia. Family are in the process on getting enduring power of attorney. Resident receives visits from [redacted] who upsets the resident daily. The resident constantly rings their family in an upset state after hearing stories from [redacted]. Family have asked for [redacted] to be banned from Nursing Home. PIC has stated they cannot ban this visitor. |

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| URI-0018437 | 21/10/19 | Resident has reported two incidents that happened to them regarding another resident coming into their room. On the first incident between the hours of [redacted] the resident received a scratch mark on their face. The resident informed their family that a man came into their room, pulled their hair and scrapped their face. The Resident would require assistance getting out of bed. When the incident was reported to management, they said nobody came into the room, the mark may have happened while personal care was being given. A few weeks later the resident had to attend hospital. On their return they became very upset and kept repeating I don't want to see that man again. When the family asked what had happened, the resident said a man came into their room, he had no clothes on and he flung the chair across the floor. A carer came in and directed him out. Again the family raised the issue with the provider; they said the resident was confused no such incident occurred. The resident pointed out the other resident to the family. They leave their light on a night time so would have a clear view on who entered their room. They were very upset and kept repeating the incident happened. Family have requested footage of the CCTV outside the resident's bedroom to see if anybody entered the bedroom. They have contacted the data commissioner to see if they are entitled to view this information and were advised to make a request to the provider under Article 15. Family believe the resident and do not appreciate the provider stating the resident is confused. They appreciate the resident can get confused at times but overall you can have a conversation with the resident. |
| URI-0018375 | 08/10/19 | CP has concerns regarding cleanliness of nursing home especially residents room. No hot water available for two of the residents scheduled shower days. |
| URI-0018270 | 09/09/19 | SU choked to the point where [redacted] was unresponsive. SU is now in [redacted]. Update: the resident has passed away RIP The has informed HIQA of this matter and the service provider will keep the case holder up to date on the progress and outcome of the investigation into the incident. |

(2)

FOIR DCOP

| Reference | Date Of Receipt | Concern Detail |
|---|---|---|
| URI-0018428 | 21/10/19 | [redacted] a number of resident's possessions have gone missing. Resident has lost [redacted] four times; which family have had to keep paying for. Family have raised this issue and their concerns and have been given the response that the resident will be supervised more. [redacted] have gone missing. However, due to a high turnover of staff, staff are not familiar with the resident's habit of removing their [redacted] |
| URI-0018416 | 16/10/19 | Resident wishes to keep their own GP but the PIC rang family to say that the tranfer had already been done for the resident to use the centres own GP and it can't be undone. Resident and family's wishes were not respected. |
| URI-0018413 | 16/10/19 | Concern relating to staff shortage. |
| URI-0018411 | 15/10/19 | Family concerned about some of the nursing practices they observed and the lack of professional care given by staff members and management. Issues Identified: On [redacted]: Poor medication management ? re qualifications of staff neglect- no shower for 5 days Poor records- no record of fluid intake Resident lost 14 pound in 6 days as resident No access to fluids/ jugs of H2O Bad/ foul smell [redacted] when come out of lift lack of act for residents with dementia |

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| URI-0018410 | 15/10/19 | Resident has sustained three falls during the past two years, all have been head injury's. The latest fall has caused a serious bleed to the brain, which may require further surgery in [redacted]. All falls have occurred during the early hours. A family member was contacted and arrived to the centre at [redacted], the ambulance arrived at [redacted] When the manager was asked what had happened, the sustained injury did not match with how the incident occurred. The Manager said the resident must have rolled out of the bed or climbed over the bed rail. The story was then changed and the HCA said the resident wriggled out of bed and slipped between the bed rail. Looking at the residents injury, it appears that the resident fell out straight and landed on their forehead. The family believe the resident was left sitting on the bed without supervision and fell . All stories received how the incident occurred have changed and are inconsistent. The resident needs two staff members to assist them from their bed and would not have the energy to wriggle out of the bed or climb over the bed rail. The family were also advised that the fall happened between [redacted] but this is inaccurate as the family and ambulance were there during this time. The resident is [redacted], when they were transferred to the hospital, no information was provided and hospital staff were not aware the resident was [redacted]. |
| URI-0018406 | 15/10/19 | Resident fell causing a serious injury. Family were not informed how it happened. Nursing home is aware of family issues and lack of communication with each other. Family upset to find resident injured without information being provided. |
| URI-0018397 | 11/10/19 | Poor quality of care provided to residents who required assistance. Not enough staff on duty to meet the dependency needs of residents. |

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| URI-0018399 | 11/10/19 | CP contacted the data commissioner regarding a concern they had which they considered a data breach. The data commissioner advised CP to write a letter to the provider regarding this incident advising this was a data breach. The resident's family had been away on leave and had requested that the residents post be held for their return. This request was not acknowledged by a member of staff. CPs relative's bank statement was opened by a staff member, they examined all transactions. The staff member sent an email to the resident's solicitor asking to whom two cheques were made out to. The Staff member PP their name on the residents behalf. They informed the family that the resident gave permission. The resident suffers with short term memory; the family do not believe that permission was given by their relative to send the email. |
| URI-0018387 | 09/10/19 | Not enough staff supervising residents especially in dementia area Accidents not followed up when needs to be seen by GP Lack of staff to help with toileting Lack of staff helping with meal times Wheelchairs not sturdy or lack of pressure cushions |

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| URI-0018383 | 09/10/19 | CP states that [redacted] is being kept in the nursing home against her will. CP was in another nursing home belonging to [redacted] previously but moved here. CP is petrified that [redacted] will die here and never return home. CP wants to leave but does not know how to or how to terminate their contract. A Doctor informed CP that staff are concerned over [redacted] memory, CP stated th ere is nothing wrong with [redacted] memory. Once you come into this nursing home everybody is tarnished with the same diagnoses. CP is surrounded with Patients suffering with Dementia. CP originally booked themselves into the nursing home for recuperation after having being in hospital recovering from an injury after falling off their bike. CP has no support from their family and had been in an [redacted]. One family member is currently living in their old home. CP has contacted SAGE but feels they are not being listened to. |
| URI-0018382 | 09/10/19 | CPs relative was pushed by another resident in the corridor and assaulted. CPs relative has a mark on their neck, this assault was witnessed buy a staff member. The other resident has a history of aggression to other residents. CP attended a meeting with management who assured CP that they would watch the resident more. CP is concerned this assault could happen again, their relative has been quite upset since the incident. |
| URI-0018360 | 04/10/19 | CPs are not confident that the home provided: • Nursing care in a safe and comfortable environment. • GP care as required. • In-house laundry service. • A full and varied daily activities schedule. The following facilities were lacking: • A remote control for the television. • Assisted shower and bathrooms. • A selection of sitting, dining and activity rooms. |

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| URI-0018359 | 03/10/19 | SU is no longer a resident of NH. CP's relative was taken to hospital with burn injuries acquired when there was a fire in their bedroom, stayed in [redacted] hospital for [redacted] and is now in a different NH There was no care plan in place while SU was in this NH, SU is [redacted] and CP refused to sign it as NH was charging [redacted] per month for activities which the SU was not taking part in. NH claims that SU was taking part in [redacted] however CP believes that this activity was a weekly bath. |
| URI-0018356 | 03/10/19 | SU fell and when examined by doctor at NH they were informed that nothing was wrong. 6 days later SU was taken to hospital with a suspected fractured hip. SU was accompanied to hospital by a care worker who was unfamiliar with SU. |
| URI-0018354 | 03/10/19 | CP's relative was in respite care for two weeks. During this time their medication was dramatically reduced resulting in the service user being impacted negatively. SU's family were not informed by the NH that their relative's medication was reduced. |
| URI-0018353 | 02/10/19 | CP's relative in NH for 2 years. CP had numerous concerns in relation to relative's care. Service user was totally dehydrated and lost 3 stone in weight. After raising concerns with the manager of NH the CP was asked to move relative from NH. CP's relative is now in another nursing home, however the service user is frightened after her experience and CP believes it will take some time for their health to improve. |
| URI-0018351 | 02/10/19 | CP has concerns relating to their relative becoming distressed when incontinence wear is changed by a male nurses aid. |

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| URI-0018347 | 30/09/19 | CP has concerns in relation to 3 highly dependent residents being moved to their relatives floor. One of these residents frequently wanders into their relative's bedroom and this frightens the relative. Another resident is verbally abusive to their relative. CP states that their relative is not being safeguarded and there are issues in relation to staffing. CP met with Director of care who wishes to give a one month trial integration period however the CP is not happy with this. |
| URI-0018345 | 30/09/19 | CP is frustrated how on the day of inspection, the DON and A/DON came out onto the floor in the day room pretending to assist feeding residents as if this was normal behavior every day. According to CP, this never happens. You are lucky if you can find a staff member in this room at all. The centre has continued to be non-compliant with regards to staffing, Governance and quality of food but are allowed to continue operating. CP and family would love to move their relative from this home but cannot afford to upset the resident due to their health and age. On Saturday, CP could not leave their relative alone and go home after visiting because there was no staff member to be found to supervise the residents in the day room. CPs relative should not be going to the bathroom on their own without assistance but has taken many risks as they can no longer wait for a staff member to arrive. |
| URI-0018344 | 30/09/19 | Concerns relating to safeguarding of CP's relative. Another resident who has dementia is extremely aggressive towards CP's relative. This resident was moved however they sit with CP's relative at mealtimes and also need to pass through their area when going to the smoking area. CP tried to defend [redacted] against the resident and incurred bruising to their arm. CP feels that their relative is not being safeguarded. |

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| URI-0018341 | 30/09/19 | Nursing home severely understaffed since new owners have taken over. Increase in Residents falling. CP's relative has unexplained scratches. Relative was assaulted by another resident. Relative had a [redacted] and staff could not give an explanation as to how this occurred. No activities or stimulation fro residents. |
| URI-0018337 | 30/09/19 | Staffing levels are unsafe leading to lack of proper supervision, engagement and safety of residents. Management's inaction to address deficiencies in care and to correctly staff based on higher patient numbers and level of assistance/supervision required has resulted in a number of Falls and injuries due to patient on patient incidents. There are [redacted] at night covering entire nursing home. |
| URI-0018336 | 27/09/19 | Resident sustained a fall and was taken to the local hospital the following day, they unfortunately passed away [redacted] days later. Family has been informed by the service provider that [redacted] out an investigation into the death. |
| URI-0018332 | 26/09/19 | CP is concerned about changes in the nursing home which are having a negative impact on residents. |
| URI-0018328 | 26/09/19 | Lack of care for relative. Concerns not being resolved by NH |
| URI-0018327 | 26/09/19 | Night staff getting residents up early as there is a shortage of staff on days and little or no experienced staff on duty for the day ahead. |
| URI-0018323 | 25/09/19 | CP has previously been in touch regarding unexplained injuries to their parent on [redacted] different occasions. Since then CP has made several requests for copies of the incident reports as to what happened. Only one report has been received which CP states does not answer anything and contains a lot of inaccuracies. CP has sent over 13 requests via the FOIR route and has still received no information. The Service Provider is failing to address any of the families concerns or share any information about these [redacted] incidents. |

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| URI-0018321 | 25/09/19 | CP has concerns relating to the poor condition of NH. Staff numbers were increased for inspection purposes only. 2 staff taking care of [redacted] residents after [redacted] |
| URI-0018318 | 24/09/19 | Failures in a fire safety. |
| URI-0018317 | 24/09/19 | CP has concerns relating to staff shortages and the high turnover of staff which is impacting on the care of residents. SU is losing weight rapidly and does not receive the required assistance at mealtimes. When Inspections take place more staff are brought in however this is not a true reflection of the staff ratios or care given to residents. |
| URI-0018309 | 20/09/19 | CP is being charged €5.00 per day for activities when SU does not partake in these activities. |
| URI-0018308 | 19/09/19 | CP states that NH remain severely understaffed and this is impacting greatly on the care of residents. Food continues to be served cold. Staff are leaving as they are unhappy with working conditions. There are issues regarding hygiene throughout the NH. CP feels that they are managing issues that arise in the NH when they visit instead of spending quality time with their relative. |
| URI-0018303 | 18/09/19 | CP has the following concerns. SU left alone in the day room where they fell. SU admitted to hospital where they remained unconscious and had bruising down their face and required stitches over their eye. SU died [redacted] after fall. SU had a previous injury [redacted] which Family was not informed about. |
| URI-0018299 | 17/09/19 | CP has concerns regarding the welfare and safety of residents in NH. Staff shortages impacting on the care and safety of the residents. High level of falls as residents are unsupervised. Lack of cleanliness and hygiene in a number of areas of the NH. Number of complaints made regarding bullying of staff which have not been addressed. |
| URI-0018296 | 17/09/19 | CP has concerns relating to the delay of Inspection for a new dementia unit within the NH. |
| URI-0018295 | 17/09/19 | CP is constantly refused telephone access to their relative. |

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| URI-0018292 | 16/09/19 | Concerns observed relating to the follow issues: Staffing levels Activities |
| URI-0018290 | 13/09/19 | NH wants resident to pay for activities which they do not take part in. When CP was visiting their relative they could not identify a nurse when they required one. There is a notice board on the wall in the main office with all of the resident's names on it and it can been seen by everyone. Only 1 toilet near the day room for a large number of residents to use. CP's relative is not incontinent however they are made wear incontinence pads. |
| URI-0018283 | 12/09/19 | CP is a resident of NH who are currently refurbishing as the authority will be holding an inspection in the near future. CP is distressed with the level of noise created because of the refurbishments. CP cannot engage with manager of NH as there has been a breakdown in communication and manager will not engage with CP. CP cut the call short and said they would call back. |
| URI-0018277 | 11/09/19 | Shortage of staff impacting on the care of residents. Another resident's medication found under resident's bed. Soiled sheets not changed. CP has witnessed residents being left in bed and also falling out of bed. |
| URI-0018274 | 10/09/19 | CP praising the care and kindness received by their relative in NH. |
| URI-0018273 | 10/09/19 | SU's money is missing and when reported to staff they are dismissed. Lack of respect and dignity for residents. No activity or stimulation for residents. Residents are unwilling to voice concerns as they feel it will have a negative impact. Residents are verbally abused by care staff. |

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| URI-0018266 | 06/09/19 | CP's relative is in hospital suffering with malnutrition after a [redacted] month stay in the NH. Relative was complaining to CP with a pain in their chest and NH staff would not seek medical attention. Relative was left in soiled incontinence wear. Very poor standards of hygiene. Food portions are too small and not adequate. [redacted] and will be going to a different nursing home once they are discharged. |
| URI-0018263 | 06/09/19 | [redacted] Poor hygiene standards in the rooms of dementia residents. Curtains not opened during the day. Faeces on resident's bedroom floor. No paper towels in the bathrooms |
| URI-0018261 | 06/09/19 | CP has concerns relating to an employee of NH having multiple criminal charges. Resident removed from NH owing to a complete lack of care and being heavily sedated. |
| URI-0018258 | 04/09/19 | Severe staff shortages impacting on the care and safety of residents. No activities for residents. PIC is verbally abusive to staff. |
| URI-0018255 | 04/09/19 | [redacted] Food which SU receives is not adequate. Poor hygiene conditions, relative needs to clean the SU's bathroom when they visit. Experienced care staff are leaving and are being replaced by inexperienced staff. |
| URI-0018253 | 04/09/19 | SU fell from hoist. Poor standard of care. |
| URI-0018252 | 04/09/19 | SU has blisters in their mouth for the last 6 months and not receiving appropriate treatment for same. |
| URI-0018250 | 03/09/19 | Relative hospitalized suffering from serious dehydration and constipation. CP has concerns relating to the health and safety of other residents. Service user often heavily sedated to manage challenging behavior. Consumption of liquids and foods not sufficiently monitored to prevent dehydration. SU was not engaged in activities in the nursing home. |
| URI-0018242 | 02/09/19 | Unexplained bruising on SU's face. |

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| URI-0018241 | 30/08/19 | CP has concerns relating to a hoist which was broken for 3 weeks and safety issues surrounding this. |
| URI-0018239 | 30/08/19 | CP feels that their relative's and other resident's care does not meet the required standards. |
| URI-0018237 | 30/08/19 | SU was administered a sleeping tablet which they should not have received as they have a pacemaker fitted and irregular heart beat. SU regularly found to have no incontinence wear on them. Residents left unattended for long periods of time owing to staff shortages. Lack of dignity and respect. |
| URI-0018236 | 30/08/19 | SU's nebulizer is broken and staff will not repair it. SU's [redacted] patches have been halved. |
| URI-0018233 | 29/08/19 | CP has concerns relating to safeguarding issues. |
| URI-0018232 | 29/08/19 | Strong odour of urine in resident's bedrooms. Staff shortages. Residents not stimulated. |
| URI-0018229 | 28/08/19 | High staff turnover/staff shortages. Management putting pressure on staff to work extra shifts. One healthcare assistant is [redacted] years old. Director of Nursing bullying other staff members. Renovations that were promised have not commenced. |
| URI-0018228 | 28/08/19 | CP has been threatened by management that they will be ejected from the service if they do not sign certain documentation. |
| URI-0018227 | 28/08/19 | Concerns relating to lack of care and dignity. Unqualified Staff. CP now looking for another nursing home for their relative. |
| URI-0018223 | 26/08/19 | SU (now deceased) fell out of bed in [redacted] and received bruising to their face, SU attended A&E. CP believes that this fall contributed to the decline in the Service User's health and wants to ensure that we were notified of the incident. |

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| URI-0018221 | 26/08/19 | Concern regarding a resident who was administered a prescribed PRN medication by injection without the resident's consent, and that deception was used to coerce the resident to engage with a staff member in order to administer the medication. |
| URI-0018220 | 26/08/19 | Concerns regarding the adequacy of the response to safeguarding concerns within [redacted] Nursing Home. |
| URI-0018215 | 23/08/19 | SU received unexplained bruising. SU's hair was wet for a long period of time resulting in the SU being cold. |
| URI-0018214 | 23/08/19 | Delay in CP being refunded monies due from the provider. |
| URI-0018209 | 22/08/19 | Client of CP has requested NH to release their late [redacted] full medical file however NH is failing to engage with them. |
| URI-0018207 | 22/08/19 | Concerns relating to change of management at NH which will take place at the end of [redacted] |
| URI-0018206 | 21/08/19 | Severe staff shortages. Residents are not been taken out of bed during the day as there are not enough staff to look after their needs. Serious falls have occurred as residents are not supervised. Resident's personal needs are not been taken care of. Current staff are under immense pressure and are visibly upset because of this. [redacted] |
| URI-0018204 | 21/08/19 | Outbreak of virus in NH - HIQA not notified. |
| URI-0018201 | 20/08/19 | CP's relative as fallen and sustained cuts and bruises on [redacted] separate occasions. When the [redacted] incident occurred the CP requested an incident report on [redacted] occasions and did not receive same until after the [redacted] incident. After the last the SU had a visible bump and bruising to the head however staff could not explain how did this occurred. Management of NH are currently investigating this incident. |

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| URI-0018200 | 19/08/19 | CP [redacted] from NH and regularly hears a male resident shouting for help for long periods of time. There are no curtains on the resident's window and the window is opened. The CP states that the resident is in a lot of distress and no one comes to assist them. CP tried to contact the NH via telephone but no one answered. |
| URI-0018199 | 19/08/19 | CP has concerns relating to the following:- Residents do not receive tea or drinks after 4.00pm CP spoke with PIC and advised them that their relative requires encouragement to take drinks however this does not occur. Residents are seated in a conservatory where it becomes very hot and CP is concerned that there is a risk of residents becoming dehydrated. There is a high turnover of staff and staff are not replaced for a period of time which is leading to staff shortage issues. There are very few activities for residents in the evening. CP believes that their relative requires Physiotherapy however they are not receiving this and relative is complaining with a lot of back pain. |
| URI-0018196 | 19/08/19 | SU unable to watch GAA hurling final as televisions were not working and this has previously occurred. |
| URI-0018192 | 19/08/19 | Poor standard of care received by SU. |

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| URI-0018191 | 16/08/19 | Resident fell in the courtyard around [redacted]. On the day of the fall it was very hot. The resident wore no sun hat nor had an umbrella protecting them from the sun. According to CP, they had a touch of sunstroke which caused them to fall and broke their hip. The resident was walked to the day room. The resident continued to cry and asked for an ambulance to be called. Staff told the resident to stop crying like a baby. A doctor was called for [redacted] hours later and ordered an ambulance. CP received a called by the nurse in the home, asking if they could go to the hospital. [redacted] informed CP that the resident had been crying since [redacted] but it was nothing serious. CP was asked to relieve the carer in the hospital with the patient. When CP arrived at the hospital, the residents [redacted]. The resident informed CP that they asked for a doctor, ambulance and family to be called for but staff dismissed their request for [redacted] hours. CP is concerned that after the fall, the resident was required to walk back into the centre, which may have caused further injury and the unwillingness to call for a doctor. |
| URI-0018188 | 16/08/19 | Concerns relating to a high turnover of staff and is concerned that this may impact on the care of their relatives. Very little space for residents to receive visitors. |
| URI-0018186 | 16/08/19 | SU had two falls - first fall the SU had severe bruising on their back and arm and second fall the SU required [redacted] on the back of their head. SU was complaining with pain and soreness in their lower back at the beginning of [redacted] weeks ago relative was informed that this was due to a pressure sore which is now a grade 4. Lack of care and dignity. SU becomes dehydrated as is not assisted with fluid intake. |

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| URI-0018183 | 16/08/19 | . CP could no longer continue taking calls from staff asking to bring resident for appointments or to come in and try pacifying the resident if they were upset. Over a [redacted] year period, the resident had numerous falls, CP would be required to bring the resident to the hospital. CP found the PIC to be condescending and patronising when they raised a concern. The resident would be prescribed a lot of medication by the [redacted], when they would visit the [redacted], [redacted] would advise that the resident did not need to be on all the medication prescribed. CP played the middle person between both doctors and found the whole experience mentally draining while their relative lived in this centre. The centre had a high turnover of staff, new staff did not know how to manage the resident. Since moving to a new home, the resident is more content, on less medication and staff appear to be more able to manage the resident sillness with Alzheimer's and do not rely on CP to assist. |
| URI-0018182 | 16/08/19 | Severe staff shortages. CP unable to receive a response from Provider regarding their concerns. Resident fell and hit their head during the night. |

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| URI-0018181 | 15/08/19 | CP believes they are being chastised by the PIC for raising concerns. CP has expressed concerns regarding lack of staff, residents having to wait in a queue to be brought to the bathroom. CP as observed Residents shout for assistance and being ignored. Staff are not visible when assistance is required. During a family meeting with the PIC, [redacted] The meeting was supposed to be about the Residents Dementia. When CP requested the minutes of the meeting, they were informed that they are private and could not have them. CP has witnessed many issues of concern but does not want to cause any further confrontation as they feel nervous. On their last unannounced visit, a resident was lying on the floor in a [redacted]. No staff were present to assist. CP could not find their relative, there appeared to be only one nurse working. |
| URI-0018180 | 15/08/19 | Resident has had two falls in a 6 week period. The resident was completely mobile before entering the nursing home; they are only there [redacted] months. Family were informed the resident fell from their bed banging their head off the radiator. However the radiator is on the opposite side of the bedroom. Residents face was badly bruised. The resident broke their hip after the [redacted] fall while walking along the corridor. CP is convinced the resident did not fall the way staff described. Measures such as a low low bed and an alarm mat have been placed in resident's bedroom since the first fall. |
| URI-0018177 | 15/08/19 | Concerns regarding a resident with dementia locking themselves into their room. GP appointed to NH had not seen residents in over 2 weeks. |
| URI-0018173 | 15/08/19 | CP has concerns in relation to their relative and the poor standard of medical care received. CP also has concerns relating to the high turnover of staff in the nursing home. |

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| URI-0018187 | 15/08/19 | CP is simply appalled by the provider sending out a questionnaire to residents and families and finds the questions being asked most intrusive. [redacted]. The questionnaire can be filled out by the resident if applicable. The questionnaire asks if staff members have been up to standard and asks questions about their attitude. Family were asked to name the staff if not satisfied. The questionnaire advises that the family can remain anonymous if they wish but the form must be returned to staff at the reception desk. CP asks how can this information be confidential if [redacted] are receiving it each month and the form is to be returned to reception. |
| URI-0018169 | 14/08/19 | SU stayed in NH for respite after being discharged from hospital. SU and [redacted] other resident had to sit in a passage way against the wall in cramped conditions. SU's walking was removed which prohibited them from walking. SU was informed that they were required to walk each day by their doctor but was unable to do so in NH. SU and a relative witnessed another male resident being 'man handled' and found this very upsetting. SU felt that residents were afraid to speak in the dining area. SU left NH after [redacted] because of the poor conditions and standard of care. |
| URI-0018168 | 14/08/19 | CP's relative is in the NH [redacted] months and has fallen on [redacted] occasions. Relative fractured their should after one fall and when discharged from hospital DON refused 1 to 1 care for relative. Relative is now in hospital as was unresponsive when CP visited. Staff were not made aware that relative had a history of falling and care plan does not reflect this. Shortage of staff in the evening time - A member of the care staff was assisting another resident when CP's relative fell again. DON was dismissive and abrupt when CP raised their concerns. |

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| URI-0018165 | 14/08/19 | Resident's health and social care needs are not been met. Not a lot of activities for residents in NH and resident spends a lot of time on their own in their room. Cleaning standards in the centre are very poor particularly at the weekend, when staff have said that there are minimal housekeeping resources rostered. No member of the family had been informed that their relative had a difficulty swallowing or advised to take care regarding what fluids they gave to them. When relative brought their concerns to the PIC [redacted] they received little or no response or even interaction. |
| URI-0018161 | 13/08/19 | Family have lost confidence in the nursing home as a result of the deterioration in their relative's condition following [redacted] admission there. Family do not want relative to return to NH when discharged from hospital. |
| URI-0018160 | 13/08/19 | Concern relates to nursing staff not listening to concerns from family members regarding their relative's health. Relative severely dehydrated and no action taken. Poor medical care. |

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| URI-0018159 | 13/08/19 | CP's relative is currently in [redacted] hospital and was informed that they were [redacted]. CP has concerns regarding the dramatic amount of weight lost by relative in a short period of time and the reluctance of NH to send relative to the hospital prior to last week when the CP suggested Staff at NH informed CP that the resident would not eat however they would eat everything CP would bring up to them when visiting. CP had ask staff at NH to ensure that their relative had enough fluids but [redacted] was severely dehydrated when admitted to hospital. Consultant at the hospital was concerned about why this resident was not sent to hospital sooner as their health was extremely poor. CP was contacted by the [redacted] manager of NH in relation to their relative returning to the NH however CP's relative does not wish to go back to the NH and the CP supports this decision. CP felt that the manager was harsh and abrupt during their telephone conversation. |
| URI-0018158 | 13/08/19 | [redacted], CP was at home when a knock came to their door. The resident has absconded from the nursing home and had walked over an hour on dangerous main roads to reach the [redacted]. The resident suffers with Dementia but was in a calm state when they arrived looking for their [redacted]. They appeared to be uninjured but their shoes were destroyed. CP contacted the nursing home who when informed that the resident was in their family home answered by saying [redacted] They later said they knew the resident had absconded, this happened when they ran a fire drill. The resident slipped out through the doors when they opened. |

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| URI-0018163 | 13/08/19 | CP witnessed an assault against their relative by another resident in the home [redacted]. CP was present in the room, when the incident occurred. The [redacted] resident inappropriately touched CP's relative, placing [redacted] hand between the resident's legs and tried to place [redacted] hands under the resident's top. [redacted] was unable to continue due to an obstruction caused by a machine [redacted]. When CP approached to ask what they were doing, the other resident backed away. This all happened [redacted], while the two staff on duty left to get lunch for the residents. When they returned the nurse shouted to the resident "you know you are not to do that", the other care assistant came in and said "not again". CP has now found out that this is not the first time this resident has done this. This resident is on 24hour watch. [redacted] CP made a formal complaint to the Provider but has still received no response. The provider keeps informing CP that he is fully compliant with the Supervision of this resident, even thou CP is aware that two other residents have also been assaulted. CP is not happy and is concerned this incident could happen again. The Provider is not addressing CP's concerns. |
| URI-0018152 | 12/08/19 | CP has concerns relating to their relative who has dementia and absconded from NH. Resident got a lift by a [redacted] to their home which is [redacted] from NH. [redacted]. When relatives contacted NH to inform them that relative arrived home they were asked to bring the relative back and their concern was not taken seriously. Inexperienced staff on duty at weekends and on Bank holidays. PIC currently on holidays and no one in charge. |

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| URI-0018151 | 12/08/19 | CP's relative is in a room which smells of urine, bed clothes are filthy dirty and the resident's room is very run down. Lack of dignity and respect for resident. When CP visited relative, no staff member came to check on relative while they were there. |
| URI-0018150 | 12/08/19 | CP has concerns relating to staff shortages and also regarding an inexperienced carer who had no knowledge of resident's needs and requirements. |
| URI-0018155 | 12/08/19 | Lack of management and governance. Resident absconding from NH. Visitors and staff accessing one ward via another is creating stress for residents. Issues with staff relations. |
| URI-0018145 | 09/08/19 | Concern relates to critical staff shortages which is impacting on the care of the residents. |
| URI-0018144 | 09/08/19 | CP has concerns regarding relative's care. Relative fell and broke their hip in NH. CP believes that relative is a high fall risk and should have 1 to 1 care however management of NH have stated this is not necessary and will not provide this care. [redacted]. |
| URI-0018138 | 08/08/19 | [redacted] Staffing levels were inadequate, there appeared to be nobody in charge. There was no PIC, receptionist or anybody in head office. Men were working on the front door and allowed anybody in. There appeared to be little or no activities on over the weekend. The [redacted] has their [redacted] stay with them for the whole day [redacted] with [redacted] residents. |
| URI-0018134 | 08/08/19 | CP had the following concerns. Described staff as unqualified. Food was poor and cold. Medications were not monitored. Family not informed of serious pressure sores on relative. Relative did not have an air mattress. Relative had a temperature for 1 week before NH transferred them to NH. Resided died from a chest infection. |
| URI-0018148 | 08/08/19 | Family concerns over the lack of care afforded to resident and have recorded numerous incidents in relation to same. |

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| URI-0018131 | 08/08/19 | CP has concerns relating to relative being fed and also if they will be 'thrown out' of nursing home. |
| URI-0018129 | 06/08/19 | Resident was slapped in face by a carer. |
| URI-0018116 | 01/08/19 | CP arrived a little later than usual. The resident was not in the reception were they usually wait. No staff were to be found in the reception area. CP went down to the residents room to find the resident being assisted to their bed by a [redacted] resident. The alarm mattress was lying over the chair and the resident had no hip protectors. The relative was a little agitated, the resident assisting was holding their hand. CP has raised several issues of concern to management but nothing improves. The quality of the food is horrendous and often served cold as it comes from the other centre. CP has observed scrambled eggs, potatoes and gravy being served cold to resident. The resident is suffering with a bad case of cellulitis, their leg is starting to blister, staff say they use cream but medical intervention is required. Staff have complained to CP that they are under staffed and become frustrated with he lack of support. On several occasions CP has helped and assisted residents in the reception area but has stopped doing this now because management are not recruiting enough staff. |
| URI-0018112 | 31/07/19 | Resident behavior has become more aggressive, family have requested for a Mental Heath assessment to be done. Family have to push for the doctor to attend. Staff in centre are not liaising with local hospitals Mental Health service, were patient previously attended. Residents strict diet is not being followed by staff. Concern regarding treatment of diabetic toe - bad odour |
| URI-0018111 | 31/07/19 | Concerns regarding building being a fire risk due to no receptionist or staff member stationed at the front door which is locked at all times. Medicine trolley left open for 15 minutes in a room with Residents walking around suffering with Dementia. Poor standards of personal care given to resident. |

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| URI-0018109 | 30/07/19 | Since this provider has taken over the NH the standard of care and safeguarding has declined dramatically. PIC divides her time [redacted] The communal dining room has been closed and the current common room is being used as a kitchen, sitting room, church, visitor's room and dining room with no ventilation and only three high windows which can be opened. The Berka in the common room can be accessed by residents and this is a health and safety risk to the residents. There is no access to the outside area unless residents are brought out. Residents are sitting in their wheelchairs all day owing to a shortage of chairs for them to sit in. Staff turnover is very high since new provider took over and there is a severe staff shortage at night. Lack of supervision in the evening time of residents who have dementia and these residents are going into other resident's rooms and causing them distress. A resident went missing from the NH [redacted] weeks ago and was noticed by an ex employee [redacted] other residents went missing from the home on previous occasions. Residents are not being assisted at mealtimes and meals are being removed from resident's untouched. When the lift breaks down the residents have to be lifted up to the next floor in their wheelchairs by staff. There is an inadequate number of toilet facilities and the commode is most common facility used. There is a lack of general maintenance and upkeep of the NH and required repairs are not being carried out, relatives are informed that this is part of the long term plans. [redacted] |

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| URI-0018108 | 30/07/19 | SU fell on bathroom floor of nursing home owing to lack of care, SU required medical attention and stitches after the fall. SU lost consciousness owing to neglect and was transferred to [redacted] hospital where they were [redacted] days in a [redacted]. SU was sent back to the NH against their will after being discharged from hospital. |
| URI-0018105 | 30/07/19 | CP feels that relative has been incorrectly placed in a [redacted] unit in the NH. NH is dark and dreary in appearance and there is no stimulation for resident other than the TV. Resident has been in the nursing home fo[redacted] weeks without a review. Resident is receiving a tranquilizer to keep them calm. |
| URI-0018102 | 29/07/19 | Letter of praise received highlighting quality of care delivered to late resident while residing in nursing home. |
| URI-0018100 | 29/07/19 | Poor standard of care and safeguarding. SU fell and incurred a serious head injury. SU left the nursing home and got a taxi home with another relative who has dementia. Poor communication between management of nursing home and SU's family. |
| URI-0018097 | 26/07/19 | Concerns regarding photos of residents appearing on Facebook posts. |
| URI-0018095 | 26/07/19 | Relative attacked in nursing home and received severe injuries which required medical attention and hospitalization. Relative who has dementia was sent to hospital unaccompanied. Nursing home failed to protect and safeguard resident. Family not notified on incidents of abuse. |
| URI-0018094 | 26/07/19 | Concern relates to photos of residents appearing on a Facebook post. Lack of respect & dignity. |
| URI-0018093 | 26/07/19 | Concerns relating to photos of residents appearing on Facebook posts. Lack of dignity and respect. |
| URI-0018092 | 26/07/19 | Concerns relating to Face book posts regarding residents. Lack of respect and dignity. |

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| URI-0018090 | 25/07/19 | Resident's [redacted] section is being deliberately damaged by another resident and the is causing considerable upset to resident. Resident closes CP's window at night time. |
| URI-0018089 | 25/07/19 | Staff shortages, nursing and cleaning. Rotas do not reflect staff on duty. Quality of care to residents. Nurses threated that they will be reported to ABA if they raise concerns- no induction for nurses recruited from abroad. [redacted] |
| URI-0018088 | 24/07/19 | CP received a call from the nursing home requesting CP to put in writing that it was ok for the resident's pension to be transferred to the nursing homes bank account. This instruction came after a recent HIQA inspection. CP thought this is the way it was all along but has now found out that the resident's money was in their own account. The family received no statements and never sought power of attorney. CP asked for statements and noticed that the residents account had minus signs to the total amount. CP knows that the resident had a few thousand in their account. CP is concerned now and worried that the nursing home is in trouble. |

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| URI-0018096 | 24/07/19 | Resident has advanced Dementia. The home is charging an additional fee for additional activities which the resident does not partake in. The resident is non verbal and stays in their bed most of the time. On the odd occasion staff may get the resident up, but usually always have an excuse as to why the resident is in bed. The resident has also developed pressure , family have been informed that the resident must pay for the air mattress. The centre has had a recent change of ownership with a high turnover of managers and staff in the past year. |
| URI-0018091 | 24/07/19 | Resident receives the Fair Deal towards their accommodation. The agreement was that the resident pays € [redacted] per week towards their care. The resident is being over charged an extra € [redacted] than what was agreed per week. Family spoke management in the nursing home and they gave a breakdown of fees. The resident does not have enough to pay for prescription, tables chiropody or other items that may be needed. The Nursing home is charging more than the fee that was agreed with the Fair deal . |
| URI-0018082 | 23/07/19 | CP's relative and another resident went missing from NH. |
| URI-0018083 | 23/07/19 | Staff do not receive appropriate training on how to clean a resident properly. Resident is not assisted with personal hygiene on a daily basis. The proper toiletries are not used to clean residents after they soil themselves.Instead, staff will use a towel that the resident uses on their face and hands and place it back on the stand. Residents are left in soiled pads and are not changed for hours. CP has witnessed their friend suffer with infections because of this poor practice. The quality of food is of a poor standard and there appears to be a lack of staff working in the centre. Staff on duty appear to be burned out and cannot attend to the residents when needed. PAR sent- Same returned: No evidence to substantiate issues raised. |

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| URI-0018081 | 23/07/19 | CP's relative who is now deceased had advanced dementia and [redacted]. Staff went on holidays and the replacement staff were not aware of their relatives care requirements. Relative became unwell and there was a [redacted] delay in contacting the GP. GP prescribed antibiotics for a chest infection which didn't arrive until late evening. CP visited the resident the following day and found no improvement in relative's condition so requested that a doctor be called. A D doc arrived and after a full examination informed the CP that their relative was [redacted]. CP feels that owing to staff shortages and lack of care their relative was in pain during [redacted]. |
| URI-0018078 | 22/07/19 | Concerns regarding staffing levels and high turnover of staff. Management of Residents pressure sores. |
| URI-0018074 | 22/07/19 | Lack of respect shown by staff nurse when CP asked for assistance for the resident. |
| URI-0018072 | 19/07/19 | Fire safety hazard. |
| URI-0018071 | 19/07/19 | High staff turnover. Staff shortages. Issues relating to hygiene and upkeep of the NH. |
| URI-0018069 | 18/07/19 | Service User's daily routine from home not met. Care plan not followed by NH in relation to a number of issues. Missing bed linen. Resident unsupervised and unassisted at mealtimes. Unexplained bruising on resident's hand. |
| URI-0018068 | 18/07/19 | Concern relating to the care and protection of other vulnerable persons. |
| URI-0018067 | 18/07/19 | Concern relating to the untimely and forceful discharge of CP's relative who was at end of life. |
| URI-0018066 | 18/07/19 | SU transferred to hospital by ambulance as unwell. Emergency services noticed bruising on SU's arm. Xray showed that SU had a break in their upper arm. NH cannot give CP or relatives an explanation as to how this injury occurred. |

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| URI-0018065 | 17/07/19 | SU wearing two incontinence pads at the same time owing to staff shortages. CP has the height of praise for nurses and care staff and understands that owing to severe staff shortages care staff are under a lot of pressure. Day room is not big enough to accommodate the number of residents. |
| URI-0018063 | 16/07/19 | CP has requested statement of fees and additional charges from NH but after numerous requests has not received same. |
| URI-0018059 | 15/07/19 | CP's relative is staying on the [redacted] floor of NH and owing to [redacted] physicality requires a larger wheelchair. NH had a recent fire inspection which deemed that the [redacted] floor would not be a safe place for SU as in the event of a fire and being unable to use the lift, care staff would be unable to move resident down to the ground floor. NH has asked CP to find an alternative NH for SU and family are having difficulties finding one. |
| URI-0018058 | 15/07/19 | CP has concern regarding SU rapid weight loss. NH states that SU is eating and drinking however is losing a lot of weight. SU who had a stroke receives no physiotherapy and there is no interaction or activities for the SU. SU is not assisted at mealtimes. Personal items belonging to SU are going missing. |
| URI-0018055 | 15/07/19 | Concern relates to a carer treating a service user with a lack of respect and dignity. |
| URI-0018054 | 12/07/19 | Concerns regarding an unregistered nurse employed by the NH. High staff turnover and staff shortages. Care of residents has deteriorated in recent months. |
| URI-0018052 | 12/07/19 | CP and family recently took their relative out of nursing home owing to the poor standard of care that they were receiving. Severe staff shortages - [redacted] Very poor standards of hygiene. Owner of NH speak to staff in a derogatory manner. lack of respect and dignity. |

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| URI-0018051 | 11/07/19 | CP noticed a group of youths loitering at the hospital entrance. CP tried to contact the hospital at 22.00hrs to inform them of this and no one answered the phone. |
| URI-0018049 | 10/07/19 | CP has issues relating to staff and residents smoking at the main entrance of the NH. |
| URI-0018048 | 10/07/19 | CP has concerns regarding the transport and treatment of residents to alternative nursing homes due to the closure of this service. |
| URI-0018047 | 10/07/19 | Service User suffered a wrist fracture and displaced bone. Care staff are unable to explain to CP how SU received the injury. |
| URI-0018043 | 09/07/19 | CP's relative was sent from [redacted] hospital to [redacted] for respite after a medical procedure [redacted] weeks ago. SU has had [redacted] infections in the last [redacted] weeks. SU asked for a GP to be called over a [redacted] day period as was in a lot of pain. GP diagnosed the SU with an acute infection. When CP visited relative and enquired about their health the PIC was abrupt and would not engage with CP. Relative has lost a lot of weight as is no eating or drinking fluids. |
| URI-0018042 | 09/07/19 | Nursing Home are not following guidelines in relation to infection control. Poor standard of care. CP relative had a an infection which was untreated for [redacted] months. |
| URI-0018038 | 08/07/19 | Poor standard of personal hygiene. No silicone gloves available in resident's bathroom. Call bells not being answered by staff for long periods of time. CP has not received a satisfactory resolution to issues raised with provider. |
| URI-0018029 | 05/07/19 | CP has concerns regarding the decreasing standards of care for residents. Resident room had a malodour and unclean. Owing to the poor standards of care previously received by resident the CP did not feel confident in leaving relative in the care of the NH and cancelled the scheduled respite. Lack of professionalism from DON. |
| URI-0018024 | 04/07/19 | CP has concerns relating to their relative falling frequently and requiring hospital visits after these falls. |

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| URI-0018023 | 04/07/19 | CP has issues relating to Manager of NH refusing to allow them visit their relative. CP states that relative has expressed a desire to see CP however the manager of NH is preventing this. [redacted] CP was informed via telephone by Manager at NH on [redacted] that they were now permitted to visit relative. |
| URI-0018020 | 03/07/19 | Excellent care and kindness received by CP during their stay in NH. |
| URI-0018017 | 02/07/19 | CP raised concerns to nursing staff about how their relative was placed into their wheel chair and not strapped in. Staff at nursing home refuse to allow CP and relative into the sitting room or conservatory area and CP states that the day room can become congested and noisy which causes their relative stress. Management of the nursing home are refusing to allow CP to visit their relative since [redacted] raised the most recent concern. |
| URI-0018016 | 02/07/19 | CP telephoned regarding issues relating to the removal of their late relative from nursing home. Late relative remains were in the nursing home [redacted] hrs after death owing to poor management by the nursing home. When [redacted] rrived to the nursing home management refused to release the remains and CP was asked to send the [redacted] away. Financial abuse by CP's [redacted] and the nursing home. |
| URI-0018014 | 02/07/19 | CP has sourced another NH closer to the service user's relatives and [redacted] has stated a move would be detrimental however CP and relatives disagree with this statement. Service user was administered medication incorrectly. Service user was allowed to keep medication in their own locker. No stimulation or activities for resident. |
| URI-0018012 | 01/07/19 | CP has concerns in relation to accessing relative's care plan. |

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| URI-0018008 | 28/06/19 | Poor quality of care and neglect. Resident had an ulcer which was left untreated by staff in NH. |
| URI-0018006 | 27/06/19 | Residents bed clothes and mattress soiled. Poor communication between nursing staff and CP. There are regular issues regarding the care of resident. |
| URI-0018005 | 26/06/19 | CP contacted concerns re an employee who was working for a period of time in NH to gain work experience. Employee alleges that a resident made sexual advances towards them and when they reported this to the head nurse [redacted] the incident was managed inappropriately. [redacted] |
| URI-0018001 | 25/06/19 | CP has concerns relating to [redacted]r relative not being able to receive respite care in the NH and this is causing stress for CP's [redacted]. NH states that they are closed for admissions and it is up to the Authority as to when they can open. |
| URI-0018000 | 25/06/19 | CP has concerns relating to relative who died in the nursing home on [redacted] and remains in the nursing home room today. |
| URI-0017999 | 25/06/19 | Issues relating to correct emergency fire evacuation procedures. No outdoor area for residents. No parking facilities for visitors. Concerns relating to the welfare of residents. |

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| URI-0017996 | 24/06/19 | CP has noticed a decline in resident appearance and personal hygiene in the last [redacted] months since new management have taken over. There appears to be a significant drop in staff, residents clothes are not ironed and their hair does not appear to be clean. Staff appear to un notice these issues. |
| URI-0017991 | 21/06/19 | CP's relative had a bad fall and broke [redacted]. CP was not informed of the fall until the following day when an ambulance was being called. CP states that the care during the day is excellent however [redacted] feels there is a staff shortage at night. |
| URI-0017990 | 21/06/19 | CP concerned of the declining well-being of relative. Relative left sitting in a chair for long periods of time. CP requested for relative to receive cold showers as they believe them to be beneficial however staff at nursing home refused to do this. Resident is given two biscuits at night against the wishes of the CP. Laxatives are being administered to the resident and CP believes it is the level of inactivity that is leading to issues for the resident which requires this type of medication. Resident is forced to wear incontinence pads constantly and CP believes that this is unrequired. |
| URI-0017988 | 20/06/19 | Resident moved from NH owing to poor standard of care. CP witnessed other residents being mistreated. CP not informed of incidents occurring to relative. Unexplained bruising. Poor communication between managers at NH and CP. |
| URI-0017980 | 20/06/19 | CP has concerns relating to relative's weight loss and the lack of contact from NH regarding same. Relative eating very little and being given ensure drinks. CP has witnessed resident being ignored by care staff on a number of occasions. [redacted]. Communication has broken down between management at NH and the CP. |

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| URI-0017975 | 19/06/19 | CP has issues relating to relative being relocated to a different wing of NH owing to building works being carried out. This wing is overcrowded with very restricted conditions. |
| URI-0017972 | 19/06/19 | Concern regarding how personal data is being handled in this centre. |
| URI-0017969 | 18/06/19 | Concerns relating to resident's oral hygiene and fitting of incontinence pad. Bruising under resident's arm. |
| URI-0017965 | 17/06/19 | Resident dehydrated when discharged and now in hospital. Batteries for hearing aid were not replaced by staff in NH. |
| URI-0017964 | 17/06/19 | Relative discharged from [redacted] to nursing home. The fax machine in NH was not working and the hospital could not send prescription. Resident was without important medication for the evening which caused distress to the resident. Staff shortages. |
| URI-0017962 | 17/06/19 | CP works with a resident who has a [redacted] injury. Resident would like to assign the nursing home as an Agent to collect their disability allowance however nursing home is reluctant as they state that the authority frown upon this. |
| URI-0017961 | 17/06/19 | Inconsistent recording of resident's behavior by a member of staff. |
| URI-0017956 | 14/06/19 | Lack of supervision of residents owing to staff shortages. |
| URI-0017954 | 14/06/19 | CP has a concern relating to an incident which took place involving their relative. CP is unhappy with the report they received from the NH. |
| URI-0017953 | 13/06/19 | Concern relating to a staff member working in the nursing home who has a criminal conviction. |
| URI-0017946 | 12/06/19 | Resident was in the centre for three years and was a falls risk. Resident suffered a serious fall while unsupervised in the communal sitting room and sustained serious injuries. Resident transferred to hospital and is presently receiving palliative care following the fall and sustaining a brain bleed with bruising on the face. |

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| URI-0017945 | 12/06/19 | Resident did not receive adequate care. Staff did not allow the resident to have a rest in the afternoon as they felt it would disrupt the resident's night's sleep. Resident was in the activity room all day and it impacted on the resident's wellbeing. There were inadequate records of intake of food, liquid or output. The bell was not answered in a timely manner. Resident suffered from a UTI infection and was transferred to hospital and died a few days later. |
| URI-0017943 | 12/06/19 | Resident has early stage dementia. There is a history of considerable health issues. The resident displays challenging behaviour towards the family and this causes stress. Resident insists on leaving the centre and going down town. [redacted]. The resident wears pads and is continuously wet. |
| URI-0017942 | 12/06/19 | CP sent in a complimentary letter relating to the care provided to the resident. |
| URI-0017940 | 12/06/19 | CP believes there is lack of competency in providing care. The resident has difficulty swallowing and there is no assistance provided at meal times. Resident's property is lost and no action has been taken. CP is not satisfied with the GP's review and believes there are falsities when information is provided. |
| URI-0017931 | 10/06/19 | Anonymous letter contains list of residents who have died and whose names appear on the website RIP.ie. |
| URI-0017930 | 10/06/19 | There is lack of infection control. |
| URI-0017924 | 07/06/19 | Resident fell from chair in communal sitting room. Staff refute CP allegations that there was no supervision; there is no CCTV to support CP's allegations. |

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| URI-0017923 | 07/06/19 | Resident fell from chair in communal room. GP reviewed resident and advised on rest. The following day family received a call advising them the resident was presenting with severe pain and was reviewed by the GP. Staff advised the resident had to go to the local A&E and was taken in a [redacted]. The diagnosis was a fractured hip requiring surgery. Family was advised the resident should have been transferred by ambulance as there was a fracture. |
| URI-0017921 | 07/06/19 | Resident has diabetes and the staff and PIC are verbally abusive towards the resident. The PIC is verbally aggressive towards the resident and searches the room looking for any sweets that may be present. There is lack of humanity, dignity or respect shown by the PIC or staff. |
| URI-0017920 | 06/06/19 | Resident is dead and was a [redacted]. There was a transfer from a local hospital to another centre and then to the current centre. There was lack of GP review and appropriate medication. There were no follow up appointments made for the resident to be reviewed. There was a connection between the GP and the coroner and no investigation was carried out relating to the lack of care and medication or review prior to the resident's death. During the period in the centre, no dignity or respect was afforded the resident. CP has now incurred a bill for € [redacted] as the Fair Deal could not be processed as [redacted]. This is the same person who applied for the [redacted] |

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| URI-0017918 | 06/06/19 | Resident had an acquired brain injury and became ill and died [redacted]. The resident was given considerable sedation and care was not provided in a timely manner. The resident appeared to be in great pain but no pain relief was given. After the resident died, the GP was putting Dementia as cause of death; however, CP objected and a subsequent autopsy was undertaken. The cause of death was recorded as [redacted]. Prior to the resident's death no palliative care was provided and the resident suffered pain prior to death. |
| URI-0017917 | 06/06/19 | Resident had a spot on the heat and although the GP reviewed the resident and prescribed cream the condition was not improving. After seven weeks of no action or further review by the GP, CP engaged with the GP and asked for the spot to be investigated. Eventually the resident was reviewed in the local hospital and a diagnosis of cancer was given. The medical staff in the hospital informed CP that the resident's health was neglected. |
| URI-0017916 | 06/06/19 | Resident is suffering from depression as there is no interaction between staff and residents. The food is not appetising or nutritious. There are no activities and the resident's clothes are missing. The staff take the clothes to the laundry and do not return them. |
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| Reference | Date of Receipt | Concern Detail |
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| 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] Has no recollection of a sexual assault by a care staff on any resident. Recounted a case around that time which had been notified to HIQA regarding a resident who put [redacted] hand on the knee of a [redacted] resident. Resident (alleged abuser) was discharged to [redacted]. Gardaí were informed but no action was taken. We are not sure if this is the same incident but we know that the initial name given by the CI in this UROI is the same as the resident at that time. Will close off and reopen if we get any additional information. Of note if the details are correct, [redacted] Will close off unless we get additional information. [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. |

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| URI-0017905 | 30/05/19 | Staff Shortages. Very little involvement from senior management. No Supervision in day room at weekends. Lack of activities for residents. No private family rooms/Chapel. |
| URI-0017899 | 30/05/19 | Poor hygiene conditions. [redacted] informed of an incident where a resident absconded from nursing home [redacted]. 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-0017895 | 30/05/19 | CP has concern with lack of hygiene and cleanliness in the nursing home. There is dried faeces on the bathroom rail and mildew behind relative's bed. CP is concerned that relative is at risk of infection. |
| URI-0017894 | 29/05/19 | CP has concerns in relation to how their relative is being fed. There have been frequent incidents of choking risks as resident is being fed incorrectly by some staff. |
| URI-0017900 | 29/05/19 | Concerns relating to resident's physical and psychological wellbeing. |
| URI-0017889 | 28/05/19 | Concerns relating to undesired changes in relative's care plan. Manager of NH insisting that frequency of showers be reduced. Bullying behaviour experienced by CP from manager. |
| URI-0017888 | 28/05/19 | Unprofessional conduct by healthcare assistant. |
| URI-0017886 | 28/05/19 | Concern relates to abusive language towards staff. Residents and staff being mistreated. |
| URI-0017884 | 28/05/19 | Minimum care received by residents. Severe staff shortages resulting in residents being left unsupervised and falling. Lack of empathy and compassion for residents. Residents receiving no stimulation. CP feels intimidated by DON and unable to voice concerns. |
| 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. |

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| URI-0017874 | 23/05/19 | Resident is [redacted] Resident asked for a female 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 a [redacted]. There was an outbreak of scabies 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 [redacted] floor. |
| URI-0017871 | 22/05/19 | CP relative was in the centre for five years. Resident had dementia and COPD. 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 pneumonia and died shortly afterward. 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. The resident passed away [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-0017868 | 22/05/19 | There was lack of professional communication regarding end of life and on-going health of the resident. |

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| URI-0017860 | 20/05/19 | The resident suffers from COPD and has the use of a wheelchair. No assistance or mobile oxygen cylinders were provided when the resident attended regular outpatient's appointments resulting in the resident travelling alone by train. A taxi service refused to take the resident to appointments without support from a care assistant. Extra payments for [redacted] were withheld without a satisfactory explanation. The resident involved the Gardaí in the issue and there were subsequently contentious engagements between the resident and the PIC. Staff did not engage or support the resident on instruction from the PIC. A commode and oxygen cylinders were removed from the resident's room and were not replaced until the medical staff at the local hospital insisted on their return. Resident was not advised on the results of a [redacted] test and there was no communication from the GP assigned to the nursing home. [redacted] The [redacted] believed the resident was unwell and alerted the local ambulance service. The resident was admitted to the local hospital for five days. The resident has to argue to get any rights and has sat in the yard for several hours. There was also a period spent in the chapel to avail of peace during the day. The care staff do not respect the resident and spend considerable time and make a lot of noise while assisting three other residents in the room denying the resident peace and quiet. |
| 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 mothers care Communication breakdown between CP and management of nursing home. |
| URI-0017850 | 16/05/19 | Concern relating to fire & safety. [redacted] |
| URI-0017849 | 16/05/19 | Concern relating to Fire & Safety. Disregard & contempt displayed by staff towards residents. |
| URI-0017847 | 15/05/19 | Lack of care, support and empathy. |

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| 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. |
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