Regulatory Guidance for Registered Providers of Residential Services for Children and Adults with Disabilities

Subject	Guidance on Directory of Residents
Audience	Registered Providers

Standard	Regulation	No.
National Standards for Residential Services for Children and Adults with Disabilities	Health Act 2007 (Care and Support of Residents in designated Centres for Persons [Children and Adults] with Disabilities) Regulations 2009	19, 21

This memo offers guidance to registered providers on the records to be kept in respect of Regulation 19(1) and (3) and Regulation 21 (1)(c) of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons [Children and Adults] with Disabilities) Regulations 2013. Please check www.hiqa.ie for the latest version of this guidance.

Matters to be maintained in the Directory of Residents

Regulation 19(1) says that you, as provider, 'shall establish and maintain a directory of residents in the designated centre'. Regulation 19(3) says that 'the directory shall include the information specified in paragraph (3) of Schedule 3'.

See page 3 onwards for details of Schedule 3 and Schedule 4.

The Authority recognises the challenge for providers in including all the information cited in paragraph 3 of Schedule 3 in one directory. Therefore, in the interests of practicality, the Authority advises that the matters in paragraphs (a) to (e) may be maintained in the directory, together with the matters in paragraphs 7 – 9 of Schedule 4.

This means that the directory would contain the following matters:

- the name, address, date of birth, sex, and marital status of the resident (child or adult)
- the name, address and telephone number of the resident's next of kin or representative

- the name, address and telephone number of the resident's general practitioner and of any officer of the Executive whose duty it is to supervise the welfare of the resident
- the date on which the resident first came to reside in the designated centre
- the name and address of any authority, organisation or other body, which arranged the resident's admission to the designated centre
- if the resident was discharged from the designated centre, the date on which he or she was discharged
- if the resident was transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident was transferred
- any dates during which the resident was not residing at the centre, excluding regular overnight visits home or arrangements relating to part-time placements.

Matters to be maintained other than in the Directory of Residents:

Regulation 19(3) also requires that the material in paragraphs (f) – (q) of Schedule 3 be maintained in the designated centre in respect of each resident.

The Authority recognises that this information often forms part of residents' care records. Therefore, in the interests of reducing the regulatory burden by avoiding the creation of duplicate records, the Authority will, in practice, consider the regulation met if the matters set out in paragraphs (f) – (q) are maintained separately from the residents' directory.

This means that a provider will be considered compliant if the following matters are satisfactorily maintained within the centre, albeit not in the directory of residents:

- the medical, nursing and psychiatric (where appropriate) condition of the resident at the time of admission
- all nursing or medical care provided to the resident, including a record of the resident's condition and any treatment or other intervention
- where a resident has not chosen to take personal responsibility for his/her own medication, each drug and medicine administered to the resident, giving the date of the prescription, the dosage, the name of the drug or medicine, the method of administration, signed and dated by a medical practitioner or the nurse or staff member administering the drug or medicine in accordance with any relevant professional guidelines
- any decision by the resident not to receive certain medical treatments and a record of any occasion where the resident refused treatment
- ongoing medical assessment, treatment and care provided by the resident's medical practitioner, where that information is available

- any medication errors or adverse reactions in relation to the resident
- all referrals and follow-up appointments in respect of the resident
- any occasion on which restrictive procedures, including physical, chemical or environmental restraint, were used in respect of the resident, the reason for its use, the interventions tried to manage the behaviour, the nature of the restrictive procedure and its duration
- any incident in the designated centre in which the resident suffers abuse or harm, including the nature, date and time of the incident, whether medical treatment was required, the names of the persons who were respectively in charge of the designated centre and supervising the resident, and the names and contact details of any witnesses
- details of any specialist communication needs and methods of communication that may be appropriate in respect of the resident
- all money or other valuables deposited by the resident for safekeeping or received on the resident's behalf, including:
  - the date on which the money or valuables were deposited or received, the date on which any money or valuables were returned to the resident or used, at the request of the resident, on his or her behalf;
  - a written acknowledgement of the return of the money or valuables
- a record of furniture brought by the resident into the room occupied by him or her.

Relevant Schedules

The following information is taken directly from Schedule 3 and Schedule 4 of the Regulations as outlined above.

Schedule 3 (Regulation 5, 19, 21)

Records to be kept in designated centre in respect of each resident:

1. The assessment of the resident's need under Regulation 5(1) and his or her personal plan.
2. A recent photograph of the resident.
3. A record of the following matters in respect of each resident in the directory of residents established under Regulation 19(1):
   a. the name, address, date of birth, sex, and marital status of the resident
   b. the name, address and telephone number of the resident's next of kin or representative
   c. the name, address and telephone number of the resident's general practitioner and of any officer of the Executive whose duty it is to supervise the welfare of the resident

d. the date on which the resident first came to reside in the designated centre
e. the name and address of any authority, organisation or other body, which arranged the resident's admission to the designated centre
f. the medical, nursing and psychiatric (where appropriate) condition of the resident at the time of admission
g. all nursing or medical care provided to the resident, including a record of the resident's condition and any treatment or other intervention
h. where a resident has not chosen to take personal responsibility for his/her own medication, each drug and medicine administered to the resident, giving the date of the prescription, the dosage, the name of the drug or medicine, the method of administration, signed and dated by a medical practitioner or the nurse or staff member administering the drug or medicine in accordance with any relevant professional guidelines
i. any decision by the resident not to receive certain medical treatments and a record of any occasion where the resident refused treatment
j. ongoing medical assessment, treatment and care provided by the resident's medical practitioner, where that information is available
k. any medication errors or adverse reactions in relation to the resident
l. all referrals and follow-up appointments in respect of the resident
m. any occasion on which restrictive procedures, including physical, chemical or environmental restraint, were used in respect of the resident, the reason for its use, the interventions tried to manage the behaviour, the nature of the restrictive procedure and its duration
n. any incident in the designated centre in which the resident suffers abuse or harm, including the nature, date and time of the incident, whether medical treatment was required, the names of the persons who were respectively in charge of the designated centre and supervising the resident and the names and contact details of any witnesses
o. details of any specialist communication needs and methods of communication that may be appropriate in respect of the resident
p. all money or other valuables deposited by the resident for safekeeping or received on the resident's behalf, including:
    i. the date on which the money or valuables were deposited or received, the date on which any money or valuables were returned to the resident or used, at the request of the resident, on his or her behalf; and
    ii. a written acknowledgement of the return of the money or valuables

q. a record of furniture brought by the resident into the room occupied by him or her.

4. A copy of correspondence to or from the designated centre relating to each resident.

Schedule 4 (Regulation 21)

Other records to be kept in respect of the designated centre:

General records

1. A copy of the current statement of purpose.
2. A copy of the current resident's guide.
3. A copy of all inspection reports.

Charges

4. A record of the designated centre's charges to residents, including any extra amounts payable for additional services not covered by those charges, and the amounts paid by or in respect of each resident.

Food

5. Where the registered provider provides food, records of the food provided for residents in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory, in relation to nutrition and otherwise, and of any special diets prepared for individual residents.

Complaints

6. A record of all complaints made by residents or representatives or relatives of residents or by persons working at the designated centre about the operation of the designated centre, and the action taken by the registered provider in respect of any such complaint.

Residents

7. If the resident was discharged from the designated centre, the date on which he or she was discharged.
8. If the resident was transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident was transferred.
9. Any dates during which the resident was not residing at the centre.

Notifications under Regulation 31

10. A record of any of the following incidents occurring in the designated centre:

    a. the death of any resident, including the death of any resident following transfer to hospital from the designated centre and the date, time, circumstances and medical cause of death when established
    b. an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre
    c. any serious injury to a resident which requires hospital treatment
    d. any unexplained absence of a resident from the designated centre
    e. any allegation, suspected or confirmed, of abuse of any resident
    f. any allegation of misconduct by the registered provider or any person who works in the designated centre
    g. any occasion where the registered provider became aware that a member of staff is the subject of review by a professional body
    h. any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used
    i. any fire, or loss of power, heating or water
    j. any incident where an unplanned evacuation of the designated centre took place
    k. any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment
    l. a recurring pattern of theft or burglary
    m. any other adverse incident, as directed by the chief inspector.

11. A copy of the duty roster of persons working at the designated centre, and a record of whether the roster was actually worked.
12. A record of attendance at staff training and development

Fire safety

13. A record of each fire practice, drill or test of fire equipment (including fire alarm equipment) conducted in the designated centre and of any action taken to remedy any defects found in the fire equipment.
14. A record of the number, type and maintenance record of fire-fighting equipment.