



STATUTORY INSTRUMENTS.

**S.I. No. 36 of 2010**

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HEALTH ACT 2007 (CARE AND WELFARE OF RESIDENTS IN  
DESIGNATED CENTRES FOR OLDER PEOPLE) (AMENDMENT)  
REGULATIONS 2010

**(Prn. A10/0169)**

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HEALTH ACT 2007 (CARE AND WELFARE OF RESIDENTS IN  
DESIGNATED CENTRES FOR OLDER PEOPLE) (AMENDMENT)  
REGULATIONS 2010

I, MARY HARNEY, Minister for Health and Children, in exercise of the powers conferred on me by section 101 of the Health Act 2007 (No. 23 of 2007) hereby make the following regulations:

1. These Regulations may be cited as the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) (Amendment) Regulations 2010.

2. These Regulations come into operation on the 15th day of February 2010.

3. Article 16 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (S.I. No. 236 of 2009) is hereby amended by the substitution of the following paragraph for sub-article (2):

“(2) The person in charge shall ensure that there is an appropriately qualified registered nurse on duty and in charge of the designated centre at all times and a record thereof maintained in the designated centre.”

4. Article 37 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (S.I. No. 236 of 2009) is hereby amended by the substitution of the following paragraph for sub-article (3):

“(3) Where the absence arises as a result of an emergency, the registered provider shall give notice in writing to the Chief Inspector of the absence within three working days of its occurrence specifying the matters mentioned in article 37(2)(a) and (b) above.”

5. The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (S.I. No. 236 of 2009) is hereby amended by the substitution for Schedule 3 of the following:

“SCHEDULE 3

RECORDS TO BE KEPT IN A DESIGNATED CENTRE IN  
RESPECT OF EACH RESIDENT

1. The resident's care plan referred to in article 8.
2. A recent photograph of the resident.

*Notice of the making of this Statutory Instrument was published in  
“Iris Oifigiúil” of 9th February, 2010.*

3. A record of the following matters in respect of each resident in the directory of residents referred to in article 23:

- (a) the name, address, date of birth, sex, and marital status of each resident;
- (b) the name, address and telephone number of the resident's next of kin or of any person authorised to act on their behalf;
- (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 was first admitted to the designated centre;
- (e) the date on which the resident was discharged from the designated centre;
- (f) if the resident is transferred to another designated centre or to a hospital, the name of the designated centre or hospital and the date on which the resident is transferred;
- (g) if the resident died at the designated centre, the date, time and cause of death; and
- (h) the name and address of any authority, organisation or other body, which arranged the resident's admission to the designated centre.

4. A record of the following matters in respect of each resident:

- (a) a record of all medicines kept in the designated centre for the resident, and the dates and times on which they were administered to the resident;
- (b) a record of any accident affecting the resident in the designated centre and of any other incident in the designated centre which is detrimental to the health or welfare of the resident, which record shall include the nature, date and time of the accident or incident, whether medical treatment was required and the name 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;
- (c) a record of all nursing care provided to the resident, including a record of their condition and any treatment or surgical intervention;

- (d) details of any specialist communication needs of the resident and methods of communication that may be appropriate to the resident;
- (e) details of any plan relating to the resident in respect of medication, nursing care, specialist health care or nutrition;
- (f) a record of any incident of pressure sores and of treatment provided to the resident;
- (g) a record of falls and of treatment provided to the resident;
- (h) a record of any restraint used on the resident; and
- (i) a record of any limitations agreed with the resident as to the resident's freedom of choice, liberty of movement and power to make decisions.

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

6. The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (S.I. No. 236 of 2009) is hereby amended by the substitution for Schedule 4 of the following:

"SCHEDULE 4

OTHER RECORDS TO BE KEPT IN A DESIGNATED CENTRE

1. A copy of the statement of purpose.
2. A copy of the resident's guide.
3. A record of all residents' accounts kept in the designated centre.
4. A copy of all inspection reports.
5. A record of all persons employed at the designated centre, including in respect of each person so employed:
  - (a) their full name, address, date of birth, qualifications and experience;
  - (b) a copy of each reference obtained in respect of them;
  - (c) the dates on which they commence and cease to be so employed;
  - (d) the position they hold at the designated centre, the work that they perform and the number of hours for which they are employed each week;
  - (e) correspondence, reports, records of disciplinary action and any other records in relation to their employment; and

- (f) a record of current registration details of nursing staff.
6. A copy of the duty roster of persons working at the designated centre, and a record of whether the roster was actually worked.
7. 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.
8. A record of all money or other valuables deposited by a resident for safekeeping or received on the resident's behalf, which
- (a) shall state the date on which the money or valuables were deposited or received, the date on which any money or valuables were returned to a resident or used, at the request of the resident, on their behalf and, where applicable, the purpose for which the money or valuables were used; and
  - (b) shall include the written acknowledgement of the return of the money or valuables.
9. A record of furniture brought by a resident into the room occupied by them.
10. 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.
11. A record of any of the following events that occur in the designated centre:
- (a) any accident;
  - (b) any outbreak of infectious disease in the designated centre;
  - (c) any injury or illness;
  - (d) any fire;
  - (e) except where a record to which paragraph 13 refers is to be made, any occasion on which the fire alarm equipment is operated;
  - (f) any theft or burglary;
  - (g) any unexplained absence of a resident from the designated centre;
  - (h) any allegation, suspected or confirmed, of abuse of any resident;
  - (i) any allegation of misconduct by the registered provider or any person who works in the designated centre; and

(j) any incident where evacuation of the centre took place.

12. 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.

13. A record of every fire practice, drill or test of fire equipment (including fire alarm equipment) conducted in the designated centre and of any action taken to remedy defects in the fire equipment.

14. A statement of the procedure to be followed in the event of a fire, or where a fire alarm is given.

15. A statement of the procedure to be followed in the event of accidents or in the event of a resident going missing.

16. A record of all visitors to the designated centre, including the names of visitors.”



GIVEN under my Official Seal,  
4 February 2010.

MARY HARNEY,  
Minister for Health and Children.

EXPLANATORY NOTE.

*(This note is not part of the Instrument and does not purport to be a legal interpretation).*

These Regulations amend articles 16 and 37 and schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009.