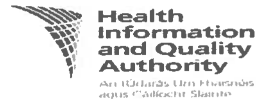


HIQA - Freedom of Information
Schedule of Records: Summary of Decision Making

FOI Request Reference FOIR 008 020

FOI Received 17 February 2020

Decision Maker Ann Delany

Decision due no later than 12 March 2020

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	all complaints that Hiqa received in relation to disability services last year	FOIR 08 020_-redacted	32	N	Part Grant	Section 35, Section 37 29(1) and Section 42 (m)	Information received in confidence, personal information, and deliberations of an FOI body	see decision	Redaction of personal identifiable information, information given in confidence, and information currently under deliberation by the authority

(1)

Reference	Date Of Receipt	Concern Detail
URI-0018703	30/12/19	
URI-0018696	19/12/19	CP has concerns about resident's weight loss, financial management of resident's funds. CP concerned about poor communication with provider.
URI-0018688	18/12/19	Concern regarding inadequate transport facilities being used. Some of the vehicles being used are not appropriate for wheelchair users or residents who may exhibit difficulties with behaviour.
URI-0018680	17/12/19	CP has concerns regarding safeguarding measures put in place that are impacting on resident's wellbeing.
URI-0018672	16/12/19	Concern regarding the change in staffing arrangements, medication management and care received following a fall.
URI-0018671	16/12/19	CP is concerned about restrictive practise being put in place. The resident's access to their iPad has been restricted if any behavioural incident occurs. Resident liked to watch DVD's at night time when going to bed; this has been taken out of bedroom. Resident has been put on new medication to supress his behaviour; CP said that there are no outbursts now because of medication not because of restrictive practise; CP feels that the resident is being unfairly punished.
URI-0018670	16/12/19	The concern relates to safeguarding concerns from a family member and the overall care of the SU.
URI-0018667	13/12/19	
URI-0018651	11/12/19	Correspondence identified concerns regarding: - Unexplained bruising. - Personal item being stolen. - High turnover of staff. - Waking night staff found sleeping on duty.
URI-0018644	09/12/19	

URI-0018636	09/12/19	
URI-0018629	05/12/19	Concern from advocate regarding lack of discharge plan for SU and lack of consultation with SU in relation to moving residence.
URI-0018613	04/12/19	
URI-0018612	04/12/19	The meals provided for dinner are frozen and reheated. Families of residents not informed of this change from fresh meals to frozen. CP told that this decision was made by SALT and a Dietician was not involved in this. CP concerned that the social aspect for residents around watching meals been prepared has now been lost. CP concerned that this is a staff cutting measure. There has been no manager in this centre for the past few months.
URI-0018608	04/12/19	Provider not respecting families wishes regarding no consent relating to vaccinations being given to SU
URI-0018606	03/12/19	CP is concerned about abusive behaviour by one resident towards their relative
URI-0018594	29/11/19	CP is unhappy with the amount of paperwork that she Is required to sign and is being told it's a HIQA requirement. CP feels that this is a lot of duplication of work as resident attends two respite services.
URI-0018593	29/11/19	CP is unhappy with the amount of paperwork that she Is required to sign and is being told it's a HiQA requirement. CP feels that this is a lot of duplication of work as resident attends two respite services.
URI-0018589	28/11/19	.
URI-0018585	27/11/19	.
URI-0018580	26/11/19	The resident's complaint is not listened to or acted upon.
URI-0018575	25/11/19	
URI-0018572	25/11/19	Concern regarding service user's relocation from this Centre to be re-housed. Concern from relative regarding ability of SU to live without 24/7 care and possible consequences on health a move would have on this person.

URI-0018554	20/11/19	
URI-0018548	19/11/19	Resident resides in residential service during the week and goes home at weekends. Residents' behaviour when at home has changed, does not sleep and has become highly agitated at night. Resident had a seizure when returned to residential unit. Parents are elderly and extremely anxious re the welfare of this resident. Resident refused to go home one weekend and is expressing a preference to stay in service full time. Resident is resident in this service for years. CP said that there is a lack of clarity in the contract of care regarding residents' entitlement to stay in residential unit on Saturday nights. Provider says funding is the issue why resident cannot stay in Centre on Saturday nights.
URI-0018536	15/11/19	CP has reason to believe the higher dose of medication their relative is currently receiving is not beneficial and making no improvements for the resident. CP has requested that they would like the resident to be put back on a lower dose. From past history, the resident suffered significant side effects from another drug previously administered and CP is concerned this could happen again. The Resident does not have the capacity to say no to higher doses but CP feels they are not being heard.
URI-0018538	13/11/19	
URI-0018525	13/11/19	
URI-0018520	12/11/19	The following three phrases are being repeated by staff in a very demanding and to service user, probably threatening, tone of voice. "Is that clear?" - "Do I make myself clear?" - "Is that clear now?"
URI-0018506	11/11/19	

URI-0018495	07/11/19	CP has significant concerns about the quality of life of a resident
URI-0018493	06/11/19	
URI-0018492	06/11/19	Concern around employment details for support worker roles.
URI-0018448	23/10/19	
URI-0018431	22/10/19	
URI-0018429	21/10/19	CPs child has been attending respite five days a week with this services. CP has been battling with the HSE for full time residential services and TUSLA to have their child placed in full time care. CP takes the child every and as they cannot manage two consecutive nights together. . When the child is not attending respite they are very challenging. They self-harm have serious physical tantrums and cause injury to their other siblings. . This week CP received a call from the centre's manager advising that they must take the child home for the week as an emergency case has arrived and the child's bed is needed. CP advised that they could not take their child for the week. It is not safe for the child or their siblings. TUSLA has advised they cannot get involved as this matter relates to Disability services. CP is frantic with worry and has had a in the past due to not coping with their child and their challenging behaviour.
URI-0018422	21/10/19	Lack of supervision and encouragement by staff
URI-0018421	18/10/19	

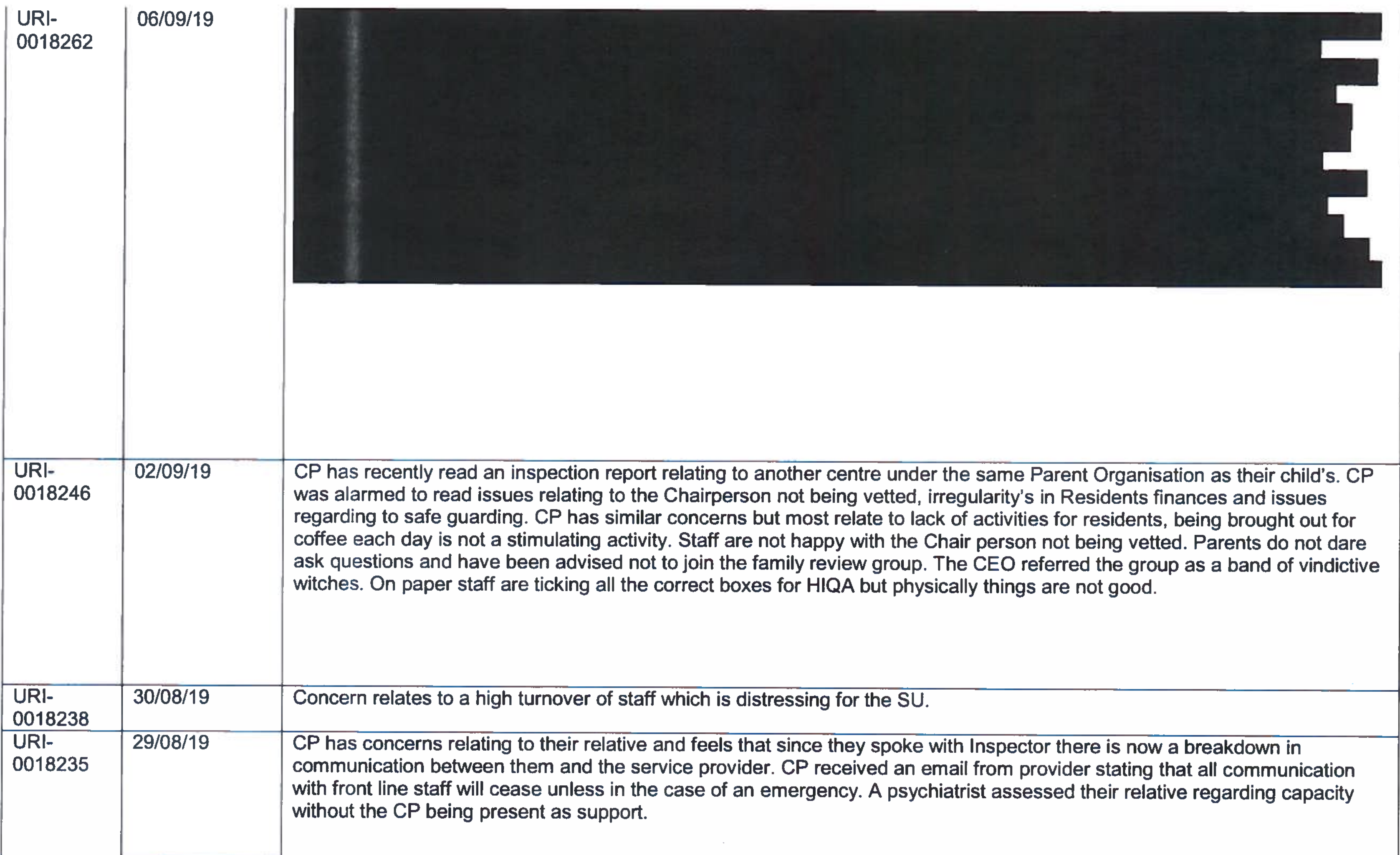
URI-0018417	17/10/19	[redacted]
URI-0018409	15/10/19	Family are distressed due to this centre not being in operation. The family member was informed by the HSE that HIQA were delaying the re-opening of this centre.
URI-0018403	14/10/19	CP is concerned to hear that there is no nurse on duty, this unit was always nurse led in the past.
URI-0018402	11/10/19	[redacted]

URI-0018401	11/10/19	Resident feels that staff do not give any independence to them and does not allow them live an independent life. CP likes to collect their own prescription and has the medication written in their Kardex. However some staff go to the Residents GP and pick up the residents prescription. CP has told staff not to do this. CP also raised concerns regarding agency staff coming into the centre and does not feel comfortable anymore. CP was involved in an incident with a staff member who pushed CP against a [redacted] and signalled the finger to CP because they said something that annoyed the staff member. CP did apologise for what they had said but they were annoyed at the time. This incident was reported to management but CP has heard nothing back.
URI-0018398	11/10/19	[redacted]
URI-0018390	10/10/19	CP has raised their concerns to two parties in this centre over a month ago. They have received no reply. CP is not happy with the quality of care their child receives.
URI-0018376	08/10/19	[redacted]

URI-0018373	08/10/19	CP believes complaints are not being dwelt with at local level. The management are using their policies and procedures to say they cannot tell a resident what to do as they have a choice and decide for them self. CP has concerns regarding the resident's lack of mobility and would like staff to encourage the resident more but they do not encourage the resident.
URI-0018372	08/10/19	The CP had nothing but praise for the service, the service user has been residing there for the past twenty years. Service user is now at end of life care and serious decisions now need to be made by the family. A meeting is to take place next week regarding the service user's medication and dehydration needs, which may involve an IV being inserted due to [redacted] difficulties. The service have informed the family under HIQA legislation they may not be entitled to keep the service user in the centre in case they pull out the IV or other issues arose. The family wish for the service user to be surrounded by their family and friends in [redacted] own bed and not sent to a hospital setting. The service have not said they won't, but staff need to be supported and if allowed under HIQA legislation.
URI-0018368	07/10/19	CP has concerns as SU is being regularly kicked, assaulted and bullied by another service user.
URI-0018361	04/10/19	Concerns surrounding SU's upcoming trip to Tayto Park.
URI-0018348	30/09/19	When service user moved into this service they were entitled to 60hrs per week of care. According to CP this was reneged. The service user asked their key worker for personal assistance but was advised to ask their social worker. There was a complete lack of support. The service was born with Cerebral palsy and was diagnosed with [redacted]. They suffered a lot of pain and did not sleep. While visiting the service user one day, CP called an ambulance as the service user was ill. Service User ended up in ICU after being admitted with a ruptured [redacted]l and sepsis. Staff in this service did not notice how ill the service user had become and did not monitor their wellbeing.
URI-0018342	30/09/19	Owing to staff shortages CP's relatives agreed 1 to 1 weekly care has been severely reduced.
URI-0018335	27/09/19	CP has concerns regarding the following: Inadequate Housekeeping Inadequate Supplies in downstairs bathroom Inadequate knowledge of SU's day to day in the day service. Inadequate attention to SU's medical requirement. CP not informed when SU's medication was not administered to them.

URI-0018333	26/09/19	Neighbours of designated centre are unhappy with the noise and activities coming from the designated centre.
URI-0018326	25/09/19	
URI-0018306	19/09/19	CP is concerned that there are frequently no staff nurses on duty at night time in a unit where there are 8 service users residing.
URI-0018304	18/09/19	CP expressed concerns in relation to financial abuse, failing to report incidents and neglect.
URI-0018302	18/09/19	CP thanking Inspectors for investigating issues surrounding incontinence management in this designated centre.
URI-0018301	18/09/19	CP received service user's dietician report which states that they are clinically obese and has gained kg since being in the care of the service provider. Email sent simultaneously to a number of different agencies.
URI-0018298	17/09/19	Service User living long term in respite arrangements.
URI-0018297	17/09/19	Service Users living long term in respite arrangements.
URI-0018293	16/09/19	CP and family cannot get to speak with the service user and believes he is being told untruths by the provider which has caused him to no longer communicate to his family. The service users family have found out that a capacity assessment will be carried out next week but no family member is allowed attend. According to CP this is against the capacity Act and a family member should be present. The Service user was abused in the past, which this service has tried to cover up. CP has been informed that the service user is walking the Road alone at night because staff are failing to safeguard him. CP is concerned should he be abused again. The family have put their concerns in writing to the provider but have not had their last correspondence acknowledged. The Service User is very vulnerable and needs family support but family are being excluded and have no input to all decisions being made.

URI-0018291	16/09/19	Over the past year the service user's behaviour has become more challenging and has become extremely aggressive. The reason for these behaviours have been identified by behaviour therapist as being due to sensory overload due to noise in house.
URI-0018289	13/09/19	Move from old residential unit to new unit was unorganized. Resident's belongings were discarded. Staff told by management not to report incidents where a residents have attacked staff members. No transition plan put in place for the move. Staff shortages at night time.
URI-0018288	13/09/19	CP has concerns relating to financial abuse and safeguarding of relative. SU absconded. Provider refuses to engage with relatives regarding concerns.
URI-0018285	13/09/19	SU has a condition which manifests in behavioural issues. SU has damaged property in their room, dismantled their room and has had numerous outbursts. Services user is [redacted] their clothing, refusing to wear [redacted] clothing. CP has requested psychiatric assessments and behavioural assessments since last [redacted] however service user has only had one meeting with a psychiatrist at the end of [redacted], previous contact with psychiatrist was via conference calling only. CP has requested that service user be assessed by a private psychiatrist however provider states that this is not an option. Service user has been discharged from [redacted] psychiatric unit, service provider refuses to take SU back into their care.
URI-0018271	09/09/19	The needs of the SU are not adequately provided for. Residents are not engaged in any decision making or planning process in relation to the restructuring plan. Continuous peer on peer incidents occurring within the service.
URI-0018267	06/09/19	[redacted]
URI-0018265	06/09/19	CP has concerns in relation to errors on service user's medication chart.

URI-0018262	06/09/19	
URI-0018246	02/09/19	CP has recently read an inspection report relating to another centre under the same Parent Organisation as their child's. CP was alarmed to read issues relating to the Chairperson not being vetted, irregularity's in Residents finances and issues regarding to safe guarding. CP has similar concerns but most relate to lack of activities for residents, being brought out for coffee each day is not a stimulating activity. Staff are not happy with the Chair person not being vetted. Parents do not dare ask questions and have been advised not to join the family review group. The CEO referred the group as a band of vindictive witches. On paper staff are ticking all the correct boxes for HIQA but physically things are not good.
URI-0018238	30/08/19	Concern relates to a high turnover of staff which is distressing for the SU.
URI-0018235	29/08/19	CP has concerns relating to their relative and feels that since they spoke with Inspector there is now a breakdown in communication between them and the service provider. CP received an email from provider stating that all communication with front line staff will cease unless in the case of an emergency. A psychiatrist assessed their relative regarding capacity without the CP being present as support.

URI-0018234	29/08/19	
URI-0018226	28/08/19	SU was allowed to go around town unsupervised. by day service staff - Not employed
URI-0018225	27/08/19	CP has ongoing issues regarding lack of care of SU. SU has previously fallen and broken their and , CP was assured by management that better care would be given to resident after this incident. SU stayed with CP for a weekend and CP noticed that the skin under their area was extremely agitated and red and the SU was in pain. CP brought the SU to the ED in Hospital and the doctor on call diagnosed a infection and also commented that it would have taken a period of 4 to 5 days for this to become that agitated. CP has contacted management and voiced their concerns on numerous occasions and feels that their concerns are not been taken seriously as the care provided continues to remain poor.
URI-0018224	27/08/19	High Staff turnover and staff shortages. Service User has complex needs and challenging behaviour. No shower facilities for staff after or during shifts. Service Users have very few outings or interaction within the community due to staff shortages.
URI-0018284	23/08/19	CP believes that SU requires 1 to 1 care as owing to their behaviour there are safeguarding risks. SU has had a number of choking incidents where they have ingested and . SU has also absconded from centre. CP met with management earlier this year and there was a commitment made that 1 to 1 care would be provided at weekends and evening time however owing to staffing levels and lack of resources the provider is unable to provide this. CP is concerned for the safety of the SU.

URI-0018208	22/08/19	
URI-0018197	19/08/19	
URI-0018195	19/08/19	
URI-0018194	19/08/19	SU has witnessed forms of psychological, emotional and monetary abuse. SU's physical disabilities have substantially deteriorated within the last 2 months - due to care practices.
URI-0018190	16/08/19	CP has concerns regarding their Son's new living conditions.
URI-0018189	16/08/19	ent are aware of the crisis but nothing has been done since last HIQA inspection. Nobody wants to work in this centre.

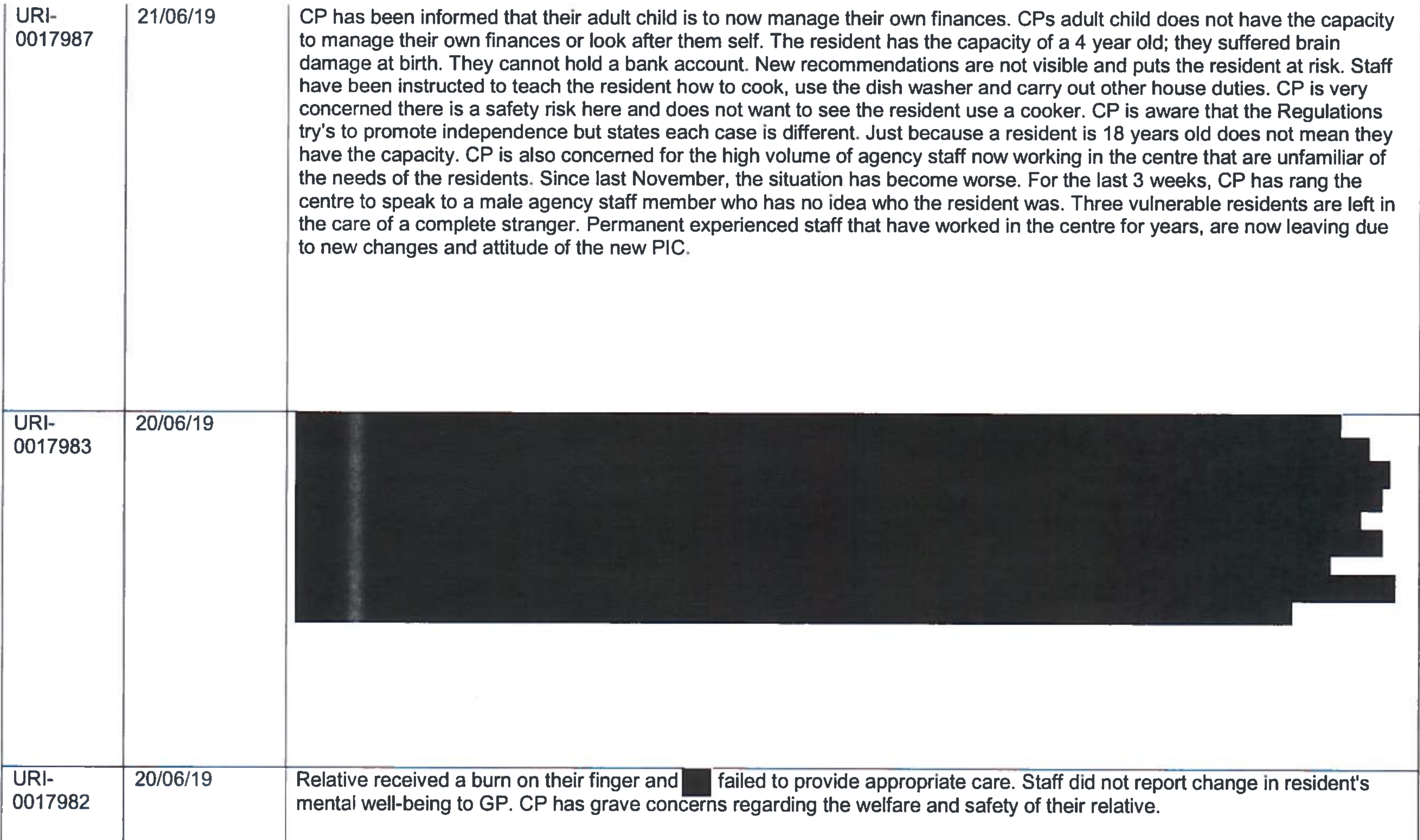
URI-0018185	16/08/19	Resident was moved into this independent living house without communication with NOK. Resident needs assistance with general tasks, CP believe this assistance is not being provided. During a recent visit to the resident's home, CP was not encouraged to come into the home by staff on duty. When they went to the Resident bedroom, the room was in an untidy state. There were no sheets on the bed and there was a pile of clothes on their bed. When CP went to remove the clothes, they were [redacted] and had not been dried. The Resident required help changing their bed sheets but staff placed wet clothes on the mattress expecting the residents to know what to do. The resident also informed CP that they found having a shower difficult as they had to step into the bath which they found difficult.
URI-0018170	14/08/19	Concerns relating to Provider requesting details of SU's debit card transactions.
URI-0018172	14/08/19	Parent of a resident who resides in this centre [redacted] They have some concerns about the services being provided to their relative. [redacted] This resident is also supported by an independent advocate. The lady said that she has attempted to raise concerns with the complaints officer in the centre but she has left message to no avail. [redacted]
URI-0018153	13/08/19	Various issues relating to staffing levels, quality of life, safeguarding, Residents increasing medical needs.
URI-0018154	12/08/19	CP has concerns regarding the following: Resident banging their head off walls and door frames for long periods of time. Residents forced to spend hours in the back of a car. Peer on Peer abuse. Staff positions unfilled.

URI-0018137	08/08/19	Resident was removed from centre by their guardian on [redacted].19. This was because they found the standards of care to be inadequate the resident appeared to be neglected. Their personal hygiene, clothes, nails and hair were dirty. After bringing the resident home, it took the CP over [redacted] weeks to get them out of their house, the resident was becoming institutionalized and feared going outside. The resident was left in the pyjama's sitting in their wheelchair in a hall all day, sometimes they were left unsupervised and staff would monitor by CCTV. The resident is prone to having seizures. The service has continued to take money from the HSE and residents account even thou the resident no longer lives there.
URI-0018133	08/08/19	CP has concerns regarding a new resident who recently moved into the centre. According to HIQA's recommendations, 4 residents is the recommendation, now there are 6. No consultation was had with families or staff before this move. The new resident has behaviours that are challenging and has been moved from another centre due to aggressive behaviour. Three of the current residents are nonverbal and some are wheel chair bound. They cannot voice their concerns. This new resident once attended mainstream school and is much more advanced than current residents. There is no space for this new resident. The office and consultation room are now converted into a bedroom. The new resident does not like noise or crowds which will impact on current residents when being brought out on trips. This new arrival is impacting on the quality of care current residents are receiving. How the whole move was handled by the provider was not proper consolation with anybody.
URI-0018136	07/08/19	Concerns regarding possible queried high staff turnover and overall governance and management. Concerns regarding the experience and expertise of staff to be recruited.
URI-0018142	07/08/19	[redacted]
URI-0018141	07/08/19	Concern relates to manager of service who has an authoritarian attitude. Residents are afraid to raise concerns. An informal complaint was made and there are issues regarding the response.
URI-0018140	07/08/19	CP has difficulties in gaining a response from Provider in relation to a concern.
URI-0018125	02/08/19	CP wishes to complain against the staff and residents living in this centre and noise coming from the centre which is next door to CP.

URI-0018120	02/08/19	
URI-0018123	30/07/19	CP making an FOI request from provider (HIQA CCd in on their request) relating to alleged sexual abuse of a resident in this centre
URI-0018107	30/07/19	
URI-0018103	29/07/19	Issues relating to Governance of centre and complaints process.
URI-0018098	26/07/19	
URI-0018085	23/07/19	Issues relating to maintenance and upkeep of the designated centre, creating a health and safety risk for the resident. Fire safety risk as bathroom and bedroom doors are not Fire doors. No guidelines in relation to resident's diet. No visual daily plan. Many visits to ED. Unexplained injuries.
URI-0018077	22/07/19	Centre is closing down. CP is concerned about the risk management procedures and where the resident may be moving to.
URI-0018075	22/07/19	
URI-0018057	15/07/19	
URI-0018044	09/07/19	
URI-0018045	09/07/19	

URI-0018031	05/07/19	CP has concerns relating to the care being received by their relative and lack of hygiene in the DC. Very poor standard of hygiene in the DC. Dead flies on windows sills. No sheets on resident's bed. SU is medicated at 7.30pm and asleep by 8.00pm. CP feels that this is not a suitable service for SU as they are not receiving the attention or treatment which they require.
URI-0018028	05/07/19	CP has a concern relating to one of the care workers in the house. Relative has been a resident for over years and CP is very happy with the overall service provided and other members of the care staff. CP has brought his concerns about this particular staff member to management but feels that his concern is not been taken seriously. CP states that the resident becomes anxious and upset as the care worker is aggressive.
URI-0018027	04/07/19	
URI-0018021	03/07/19	CEO has departed services and they have not appointed an interim CEO.
URI-0018026	03/07/19	
URI-0018018	02/07/19	CP has concerns regarding the noise levels coming from the DC. CP very irate about a resident in the DC roaring and shouting constantly. There is an unbearable malodour coming from the DC next door to the CP.
URI-0018025	02/07/19	
URI-0018015	02/07/19	

URI-0018004	26/06/19	The complaints lodged by two residents regarding multi-occupancy in 2018 have not been dealt with in a timely manner nor have they been resolved in a satisfactory manner for either residents. Both residents have been sharing one bedroom for roughly [redacted] years in the same service provider with no progress being made although previous commitments to extend the centre were given. The complaints by both residents were never formally acknowledged or responded to and the complaints have never formally been escalated.
URI-0018003	26/06/19	Resident has limited communication. Resident had unexplained bruising currently being investigated by the Gardaí, HSE and Adult Safeguarding Team. CP is not informed when the resident is injured. Resident to be moved to an adult centre in [redacted] which CP feels is too far away to regularly visit. The resident's relocation has not been discussed with the resident and CP is worried about their emotional well-being regarding the move.
URI-0018002	26/06/19	[redacted] CP has concerns in relation to financial abuse. CP's relative had a bank account and credit union account, large sums of money were withdrawn from bank account, some lodged to credit union account but there were large amounts unaccounted for.
URI-0017997	24/06/19	SU describes their life living in this centre as torture for the past number of years. The SU is very unhappy and cannot keep up with management's constant change. These changes are conflicting on SU's brain. Staff are aware that the SU is not happy but ignore this issue. SU has requested to move many times and has been placed on a transfer list then removed over and over again. SU [redacted] does not have much support. SU finds it difficult to manage their own finances and receives little support from staff. SU feels they have no rights, they are not consulted with new changes happening. They were previously assaulted by another resident in the past who has now moved but this took a long time to sort out. During the last HIQA inspection CP did not have the confidence to speak with the inspector.
URI-0017998	23/06/19	[redacted]

URI-0017987	21/06/19	CP has been informed that their adult child is to now manage their own finances. CPs adult child does not have the capacity to manage their own finances or look after them self. The resident has the capacity of a 4 year old; they suffered brain damage at birth. They cannot hold a bank account. New recommendations are not visible and puts the resident at risk. Staff have been instructed to teach the resident how to cook, use the dish washer and carry out other house duties. CP is very concerned there is a safety risk here and does not want to see the resident use a cooker. CP is aware that the Regulations try's to promote independence but states each case is different. Just because a resident is 18 years old does not mean they have the capacity. CP is also concerned for the high volume of agency staff now working in the centre that are unfamiliar of the needs of the residents. Since last November, the situation has become worse. For the last 3 weeks, CP has rang the centre to speak to a male agency staff member who has no idea who the resident was. Three vulnerable residents are left in the care of a complete stranger. Permanent experienced staff that have worked in the centre for years, are now leaving due to new changes and attitude of the new PIC.
URI-0017983	20/06/19	
URI-0017982	20/06/19	Relative received a burn on their finger and failed to provide appropriate care. Staff did not report change in resident's mental well-being to GP. CP has grave concerns regarding the welfare and safety of their relative.

URI-0017968	17/06/19	CP has concerns regarding financial abuse which they have reported to the Gardaí. CP in formed by GP that resident had a broken rib in April however CP was not informed of this by the centre. Poor communication from staff and an unwillingness to engage with CP and resident's family.
URI-0017960	17/06/19	Provider failing to put adequate measures in place to address the safety and well-being of residents and staff. No separate areas for children within the centre with all communal areas being shared between adults and children. Provider failing to address concerns of staff.
URI-0017955	14/06/19	
URI-0017944	12/06/19	Resident received respite care and became unwell. CP was advised there is no GP service provided for respite residents and recommended the resident to be brought to A&E. Initially there was a GP service for all residents; there is a change to this policy, however, the parents and/or family were not advised of this change.
URI-0017938	11/06/19	Staff are not trained to manage people with Autism. Property is not completed and does not resemble a home. Concerned that resident had to spend money on take aways when property was being maintained. (provider should have paid for this) Feels restrictions in place around access in the centre are not right. Feels resident does not have access to appropriate supports particularly psychologist. Feels Not notified when resident was brought to casualty in a timely manner.
URI-0017936	11/06/19	Resident with challenging behaviour causing disharmony and restrictions.
URI-0017935	11/06/19	Resident with challenging behaviour is disrupting the harmony within the house and upsetting other residents and staff.
URI-0017932	10/06/19	Residents are disturbed by another resident who drinks and this has occurred on three occasions. The residents are afraid of the resident when there is drink taken. Concern was reported to management but no action was taken.
URI-0017927	10/06/19	
URI-0017922	07/06/19	

URI-0017915	06/06/19	[redacted]
URI-0017948	05/06/19	CP has concerns relating to a resident who attended [redacted] dental practice. Care assistant who accompanied the resident to appointment had a lack of knowledge in relation to the resident.
URI-0017902	30/05/19	Resident informed CP of experiencing emotional and psychological abuse from care workers. Staff name calling the resident. CP is worried about resident's wellbeing.
URI-0017890	28/05/19	[redacted]
URI-0017879	24/05/19	Safeguarding and management of centre
URI-0017876	23/05/19	CP is aware of a recent unannounced inspection and wishes to review the relevant report to ascertain if the report reflects what CP has witnessed in the service. [redacted]
URI-0017867	22/05/19	There are issues on a continuous basis with residents escaping and causing mayhem in the local area. Residents witnessed the arrival of an ambulance that was alerted to an assault of a staff member by a resident. Local children are afraid to play outside due to the uncontrolled behaviours of the residents in the centre.
URI-0017864	22/05/19	[redacted]
URI-0017856	20/05/19	[redacted]
URI-0017839	13/05/19	Legal court document relating to Breaches of the Companies Act regarding the provider of the [redacted].
URI-0017830	09/05/19	Resident died [redacted] There were care issues prior to HIQA's regulatory remit (November 2013) and up to the resident's death in [redacted] The family requested a second opinion and choice of GP and this was declined. There were many issues and following on from complaints made, there were meetings and the outcome of the meetings were not satisfactory.

URI-0017825	08/05/19	
URI-0017820	07/05/19	Poor quality of care and staff shortages.
URI-0017819	07/05/19	
URI-0017810	02/05/19	Residents at risk of "not being able to live in a safe, secure environment, at risk of psychological/emotional and physical abuse from another resident in her own home" An unacceptable number of people living together in the house in total, and there were no day services outside of the house and very little in the line of activities provided for the residents. Agency Staff changing constantly.
URI-0017806	02/05/19	CP has concerns relating to his sibling and a previous safeguarding officer. CP believes that the previous safeguarding officer made sexual advances towards his sibling. Trend of communication failure between management and CP over the years. Breakdown in communication between the current PIC and CP.
URI-0017788	26/04/19	
URI-0017785	25/04/19	
URI-0017784	25/04/19	
URI-0017786	25/04/19	Staffing issues. Resident's needs not being met.
URI-0017778	24/04/19	
URI-0017770	17/04/19	CP is in the house neighbouring another house that accommodates another service user who has 'challenging behaviour' The other resident screams during the night and early morning and disturbs CP's sleep. There appears to be ongoing issues between the two residents. Although CP brought his concerns to the attention of the various key workers and PIC, no action has been taken.

URI-0017764	15/04/19	There are no activities in the centre. The last HIQA report mentioned day centres but the residents do not attend them. The CEO of the centre has resigned and there is an atmosphere of apathy among the staff CP met and engaged with.
URI-0017760	15/04/19	Resident was admitted to the centre [redacted] months ago. The parents were advised that a programme would be in place to progress the resident's lifestyle and behaviour. However, there is no programme in place and the resident's behaviour and appearance has deteriorated. The resident's [redacted] are in deplorable condition with the [redacted] curling around the [redacted] and the [redacted] are infected. Cream was prescribed by the GP for the resident's [redacted] but this has not been applied. There is no encouragement given to the resident and personal hygiene is ignored. The resident's diet is not conducive to a good healthy one and the resident is sometimes given [redacted]r ice-creams to eat in the one day with no regard to over-eating. The resident's parents have engaged with the staff to reach a resolution but this is not forthcoming.
URI-0017758	15/04/19	CP was informed of an incident that involved the resident and had to be reported. CP engaged with the PIC and was not happy with the outcome. CP believes the incident involved two residents. CP's child was having dinner at 8.30 pm. A glass of [redacted] was taken from the resident. The glass was brought into the kitchen and the [redacted] emptied and the glass was dropped on the floor. After the breakage, CP's child's feet were placed on the other resident's foot. Although CP has not seen the incident report, CP disagrees with the content and believes it will not reflect the factual events.
URI-0017756	12/04/19	Issues relate to the provision of respite care and the reduction in the days allocated.
URI-0017747	11/04/19	[redacted]
URI-0017744	10/04/19	[redacted]
URI-0017739	10/04/19	CP changed from the assigned GP for the service to a private GP. CP is capable of self-medicating using the kardex structure. The private GP will not complete the kardex for CP to enable CP to tick the kardex when self-medicating. CP was advised to speak with the key worker and social worker in an effort to resolve the issue.
URI-0017736	10/04/19	[redacted]

URI-0017729	09/04/19	
URI-0017728	09/04/19	Issues relating to resident's Positive Behavioural Support Plan
URI-0017727	09/04/19	
URI-0017722	05/04/19	
URI-0017718	05/04/19	CP's sibling was injured in a peer to peer incident that took place on the 19
URI-0017712	04/04/19	Resident suffered a fall and CP was not notified. There were different accounts on how the accident happened. The resident had surgery on the following the incident. Resident was provided with a prescription for pain relief but it was not filled.
URI-0017708	04/04/19	The capacity in the centre is outside HIQA's recommendation. There are residents; male and female. There is one resident aged and there is a safety issue around a child resident with adult male residents. There are no personal alarms for staff caring for residents with challenging behaviour.
URI-0017707	04/04/19	Centre has a policy that care assistant can accompany resident to the A&E of the local hospital but they are now allowed to accompany the resident in the A&E. The resident has a lot of health problems and has been admitted to the hospital on occasion. The resident was provided accommodation in a 2 bed room but did not know the other patient and this caused the resident stress as the patient is familiar with the care assistants in the residential centre.
URI-0017689	01/04/19	Resident developed and following treatment was accommodated next door to the original place of accommodation. The resident wishes to return to the original accommodation next door but staff are insisting on the resident staying in the current place as they consider the resident to be unwell and requiring 24/7 care.
URI-0017683	01/04/19	Service is not compliant with standards. There is no follow up regarding falls.

URI-0017682	01/04/19	Resident left the centre for over two hours unsupervised. Notification of incident was not issued to resident's sibling.
URI-0017681	29/03/19	Safeguarding concern. The service user made an enquiry to NAS about a sibling's interference in the Service User's financial affairs.
URI-0017679	29/03/19	Resident is [redacted] years old and displays challenging behaviour. There is 2:1 and sometimes 3:1 care provided due to the challenging behaviour. Currently the resident is accommodated downstairs; however, the provider has advised the resident will be moved upstairs and the rest of the house will be used for respite care. CP did not know respite care could be provided along with residential care and is fearful for the resident due to the challenging behaviour.
URI-0017667	27/03/19	Staff member inebriated while on duty.
URI-0017660	26/03/19	Issues relating to residents making hot drinks.
URI-0017638	19/03/19	Issues relate to care of resident who displays challenging behaviour. Staff not trained appropriately to care for the needs of the resident. [redacted]
URI-0017634	19/03/19	Resident has been in residency for over [redacted]. There are ongoing preparations to transfer the resident to alternative accommodation. The resident uses a [redacted] and has suffered falls. The resident's family have been advised as the incidents are falls it is not a safeguarding issue. Resident's family have received no information relating to the compatibility tests for the resident and there is no communication or clarity regarding the coordination of the transfer of residents.
URI-0017632	19/03/19	CP's adult child was refused respite care on the grounds that there was high dependency and that there was no nurse to provide the necessary care. The centre is not wheelchair accessible
URI-0017633	15/03/19	CP has concerns as witnessed their relative being physically restrained by two staff members. Relative has challenging behaviour but CP states that behaviour has become more problematic owing to stress. Concerns also relating to constant staff changes.
URI-0017627	13/03/19	Resident had treatment for a [redacted] and unfortunately, the [redacted]. The resident suffers falls and is at further risk from falls. CP is not notified when the resident falls. The consultant in the hospital recommended that every effort be made to ensure the resident did not suffer falls. There is no safeguarding measures in place for the resident.

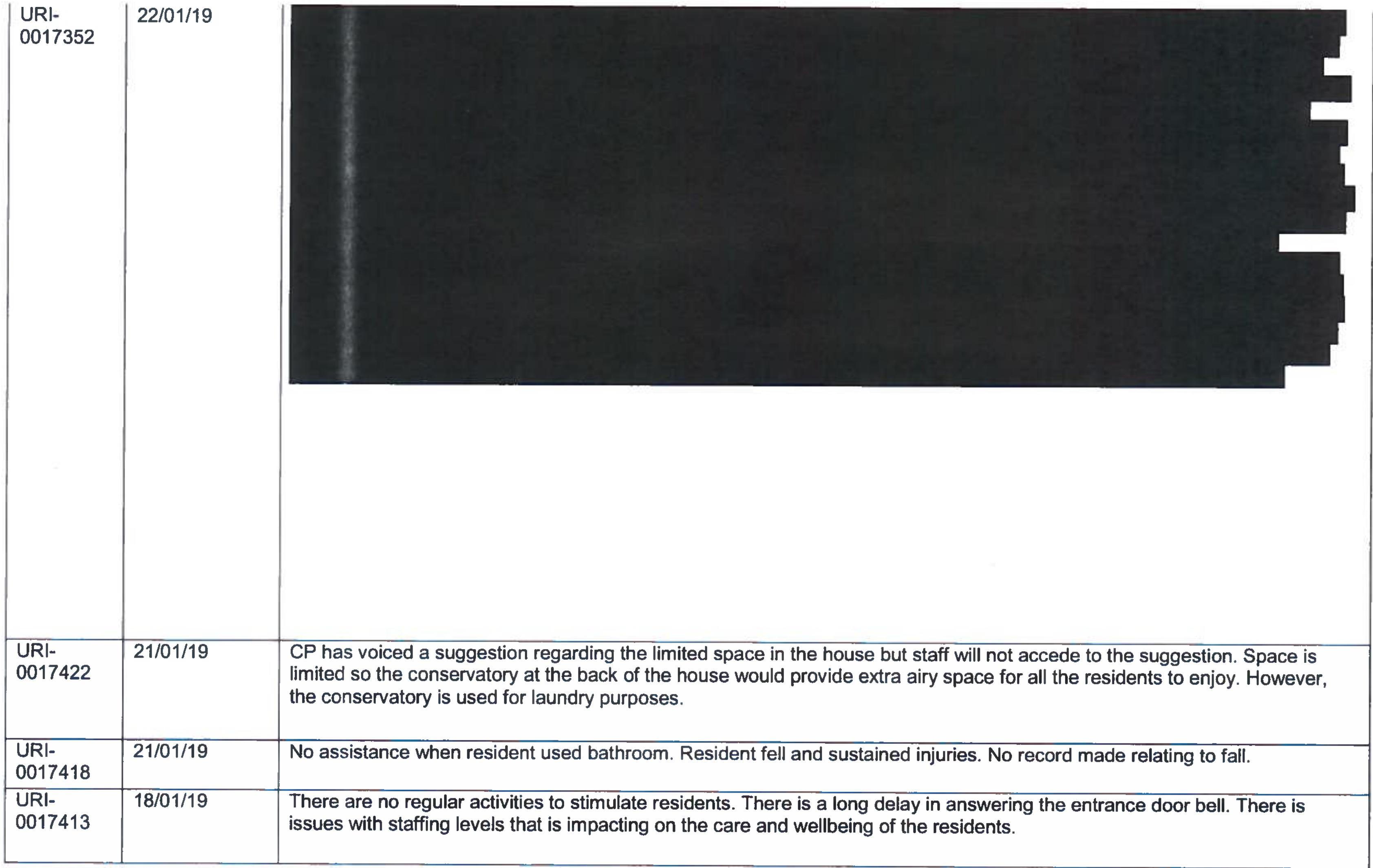
URI-0017616	11/03/19	
URI-0017609	07/03/19	Concerns relating to breeches of confidentiality and data protection.
URI-0017607	07/03/19	
URI-0017603	06/03/19	Resident was assaulted by a staff member on .2018. The resident received 1:1 care and is non-verbal. There was an internal investigation and the Garda were involved. The DPP decided there was no case to answer. The investigation and allied checks took six months to complete. CP has been advised the staff member is returning to work and will be assigned as the 1:1 care provided to the resident.
URI-0017602	06/03/19	CP's sibling is resident in the centre and has suffered physical and verbal abuse. CP brought these issues to the attention of the management and had a meeting to further discuss. However, the resident is still at risk. Management was dismissive of CP's concerns and fears.
URI-0017601	06/03/19	disclosed that following receipt of correspondence from the authority seeking confirmation that residents were registered with and availing of national screening programmes, that residents were being taken to appointments such as cervical checks without prior knowledge or informed consent. stated that concerns raised to the provider by staff in relation to residents rights were ignored, and that the priority is to ensure that they are complete for when records are checked by the authority. Concern is that residents are subject to invasive procedures without adequate knowledge, preparation or consent.
URI-0017600	05/03/19	Resident is at risk as there is no safeguarding measures in place. There is another resident with challenging behaviour who is liable to assault the resident. CP has engaged with the PIC and other staff members and has received no reassurances regarding the future safety of the resident.
URI-0017594	04/03/19	
URI-0017606	04/03/19	

URI-0017590	01/03/19	CP refers to an inspection report relating to findings of safeguarding. CP believes the findings may refer to the resident.
URI-0017589	01/03/19	Resident appeared to be unwell and no appointment was made for a GP review.
URI-0017586	28/02/19	CP refers to an inspection report relating to findings of safeguarding. CP believes the findings may refer to the resident.
URI-0017583	27/02/19	[redacted]
URI-0017579	27/02/19	Resident is nonverbal and has minimum mobility and has been in care since [redacted] years old. The service provided is excellent and very professional. There is no assistance for the resident to visit siblings who are old and unable to travel to visit the resident. There is an expectation that staff should accompany and assist the resident abroad to visit some of the siblings and also to travel for overnight stays to other parts of the country.
URI-0017568	25/02/19	Staff Shortage.
URI-0017559	21/02/19	CP is concerned with the severe reduction in care staff which will put their relative at risk.
URI-0017558	21/02/19	[redacted]
URI-0017557	21/02/19	[redacted]
URI-0017556	20/02/19	Provider has installed an entrance gate with a code panel. CP has not received the details of the code to ensure CP can enter the centre and this is causing anxiety about the wellbeing of the resident. The gate is large and constructed of [redacted] and is approximately [redacted] feet high. The resident is unable to look out and will not see any visitors as they arrive. Neighbours have asked CP if the resident might be dangerous when the gate was installed. CP believes the code to the gate should be provided.

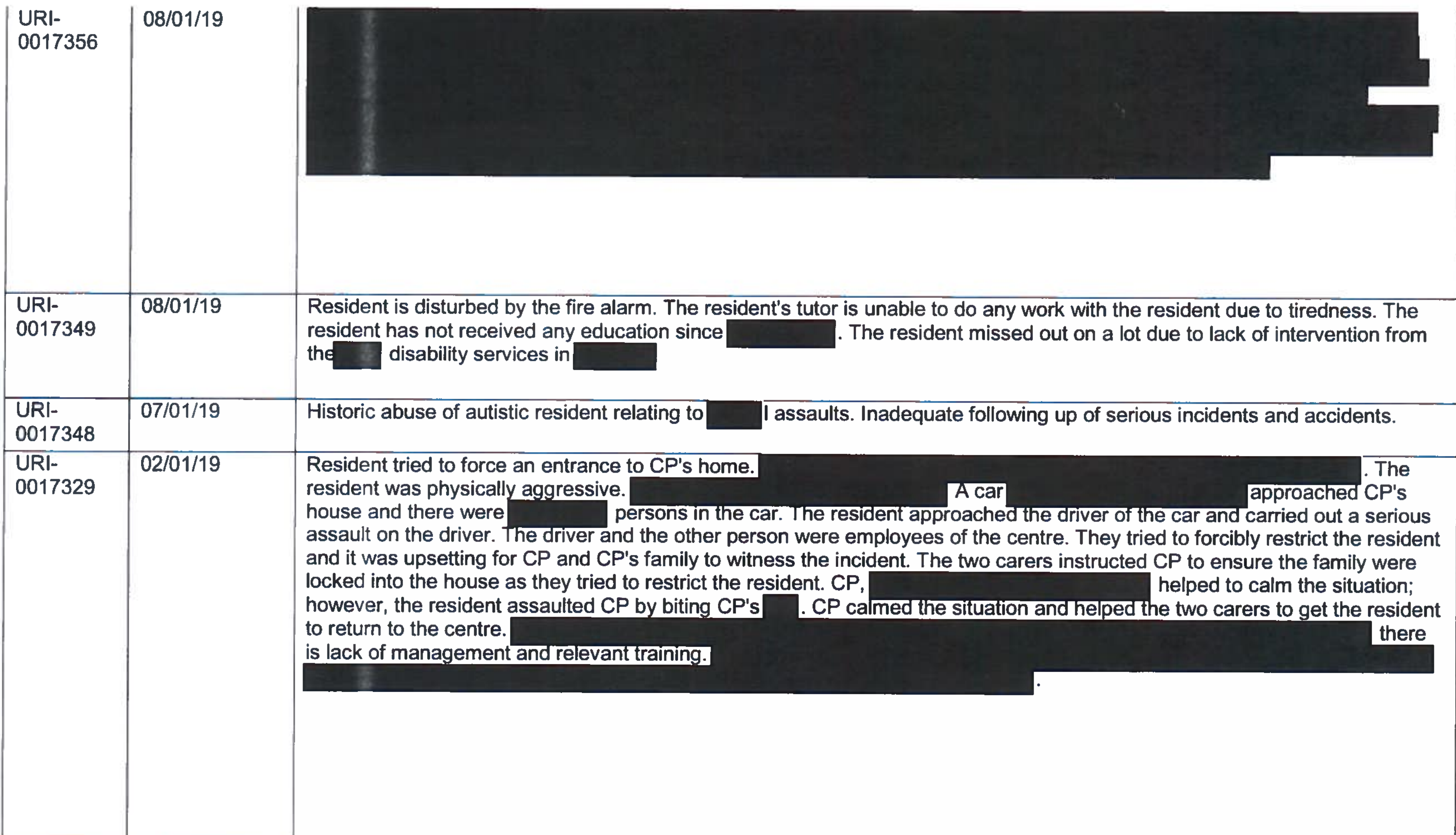
URI-0017544	18/02/19	CP was advised the resident is moving to an apartment and CP is anxious as CP believes the resident is not capable of independent living. There is a historical incident of a [redacted] attack that CP believes impacted on the resident's ongoing wellbeing. CP engaged with the resident's carer who confirmed the resident is capable of taking medication and other personal actions such as using an ATM. The carer advised CP the resident has lost weight and is aware of eating appropriately. The resident can attend to personal hygiene. The resident was previously threatened by staff regarding challenging behaviour.
URI-0017530	14/02/19	[redacted].
URI-0017528	13/02/19	There is lack of management and the PIC is covering other centres resulting in lack of continuity of care. One resident took [redacted] sausages from the fridge and was eating them.
URI-0017516	11/02/19	CP's relative shares the accommodation with three others and is in the centre for [redacted] years. Another resident entered the bedroom and was lying on top of CP's relative until staff removed this resident from the room. A few days while CP's relative was in the communal sitting room the other resident who was undressed and [redacted] in front of CP's relative. Agreement was reached that the resident with challenging behaviour would be moved to another centre. However, a transfer would take time to organise and in the meantime, there would be safeguarding arrangements put in place. A staff member would be provide 1:1 care and alarms would be installed to alert staff. Senior management stated there would be [redacted] unannounced visits by them to ensure these arrangements were adhered to by all concerned. There were some unexpected circumstances due to [redacted] and hospital visits and the arrangements to transfer the resident were left in abeyance. However after a time lapse, the transfer did not take place. CP was informed that the management allowed the resident remain in the centre. Staff advised CP the alarms were removed as the resident was behaving well. However, the challenging behaviour continues to frighten and sometimes CP's relative is hit by the resident. CP made a further formal complaint and was advised that the best solution was to transfer CP's relative to another centre. CP is not happy with this suggestion as CP's relative has been resident for over [redacted] years and gets on well with the other residents.
URI-0017507	08/02/19	[redacted]

URI-0017503	08/02/19	, safeguarding issues and variances on data and minutes of meetings
URI-0017498	08/02/19	Resident has limited communication. Resident had unexplained bruising, and, while the issue was investigated, the result was inconclusive. Staff fail in their duty of care towards the resident and CP noted a staff member lying on a bed watching TV while the resident was . There is lack of appropriate information provided during staff changeover. There is lack of proper communication between the centre and CP regarding the ongoing care of the resident.
URI-0017497	07/02/19	Resident is suffering verbal abuse from a staff member and is feeling upset as it is ongoing with threats that the resident will be forced to leave the centre.
URI-0017491	06/02/19	g each respite period and this is inconvenient as the parent works and is not always in a position to answer the phone.
URI-0017486	05/02/19	Death of resident, loss of keys and verbal abuse.

URI-0017480	05/02/19	[redacted]
URI-0017472	01/02/19	Allegation of historical sexual abuse.
URI-0017466	31/01/19	There are issues of safeguarding for the resident.
URI-0017464	31/01/19	Staff member was drinking while on duty.
URI-0017450	29/01/19	Restrictive practices in place for young person living in apartment.
URI-0017445	28/01/19	[redacted]
URI-0017427	22/01/19	Resident is aged in the 50/s and has a care plan that includes various activities to promote the resident's wellbeing. The care plan is not adhered to and the resident was taken to meet Santa regardless of age and the outing was in place of swimming. Staff are not receptive to CP engaging with the resident and when appointments are made, staff ensure the resident is taken out to avoid meeting CP.

URI-0017352	22/01/19	
URI-0017422	21/01/19	CP has voiced a suggestion regarding the limited space in the house but staff will not accede to the suggestion. Space is limited so the conservatory at the back of the house would provide extra airy space for all the residents to enjoy. However, the conservatory is used for laundry purposes.
URI-0017418	21/01/19	No assistance when resident used bathroom. Resident fell and sustained injuries. No record made relating to fall.
URI-0017413	18/01/19	There are no regular activities to stimulate residents. There is a long delay in answering the entrance door bell. There is issues with staffing levels that is impacting on the care and wellbeing of the residents.

URI-0017408	18/01/19	
URI-0017402	17/01/19	Resident's rights are not respected. Staff are changing continuously and it disrupts the harmony in the centre. The resident is unhappy living in the centre with all the changes taking place.
URI-0017400	16/01/19	Carer pushed resident and as a result resident is afraid of carer.
URI-0017379	14/01/19	
URI-0017375	14/01/19	. CP expressed concerns about prescribed medication and care/support received by resident.
URI-0017369	10/01/19	Staff changed without any notice or period of adjustment provided for the residents who were upset and disoriented
URI-0017363	09/01/19	Resident left centre and went to a neighbour's home and there was a fracas involving the resident and the care workers.
URI-0017361	09/01/19	Professional incompetence of a manager to meet the required standard to fulfil her role as a CNM 2
URI-0017357	09/01/19	did not have access to own underwear and was not being emotionally supported.



URI-0017356	08/01/19	
URI-0017349	08/01/19	Resident is disturbed by the fire alarm. The resident's tutor is unable to do any work with the resident due to tiredness. The resident has not received any education since . The resident missed out on a lot due to lack of intervention from the disability services in
URI-0017348	07/01/19	Historic abuse of autistic resident relating to l assaults. Inadequate following up of serious incidents and accidents.
URI-0017329	02/01/19	Resident tried to force an entrance to CP's home. . The resident was physically aggressive. A car approached CP's house and there were persons in the car. The resident approached the driver of the car and carried out a serious assault on the driver. The driver and the other person were employees of the centre. They tried to forcibly restrict the resident and it was upsetting for CP and CP's family to witness the incident. The two carers instructed CP to ensure the family were locked into the house as they tried to restrict the resident. CP, helped to calm the situation; however, the resident assaulted CP by biting CP's . CP calmed the situation and helped the two carers to get the resident to return to the centre. there is lack of management and relevant training. .