Lydia Buckley

From: [redacted]
Sent: Monday 21 October 2019 17:02
To: FOI
Subject: FOI - Unsolicited information

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 5 June 2019 and 21 October 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

[redacted]

CONFIDENTIALITY NOTICE

[redacted]

Sent via email

24 October 2019

Our Ref. FOIR 052 019

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 5 June 2019 and 21 October 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 21 October 2019. If you have any queries in relation to your request you can contact the FOI Officer by telephone on 021 4547722 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

☐ **Head Office:**
Unit 1301, City Gate, Mahon,
Cork, Ireland.
Tel: +353 (0) 21 240 9300
Fax: +353 (0) 21 240 9600

☐ Dublin Regional Office:
George's Court, George's Lane,
Dublin 7, Ireland
Tel: +353 (0) 1 814 7400
Fax: +353 (0) 1 814 7499

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

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 this 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,

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Lydia Buckley
FOI Officer

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

[redacted]

15 November 2019

Our Ref: FOIR 052 2019

Re: FOI request, part granting request 052 2019

Dear [redacted],

I refer to your request dated 21 October 2019 made under the Freedom of Information Act 2014, which was received on 21 October 2019 for records held by the Health Information and Quality Authority. Your request sought:

> *"All information in Hiqa's possession in relation to unsolicited information received by Hiqa between the dates of 5 June 2019 and 21 October 2019 in relation to older people, disability services and children's services"*

I, Ann Delany, Regional Manager, have now made a final decision to part grant your request on 15 November 2019.

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. an explanation of the relevant findings concerning the records to which access is denied, and
3. a statement of how you can appeal this decision should you wish to do so.

☐ **Head Office:**
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This letter addresses each of these three parts in turn.

1. Schedule of records

A schedule is enclosed with this letter, it shows the documents that the Authority considers relevant to your request. It describes each document and refers to the sections of the FOI Act which apply to prevent release. The schedule also refers you to sections of the detailed explanation given under heading 2 below, which explains the consideration given to these sections of the FOI Act. It also gives you a summary and overview of the decision as a whole.

2. Findings, particulars and reasons for decisions to deny access

The FOI Act contains a number of sections which can apply to deny access to certain information, these sections are known as exemptions. The following exemptions are relevant to your request.

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.

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 all records identified in the schedule, each contains matters where access to the records would involve disclosure of personal 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 information so as to part grant records identified and provide you with a copy of non-exempt information.

Head Office:
Unit 1301, City Gate, Mahon,
Cork, Ireland.
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Fax: +353 (0) 21 240 9600

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Fax: +353 (0) 1 814 7499

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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 information which constitute personal information. This information has been redacted from the records in order not to disclose the personal information.

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.

There are no discernible or particular public interest grounds leaning in favour of a release of the information in question. However, there is a strong public interest in preserving the right of privacy, particularly given the sensitivity of the information concerned. Accordingly, the decision maker has redacted the information which constitutes personal information from the records in question.

Head Office:
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Section 42 (M) – Restriction 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.

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 where information is provided for the purpose of the administration of law. The information contained in the relevant records was received in confidence and could reveal the source of the information; therefore, such information is excluded from the scope of the FOI Act.

3. Rights of appeal

If you are unhappy with this decision you may appeal it. 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, Dublin Regional Office, George's Court, George's Lane, Smithfield, Dublin 7,

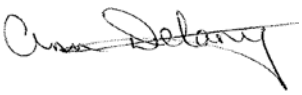
D07 E98Y or by e-mail to foi@hiqa.ie. Payment should be made by way of electronic transfer. Please contact the FOI Office for further details.

You should make your appeal within 4 weeks, from the date of this notification, where a day is defined as a working day excluding, the weekend and public holidays. However, the making of a late appeal may be permitted in appropriate circumstances. The appeal will involve a complete reconsideration of the matter by a more senior member of the staff of the Authority.

4. Publication

All non-personal FOI requests will be recorded on an FOI disclosure log which will be published on the Authority's website in due course.

Yours sincerely,



Ann Delany
Regional Manager

Head Office:
Unit 1301, City Gate, Mahon,
Cork, Ireland.
Tel: +353 (0) 21 240 9300
Fax: +353 (0) 21 240 9600

Dublin Regional Office:
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HIQA - Freedom of Information
Schedule of Records: Summary of Decision Making

FOI Request Reference FOIR 052 019

FOI Received 21 October 2019

Decision Maker Ann Delany

Decision due no later than 18 11 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
1	Unsolicited information received by Hiqa between the dates of 5 June 2019 and 21 October 2019 in relation to Designated Centres for Older Persons	FOIR 052 019_DCOP	36	N	Part Grant	Section 35 and Section 37	Information received in confidence and personal information	See decision letter	Redaction of personal identifiable information
[redacted]									
[redacted]									

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

FOI Request Reference FOIR 052 019

FOI Received 21 October 2019

Decision Maker Ann Delany

Decision due no later than 18 11 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

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. [redacted] due to a high turnover of staff, staff are not familiar with the resident's habit of removing their [redacted] around the nursing home. [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. [redacted] Poor medication management [redacted] qualifications of staff neglect- no shower for [redacted] days Poor records- no record of fluid intake Resident lost [redacted] pound in [redacted] days as resident No access to fluids/ jugs of H2O Bad/ foul smell on ground floor when come out of lift lack of act for residents with [redacted]

URI-0018410	15/10/19	Resident has sustained [redacted] falls during the past [redacted] years, all have been [redacted] 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. [redacted] When the manager was asked what had happened, the sustained injury did not match with how the incident occurred. [redacted] All stories received how the incident occurred have changed and are inconsistent. [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 [redacted] injury. Family were not informed how it happened. [redacted] 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.

URI-0018399	11/10/19	CP contacted the data commissioner regarding a concern they had which they considered a data breach. [redacted] CPs [redacted] bank statement was opened by a staff member, they examined all transactions. The staff member sent an email to the [redacted] 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

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. [redacted] CP wants to leave but does not know how to or how to terminate their contract. [redacted]
URI-0018382	09/10/19	CPs [redacted] was pushed by another resident in the corridor and [redacted]. CPs relative has a [redacted] on their [redacted] this assault was witnessed buy a staff member. The other resident has a history of [redacted] to other residents. CP attended a meeting with management who assured CP that they would watch the resident more. CP is concerned this [redacted] 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.

URI-0018359	03/10/19	[redacted] CP's [redacted] was taken to hospital with [redacted] injuries acquired when there was a [redacted] in their bedroom, stayed in [redacted] hospital for [redacted] month and is now in a different NH There was no care plan in place while SU was in this NH, [redacted]
URI-0018356	03/10/19	SU fell and when examined by doctor at NH they were informed that nothing was wrong. [redacted] 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 [redacted] 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	[redacted] CP had numerous concerns in relation to relative's care. Service user was totally dehydrated and [redacted] 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 [redacted] becoming distressed when incontinence wear is changed by a male nurses aid.

URI-0018347	30/09/19	CP has concerns in relation to [redacted] highly dependent residents being moved to their relatives floor. [redacted] 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. [redacted] 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 [redacted] 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 [redacted]. Another resident who has dementia is [redacted]. This resident was moved however they sit with CP's [redacted] at mealtimes and also need to pass through their area when going to the smoking area. [redacted] CP feels that their relative is not being safeguarded.

URI-0018341	30/09/19	Nursing home severely understaffed since new owners have taken over. Increase in Residents falling. CP's relative has unexplained [redacted] was assaulted by another resident. [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. [redacted]
URI-0018336	27/09/19	[redacted] sustained a fall and was taken to the local hospital [redacted], they unfortunately passed away [redacted] days later. [redacted]
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	[redacted] CP has made several requests for copies of the [redacted] 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 [redacted] requests via the [redacted] 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.

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] pm
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 [redacted] 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 [redacted]. SU [redacted] days after fall. SU had a previous injury on [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.

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. [redacted]
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 [redacted] 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.

URI-0018266	06/09/19	CP's relative is in hospital suffering with [redacted] in the NH. Relative was complaining to CP with a [redacted] and NH staff would not seek medical attention. Relative was left in [redacted] Very poor standards of hygiene. Food portions are too small and not adequate. SU is currently in hospital [redacted]
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 [redacted]. Poor standard of care.
URI-0018252	04/09/19	SU has blisters in their [redacted] months and not receiving appropriate treatment for same.
URI-0018250	03/09/19	Relative hospitalized suffering from [redacted]. CP has concerns relating to the health and safety of other residents. Service user often [redacted] 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.

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 [redacted] tablet which they should not have received as they have a [redacted] fitted and irregular [redacted]. 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. [redacted]
URI-0018223	26/08/19	SU ([redacted]) fell out of bed in [redacted] and received [redacted], SU attended A&E. CP believes that this fall contributed [redacted]

URI-0018221	26/08/19	Concern regarding a resident who was administered a prescribed [redacted] 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 [redacted] 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 [redacted] on [redacted] separate occasions. When the [redacted] incident occurred the CP requested an incident report on five occasions and did not receive same until after the [redacted] incident. After the [redacted] the SU had a visible [redacted] however staff could not explain how did this occurred.

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 [redacted] however they are not receiving this and relative is complaining with a lot of [redacted] 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.

URI-0018191	16/08/19	Resident fell in the [redacted] around [redacted]. On the day of the fall it was very hot. [redacted]. 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. [redacted] 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] 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 [redacted]
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	[redacted] SU had [redacted] bruising on their [redacted] and [redacted] the SU required [redacted] on the back of their [redacted]. SU was complaining with pain and soreness in [redacted] at the beginning of [redacted] weeks ago relative was informed that this was due to a [redacted] Lack of care and dignity. SU becomes dehydrated as is not assisted with fluid intake.

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] would advise that the resident did not need to be on all the medication prescribed. [redacted] 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 [redacted] 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 [redacted] during the night.

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 [redacted] meeting with the PIC, CP had to leave the meeting as the PIC belittled CP and implied that CP was the only person present who had an issue with the quality of care the resident received. [redacted] 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 [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 [redacted] falls in a [redacted] week period. The resident was completely mobile before entering the nursing home; they are only there [redacted] months. Family were informed the resident fell [redacted]. Residents face was badly bruised. The resident [redacted] after the [redacted] fall while [redacted]. CP is convinced the resident did not fall the way staff described. [redacted]
URI-0018177	15/08/19	Concerns regarding a resident with [redacted] locking themselves into their room. GP appointed to NH had not seen residents in over [redacted] 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.

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 only 6 families are receiving it each month and the form is to be returned to reception.
URI-0018169	14/08/19	SU stayed in NH for [redacted] after being [redacted]. SU and [redacted] other resident had to sit in a passage way against the wall in cramped conditions. SU's [redacted] was removed which prohibited them from [redacted]. 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. [redacted]
URI-0018168	14/08/19	CP's relative is in the NH [redacted] months and has fallen on [redacted] occasions. Relative [redacted] after [redacted] fall and when discharged from hospital DON refused [redacted] for relative. Relative is now in hospital as was [redacted] 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.

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 [redacted] or advised to take care regarding what [redacted] they gave to them. When relative brought their concerns to the PIC yesterday 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 [redacted] and no action taken. Poor medical care.

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 [redacted] to ensure that their relative had enough [redacted] but [redacted] was severely [redacted] 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. [redacted]
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 [redacted] to reach the family home. The resident suffers with [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 "really?". 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.

URI-0018163	13/08/19	CP witnessed an [redacted] against their relative by another resident in the home [redacted]. [redacted]
URI-0018152	12/08/19	CP has concerns relating to their relative who has [redacted] 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.

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 [redacted] in NH. CP believes that relative is a high fall risk and should have [redacted] 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] Coordinator has their [redacted] child stay with them for the whole day [redacted] with [redacted] residents.
URI-0018134	08/08/19	[redacted] Described staff as unqualified. Food was poor and cold. Medications were not monitored. Family not informed of serious [redacted] on relative. Relative did not have an [redacted] mattress. Relative had a temperature for 1 week before NH transferred them to NH. Resided [redacted] 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.

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 [redacted] protectors. The relative was a little [redacted], 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. [redacted]. 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 [redacted], family have requested for a [redacted] assessment to be done. Family have to push for the doctor to attend. Staff in centre are not liaising with local hospitals [redacted] service, were patient previously attended. Residents strict diet is not being followed by staff. Concern regarding treatment of [redacted] 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.

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 between two centres. 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]

URI-0018108	30/07/19	SU fell on [redacted] floor of nursing home owing to lack of care, SU required medical attention and [redacted] after the fall. SU [redacted] 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 for [redacted] weeks without a review. Resident is receiving a [redacted]r 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 [redacted] home with another relative who has [redacted]. 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 [redacted] 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.

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. [redacted]. CP is concerned now and worried that the nursing home is in trouble.

URI-0018096	24/07/19	Resident has advanced [redacted]. The home is charging an additional fee for additional activities which the resident does not partake in. The resident is [redacted] and stays in their [redacted] most of the time. [redacted]. The resident has also developed [redacted], 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 €150 per week towards their care. The resident is being over charged an extra €80 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, [redacted] 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.[redacted]

URI-0018081	23/07/19	CP's relative [redacted] had advanced [redacted] 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 [redacted] 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 [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 [redacted] 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 [redacted]
URI-0018066	18/07/19	SU transferred to hospital by ambulance as unwell. Emergency services noticed bruising on SU's [redacted]. Xray showed that SU had a break in their [redacted]. NH cannot give CP or relatives an explanation as to how this injury occurred.

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] requires a larger wheelchair. NH had a recent fire inspection which deemed that the [redacted] floor would not be a safe place [redacted] 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 [redacted].
URI-0018058	15/07/19	CP has concern regarding SU rapid weight loss. NH states that SU is eating and drinking however is [redacted]. SU who had a [redacted] receives no [redacted] 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.

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 [redacted] 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 three 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 [redacted].
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 [redacted] and requiring hospital visits after these falls.

URI-0018023	04/07/19	CP has issues relating to Manager of NH refusing to allow them visit their relative. [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 [redacted] 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. [redacted] abuse by [redacted] the nursing home.
URI-0018014	02/07/19	[redacted] 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.

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	[redacted]
URI-0018001	25/06/19	CP has concerns relating to [redacted] 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.

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.

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 [redacted] years and was a falls risk. Resident suffered a serious fall while unsupervised in the communal [redacted] room and sustained serious injuries. Resident transferred to hospital [redacted]

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 [redacted] infection and was transferred to hospital and died a few days later.
URI-0017943	12/06/19	[redacted]
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 [redacted] 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 [redacted] in [redacted] room. Staff refute CP allegations that there was no supervision; there is no CCTV to support CP's allegations.

URI-0017923	07/06/19	Resident fell from [redacted] in [redacted] 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 [redacted] 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 [redacted] that may be present. There is lack of humanity, dignity or respect shown by the PIC or staff.
URI-0017920	06/06/19	[redacted] 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. [redacted]

URI-0017918	06/06/19	Resident had an [redacted] 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] cancer. 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 [redacted] 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 [redacted] 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.