St. Michael's House

Policy for Creation, Maintenance, Destruction and Access to Records

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Policy for Creation, Maintenance and Access to Service User Records

St. Michael's House is committed to ensuring all records are managed appropriately to ensure confidentiality and are in line with legislative requirements under the Data Protection Act 2003, Freedom of Information Act 2003 and are in line with the Health Act 2007.

This policy is divided into 3 sections:

- Section A: Service user records
- Section B: Other Records
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SECTION A: SERVICE USER RECORDS

1) Policy for Creation and Maintenance of Service User Records in St. Michael's House

Policy Statement

It is the policy of St. Michael's House to create and maintain personal records relating to each individual service user. Service User records will document assessments, plans, guidelines, therapeutic interventions and services offered or delivered to each person. The important activity of making and keeping records is an essential and integral part of care. Records are a tool for communication with other staff to enable decision-making and service delivery as well as evaluation and review.

Consent

Before accessing or sharing information staff must seek to obtain permission from the service user or in the case of children their parents/guardian. The organisation works with service users to inform them and assist people to exercise their right to refuse or restrict sharing of information. Consent should be limited to specific pieces of information for a particular purpose for a defined time period. The organisation seeks to ensure there is fair processing of sensitive personal data as outlined in the Data Protection Act.

Practice and Procedures:

St. Michael's House will:

- Maintain service user information that is accurate and up to date.
- Ensure that all records preserve the confidentiality of personal information.
- Define clearly who can access service user information.
- Correct factual inaccuracies at the request of the service user and or the carer.
- Comply with the Data Protection and Freedom of Information Acts.
- St. Michael's House staff will work at all times to assist and facilitate all requests in relation to personal records held by the organisation.

Definition of a record:

"A record is defined as including any papers, memorandum, text or other document, any photograph, film or recording, or any form in which data are held (whether manual, mechanical or electronic), and anything that is a part, or a copy, or a combination of the foregoing. A copy in any form of a record is deemed to have been created at the same time as the original".

(FOI (Amendment) Act 2003).

Compliance with Legislation and the Legal Status of records

Under the Freedom of Information Act 2003 service users and their families have the right to request, review and amend (if necessary) the data in their personal file. The Data Protection (Amendment) Act 2003 permits access by the person to access data relating themselves. The Health Act 2007 (Care and Supports of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulation 2013 outlines specific records and the time frames these records must be held. These records and timeframes are set out in this policy.

2) Standards for Creation and Maintenance and Retention of Service User Records.

Responsibilities of St. Michael's House in relation to Personal Records:

- **Fair Obtaining:**

When collecting personal information St. Michael's House will make the service user aware of the uses of that information. Consent will always be sought regarding disclosures of personal information to third parties or for any secondary uses of their personal information that might not be obvious to them.

- **Purpose Specification**

St. Michael's House is required to maintain a database of people in receipt of service from the organisation. St. Michael's House is also required to export certain categories of service user data to the National Intellectual Disability Database (NIDD). In so doing St. Michael's House works in the context of the confidentiality and consent procedures laid down by the NIDD and the HRB.

It is the policy of St. Michael's House to maintain a personal record/file for all service users. Record keeping is a fundamental tool of professional work practice. Good record keeping protects the interests of service users by promoting:

- Excellence in standards of care

- Continuity of care

- Good communication between members of the team

- Evidence of care and rationale for decisions taken

- Baseline record to assist review and evaluation of services received

- **Use and Disclosure of Information**

St. Michael's House operates a strict policy of fidelity and confidentiality that is detailed in all contracts of employment. Staff members may not disclose any information of a confidential nature relating to St. Michael's House or its service users. This applies during or after employment with the organisation. On termination of employment, all documentation, files etc in a staff member's possession must be returned to St. Michael's House.

- **Security**

All files and service user records are stored in a secure location. Only authorised personnel have access to all files containing personal information on service users in accordance with the Policy on Staff Access to Service User Files.

Computers and databases are password protected with other factors of authentication as appropriate to the sensitivity and confidentiality of the information.

- **Adequate, relevant and not excessive**

The purpose of personal records in St. Michael's House is outlined above. It is the policy to collect only information that is directly relevant to delivering the best possible individualised service to the individual and their family.

- **Accurate and up-to-date**

All records must be accurate, clear and unambiguous. Information contained in records must be up-to-date. Staff have a responsibility to report any changes in personal data to the relevant admin staff who will change the record,

- **Retention time**

St. Michael's House retains all personal information as long as it is relevant to delivery of service; in all cases this is for not less than seven years after the resident has ceased to reside in / attend a centre. Records relating to children in residential services will be kept in perpetuity and transferred to the Executive not later than seven years from the date on which the child ceased to reside in the designated centre. When a service user leaves the service their personal information is securely archived and can be retrieved in the event of a query in relation to services delivered or in relation to family queries.

All records must:

- Be directed primarily to serving the interests of the service user to whom it relates and enables the achievement of priority goals and outcomes for the individual.
- Demonstrate an accurate chronology of significant events, consultations, assessments, observations, decisions, interventions and outcomes for the service user. The record should also document any reference to complaints or other investigations and it's resolution.
- Be written as soon as possible after the events to which they relate.
- Distinguish clearly between fact and opinion
- Be written legibly and indelibly using blue or black ink. Pencil or unusual ink colours should not be used to avoid the risk of erasure or poor quality photocopying or reproduction if required at a later stage.
- Accord to the standard use of the English language. Only universally accepted abbreviations should be used. Slang or subjective statements not relating to the care of the service user should not be used.
- Include the full name of the service user on each entry. Continued records should be marked clearly (i.e. if a note is continued on the reverse side of a page.)
- Be clearly signed and dated by the author and the title or position of the author should also be clearly discernible on each entry. Initials are not acceptable for major entries. However, where the use of initials is allowed for other entries, a local system must be in place to identify initials.
- Be objective, clear and accurate.
- Any discrepancies between different entries should be discussed and clarified. The resolution should be entered into the record and signed by the parties concerned.
- Ensure that alterations are made scoring out with a single line followed by the initialled, dated and timed correct entry. Tippex or correction fluid should not be used.
- Be maintained in chronological order
- Avoid excess empty space on a page.

Electronic Communication and Digital Recording and Imaging

E-mail can be a valid, simple and convenient method of communication in the workplace. However, the same standards for record keeping and confidentiality apply to e-mails as to paper communications.

- Emails relating to service delivery should be written in clear concise language avoiding use of abbreviations or informal comment.
- As e-mail is an instant form of communication it is advisable to re-read all messages before sending to avoid errors or misinterpretation.
- Emails should not be considered as a report. In all circumstances communication memos regarding service users should be on official headed St. Michael's House stationery and sent as an email attachment if necessary or appropriate.
- Emails containing attachments with confidential information should only be forwarded or copied with consent of the service user.
- E-mails that are printed should be securely filed according to the Policy.
- Reports or information relating to service users should only be stored in S-Drive of St. Michael's House Networked Computers. A standard practice for using the S-Drive should be implemented in all regions.
- Personal information about service users may only be stored replicated or transferred to St Michaels House electronic devices that have been encrypted by the organisation with the express permission of the relevant manager and service user. Such devices include USB keys, PDAs, Mobile Phones, Multi-media players or other mobile external devices. Under no circumstances can service user information be stored on personal computers or other electronic devices.
- Digital, photographic or video images should only be recorded, stored or used with the explicit consent of the service user or their family and from the relevant line manager. Photographs or images for clinical or medical purposes should be specific to the nature of the pertaining issue or purpose (e.g. pressure sore, rash, bruises etc). Images should be deleted from the camera/ device at the earliest opportunity and should be stored in the clinic file.

Service User Records in St. Michaels House can be categorised into two main types:

A) Records held in residential and day services:

The regulatory requirements for records to be kept in residential centres are set out in The Health Act 2007 and are included as Appendix 1 to this policy.

St. Michael's House have a standardised recording system for the maintenance of Service User records in residential centres. The recording system will ensure the regulations outlined above are complied with. See appendix 2 for guidance on how to use the standardised recording system.

The person in charge with the support of their service manager will ensure that the Service User records in the designated residential centre will be managed in line with this policy.

St. Michael's House Day services will have a similar system for recording information about service users.

B) Records held in Headquarters buildings known as Clinic Files:

Clinic files offer clinicians the opportunity to store, share and review information about a service user. This information is kept in the headquarters buildings to ensure ease of access in advance of a meeting with/ about a service user or to review previous actions/ assessments carried out. The clinic file contains copies of clinical inputs to a service uses over a period of time.

Any clinical files relating to service users that are created in addition to the main Clinic File should be created for the area of service, department or discipline and not for an individual staff member. Where this is the case all additional files and their location must be clearly recorded on the Green Reference Sheet (See appendix) at the front of the Clinic File. This is to ensure continuity of care, good communication and ease of access in the event of a query by a service user. The person in charge / Department Head must be able to access such files at all times.

The use and frequency of record and the format of various reports may vary across the organisation. It is recommended that each Service Manager/Lead clinician define the appropriate recording structures and frequency of same that best meets the developmental and care needs of the service users in each centre. It is recommended that standard organisational templates should be used where possible and these are available for download through the Intranet (Records relating to discussion of individual service users at team meetings/ICM's (Individual Co-ordination Meetings) strategy meetings should be maintained and filed in the Service User's file in their residential or day service. A copy can be placed on the clinic file if necessary.

3) Access to Service User Files by St. Michael's House Staff Members

Confidentiality

All staff are required to sign and are bound by a Confidentiality clause in their contract of employment.

Consent

It is the responsibility of all staff to establish and respect the preferences of the service user in relation to their personal information and to seek consent from the service user appropriately.

Storage and Access to Service User Files:

- All Files must be stored securely.
- Authorised staff outlined below may only access individual files.
- For clinic files a File Tracer System is operational and must be used by all staff. Staff must give a specific reason on each occasion for requiring access to the file.
- Removal of Files from the building in which they are stored should be minimised or avoided.
- Staff must ensure that the confidentiality and security of the files are protected whilst in their possession. Files must not be read in public areas of a building and must not be left unattended.

Authorised Staff:

- **Person in Charge**

The person in charge must ensure that only relevant staff have access to personal information. Access to the archive folder (red) will be restricted to the PIC or the person's keyworker or clinicians as necessary. Access to clinical files for frontline staff is organised through the PIC.

- **Clinicians**

Clinicians who are working with a service user have access to the clinical file.

Clinicians who are not on the cluster clinical team may have access to the file through a member of the team with a valid reason.

- **Service Managers**

Managers may access to relevant portions of the file to enable them to deal with enquiries, complaints or to undertake investigations.

- **Administration Staff**

Administration Staff will have access to files in order to carry out specific admin duties.

- **Other Designated Staff**

The Chief Executive may designate staff members to access files in order to comply with Freedom of Information Requests or Data Protection Requests. Staff may also be designated to fulfil a legal request for record.

The relevant Head of Department must be notified that records are being released.

- **Research Staff**

All service user related research must be approved by the Research and Ethics Committee who will lay down procedures specific to the area of research regarding relevant access to service user records and the required consent by the service users involved.

- **Students**

Clinicians who are supervising Students on formal placements in the organisation must ensure that the student signs a confidentiality agreement and ensure that the student fully understands the obligations of the agreement and this policy. If a student requires access to a file it must be signed out on the tracer card to the supervisor or the Head/Principal of the Department.

4) Access by Service Users to their Personal Records

In order to support service users to exercise their rights the organisation must work to ensure that service users are informed about the nature and type of personal information that is held about them. The organisation must also make personal records available on request and assist with interpretation as required. The organisation must work with service users about the meaning of confidentiality and their right to refuse to share information.

Procedure for Service Users who wish to access their Personal Records:

- As a general principle, requests by service users to see their files are welcomed and should be facilitated without recourse to Freedom of Information procedure. However, the FOI procedure is available in suitable situations.

1. Requests from service users to see their files should be directed to the person in charge.

2. In order to meet the service user's request to the best of our ability, and to nominate the appropriate staff to assist in interpretation the following points may need to be considered:

- Is there very specific information that the service user wishes to access from their file (e.g. family or medical information) or is the request more general?
- In some cases the service user may simply wish to see the format of the file and the storage facilities.
- Service users may wish to clarify who has access to the file and how this is managed. They may wish to restrict access to some parts of their file.
- Does the service user need an explanation about all information kept in the organisation about them, not just the files in the centre (eg: clinical file, restricted access files, medication administration sheets etc.)

3. Consent must be sought from relevant clinicians before information is made available to service users.

4. Clinic files can only be viewed in the clinic and not taken out of the building.

5. In some exceptional circumstances service user files may contain records relating to other people (eg: family members.) The service user only has an entitlement to see information relating to themselves. The person in charge will need to identify such information and may need to provide an explanation to the service user

6. When it is appropriate the person in charge will arrange for the Service User to review their file with an appropriate staff member (Keyworker/ person in charge/ clinician)

7. It is appropriate for family member or other person nominated by the service user to be present when they are reviewing their file, should the service user so wish.

8. If it is a clinical file that the service user wished to see a senior clinician will be nominated to support the service user to access their file. The senior clinician will usually be the clinician who knows the service user best in the context of the information being sought. In some cases more than one clinician may be involved. In the absence of an obvious senior clinician the Clinic Manager will nominate a clinician.

9. The senior clinician/ or person in charge should read through the clinical file to identify any potentially sensitive information. If there is potentially sensitive information, the senior clinician/ person in charge must discuss this with their line manager and/or the Clinic Manager. The service user-and in some cases family members- may need to be forewarned about this sensitive information and offered support.

10. Before proceeding further the senior clinician should notify a clinician from each of the clinical disciplines who has records or notes on the file. This will allow time for other disciplines to review their notes and to clarify potentially difficult/sensitive issues where needed. This notification can be done by email. If no reply is received within a reasonable length of time the senior clinician can presume it is appropriate to proceed. In the case of somebody being on leave or un-contactable, the principal/head of department can be consulted.
11. Any clinician who is facilitating a viewing of a service user's file must not interpret information from another clinical discipline without first receiving consent and clarification from the clinician concerned.
12. The senior clinician must follow up with the service user and the clinic cluster team soon afterwards to clarify if the viewing was satisfactory and whether it raised any issues that require further discussion and/or follow-up.
13. Service Users may also see notes in relation to themselves that are stored on Restricted Access Files. Such requests must always be discussed with the Principal Social Worker in the region. (See access to restricted files policy).
14. Requests by service users for copies of reports on their file should be facilitated. A record should be placed on the file of which documents were supplied to the service user. Service Users may need advice or assistance in storing the information securely.

5) Policy for access by Service Users and Staff to Restricted Access Files

Restricted Access Files

Restricted access files are those files, which are opened when an allegation of abuse is made. Due to the nature of the information these files are restricted to a small number of people to ensure confidentiality.

WHO CAN HAVE ACCESS TO A RESTRICTED ACCESS FILE?

- The Designated Officer in St. Michael's House, or her/his Deputy.
- The person in charge
- The person in charge
- The Director of Operations
- The Principal Social Worker in the region.
- FOI decision-makers may access these files, through the Designated Officer or the Director of Operations.
- The Clinicians named at the front of the file and authorised by the Principal Social Worker.
- If, for some reason, a person other than the above needs access to a file, he/she must do so through the Designated Officer.
- The Service User who has a Restricted Access File, can access this through one of the Clinicians named on the file, and can view the file in the company of one of the named clinicians in accordance with the policy on Service Users seeing their own files.

STORAGE

- Restricted access files will be stored in the Records Department of each region, in a separate filing cabinet to any other files, except for those relating to staff, which will be kept separately by the Designated Officer.
- They will be kept locked at all times. The **key** will be held in the **Records Department**, and may not be accessed by anyone, except the Secretary in the Records Department (or her/his designate, in case of absence).
- Restricted access files may **not** be taken from the building.

HOW TO OPEN A NEW RESTRICTED ACCESS FILE

- Permission to open a new Restricted Access File must be obtained from the Designated Officer (The Head of the Social Work Department) or her/his Deputy.
- When the decision is taken that a Restricted Access File is to be opened, the Principal Social Worker in the region, will inform the secretary in the Records Dept. that a file is to be opened and add to list on green form on main file.
- The secretary in the Records Dept. will number and date the file and add the name to the list of files already opened.
- The secretary of the Records Dept. will request the investigation team to sign their names on the relevant form, on the front of the file, so that she/he will know who is entitled to access the file.

HOW TO MAINTAIN A RESTRICTED ACCESS FILE.

- If a file is being taken from the Records Department, by any of the above, they must sign for the file on the Tracer Card and date it.
- Information and Reports in the file will be kept in chronological order.
- Reports and information in the file must be dated and signed.
- Forms on the front of the file must be completed.

SECTION B: OTHER RECORDS:

1. Human Resources Records:

It is the policy of St. Michael's House to create and maintain personal records relating to each individual staff member. The human resources department ensure that staff records contain the necessary documentation including documents listed in schedule 4 of The Health Act 2007, (Care and Support of residents in designated centres for persons with a disability) See Appendix 3 for full details.

All staff records are stored securely in Human Resources. Staff members have access to their personal HR file. Person in Charge has access to files for staff working in their centre. Service managers, administration managers, regional directors may access staff records for staff reporting directly to them.

Access in the event of an allegation of misconduct, abuse or fitness to practice concerns, must be agreed with the manger of the human resources department.

Staff files are retained in line with HSE 'Record Retention Periods 2013' and in line with The Health Act 2007, (Care and Support of residents in designated centres for persons with a disability). In all cases this is for a period of not less than 7 years after the employee has left the organisation.

Staff training records are maintained by the Staff Training and Development Department. At each training event the staff member attending must sign an attendance sheet as evidence that they were present on the day. The attendance sheet is entered onto a database and the sheet with the staff member's original signature is filed securely.

Access to training records is arranged with the Training Manager.

2. Other Records:

The other records that must be held in respect of residential services as listed in Schedule 4 of Health Act 2007 (Care and Support of residents in designated centres for persons with a disability).

It is the Policy of St. Michael's House to create, maintain and manage the documents listed in Appendix 3. The person in charge is responsible for the maintenance of the required documents

A copy of the schedule and related information is included as Appendix 4.

There are a number of St. Michael's House Policies that support the maintenance of these documents:

- St. Michael's House Complaints Policy
- St. Michael's House Notifiable Events Policy

Appendix 1

The records that are held in residential services as listed in Schedule 3 of Health Act 2007 (Care and Support of residents in designated centres for persons with a disability).

1. The assessment of the resident's need under 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: (Green File)

(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 residents have 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) On-going 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;

(iii) 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.
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Appendix 2

Guidance on the Implementation and Use of the Service User Information recording system:

To ensure St Michael's House meets the standards as set out by HIQA under Theme 8: "Use of Information". The new system for recording Service User information needs to be implemented with immediate effect.

The new standardised recording system allows for each service user to have a green folder, a red folder and a cardex folder.

All service users information should be recorded and stored in the same way in each residential house.

The green folder is the 'active file'. This is the file that contains all the up to date/current information and is used daily for recording information about individual service users.

The red folder is the 'storage folder'. This will contain the information about the service user for the current year.

Information will be transferred from the active file to the storage folder monthly.

The medication administration folder will contain all information related to medication and the person's hospital passport. The medication administration folder will be kept in the medication press. The information from the Cardex file will be transferred to the storage file at the end of the month.

At the end of the year the information in the storage file will be placed into a box for storage in King's Inn.

Service users folders must only contain the sections that are relevant to them. For example if the person does not need transport then the transport section of the file should be removed.

All of the templates that are required to keep the recording system in operation are available on the intranet for you to download as needed. There will be periodic reviews of the system to ensure it continues to represent best practice and that it meets the needs of service users. Please do not change any documents.

The practice of recording information in communal files such as in the Essential Guide, Service Users Money, or Medication records should cease immediately. The new recording system will enable you to record all relevant information in individual files for each person. The exception is the Fire Fact File, which will continue to have evacuation information about all service users in it.

The standardised Service User Information Recording System should be implemented in each residential house.

Each service user should have a Green (active) file, Red (storage) file and a medication administration file All Service users will continue to have a clinic file stored in the regional headquarters building.

Information in the Active file should only contain information relevant to the current care needs of the service user as follows:

- Guidelines no longer in use must be removed from the active file and archived in the clinic file. A note identifying that the guidelines have been reviewed and updated, must be signed, dated and included with the old guidelines.
- Daily reports should include time of report (ie from 9am to 2pm), and all reports should be signed by staff member. Daily reports should be written in a chronological order in relation to day/night reports. Daily reports should be summarised into a monthly report and then stored in the storage file. The monthly reports should remain in the active file for the current year.
- Information should not be duplicated in the active file.
- There should be no empty sections or subsections in the individual's file. These should be removed and can be reinserted later if required.
- All information about service users must be stored confidently and staff should seek permission to access service users files.
- Information recorded about service users should be available to the service user and should give consideration to how the information contained in the file is accessible to the person.

N.B. No information should be stored in communal files (except the Fire Fact File and information held on Transport).

- Information about service users should not be recorded in the staff communication book or on communal handover notes. The communication book/ handover notes can refer the staff member to review the appropriate area of the service users personal file.

Appendix 3

List of documents stored in Human Resources File:

Information and Documents to be obtained in respect of Staff, Currently and Previously Employed at the Designated Centre:

A record of all persons, currently and previously, employed at the designated centre, including in respect of each person so employed:

(a) Full name, address and date of birth of each person;

(b) Evidence of the person's identity, including a recent photograph;

(c) The dates on which he or she commenced and ceased employment (if relevant);

(d) A vetting disclosure in accordance with the National Vetting Bureau(Children and Vulnerable Persons) Act 2012;

(e) Details and documentary evidence of any relevant qualifications or accredited training of the person;

(f) Relevant current registration status with professional bodies in respect of nursing and other health and social care professionals employed in the designated centre;

(g) A full employment history, together with a satisfactory history of any gaps in employment;

(h) Details of any previous experience (if any) of carrying on the business of designated centre;

(i) Two written references including a reference from a person's most recent employer (if any). Where a format has been specified by the chief inspector the references should be in that format.

(j) The position the person holds, or held, at the designated centre, the work the person performs/performed and the number of hours the person the person is or was employed each week.

(k) Correspondence, reports, records of disciplinary action and any other records in relation to his or her employment.

Appendix 4

The other records that must be held in respect of residential services as listed in Schedule 4 of Health Act 2007 (Care and Support of residents in designated centres for persons with a disability)

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.

4) Charges:
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. This information can be found in the contract of care.

5) Food:
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. This can be found on the menu planner.

6) Complaints:
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. Records relating to complaints must be kept for a period of 4 years. All complaints must be managed as outlined in the St. Michael's House Complaints Policy.

7) Residents:
If the resident was discharged from the designated centre, the date on which he or she was discharged. This information must be retained for a period of not less than 7 years from their making. This will be recorded in the service users green file.

8) Residents:
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. This information must be retained for a period of not less than 7 years from their making. This will be recorded in the service users green file.

9) Residents:
Any dates during which the resident was not residing at the centre. This information must be retained for a period of not less than 7 years from their making. This will be recorded in the service users green file.

10) Notifiable Events:
A record of any of the following incidents occurring in the designated centre must be kept for a period of not less than 7 years:

(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;

Note these events above are notifiable to HIQA within 3 days of them occurring.

(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; and

(m) Any other adverse incident, as directed by the chief inspector.

Note these events above are notifiable to HIQA quarterly.

11) *Duty Roster*:
A copy of the duty roster of persons working at the designated centre, and a record of whether the roster was actually worked. The roster must have the staff members full name and job title included. Rosters must be kept for a period of not less than 4 years.

12) *Staff Training:*
A record of attendance at staff training and development. These records must be kept for a period of not less than 4 years.

13) *Fire Safety*
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. These records must be kept for a period of not less than 4 years.

14) *Fire Safety:*
A record of the number, type and maintenance record of fire-fighting equipment. These records must be kept for a period of not less than 4 years.