Health Information and Quality Authority
Social Services Inspectorate

Inspection report
Designated centres for older people

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

Centre name:	Mullross Nursing Home
Centre ID:	0366
Centre address:	Kilclare Carrick-on-Shannon, Co. Leitrim
Telephone number:	071-9641165
Fax number:	071-9641662
Email address:	mullross@eircom.net
Type of centre:	☒ **Private** ☐ **Voluntary** ☐ **Public**
Registered providers:	Stephen Buckley
Person in charge:	Caroline McCormack
Date of inspection:	4 May 2012
Time inspection took place:	**Start:** 10:30 hrs **Completion:** 15:30 hrs
Lead inspector:	Sonia McCague
Support inspector:	Damien Woods
Type of inspection:	☒ Announced ☐ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☒ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Follow-up inspection

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up matters arising from a previous inspection to ensure that actions required of the provider have been taken
- following a notification to the Health Information and Quality Authority's Social Services Inspectorate of a change in circumstance for example, that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- to randomly "spot check" the service.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Mullross Nursing Home is a purpose-built, single-storey facility registered to provide accommodation for up to 30 residents. At the time of this inspection all residents were over 65 years of age, 28 are long stay residents and one person was on respite stay. The provider is currently leasing this centre.

The centre was built in 1987 and established as a nursing home in 1995. There is an internal courtyard available with potted plants, garden chairs and table. There is car parking to the front and side of the building.

Resident accommodation includes 15 single bedrooms with en suite shower and toilet facilities, four twin rooms and two three-bedded rooms all with en suite shower and toilet facilities. There is one assisted bathroom and two assisted toilets. Other facilities include the provider's office, a nurses' office, a clinical room, a kitchen and pantry, a dining room, two sitting rooms, a smoking room, a sluice room, a laundry room and a spacious chapel.

Location

Mullross Nursing Home is situated in a rural setting, approximately 13 kilometres from Carrick-on-Shannon. The Lough Erne waterway canal runs along one side of the centre.

Date centre was first established:	1995
Number of residents on the date of inspection:	29 + 1 in hospital
Number of vacancies on the date of inspection:	0

Dependency level of current residents	**Max**	**High**	**Medium**	**Low**
Number of residents	0	2	19	8

Management structure

The Provider is Stephen Buckley. Caroline McCormack was employed October 2011 as a clinical nurse manager and has since been appointed to the position of the Person in Charge and reports to the provider. Nurse Linda Cullen has been nominated to deputise in the absence of the Person in Charge.

All other staff, including nurses and care assistants, kitchen and cleaning staff report to the person in charge.

Staff designation	Person in Charge	Nurses	Care staff	Catering staff	Cleaning and laundry staff	Admin staff	Other staff
Number of staff on duty on day of inspection	1	1	5	2	1	0	1*

* Provider

Background

An unannounced monitoring inspection was carried out 9 February 2012 to consider information received by the Authority in relation to the expiry of the lease agreement.

The provider was unavailable 9 February 2012; therefore, a meeting was arranged and held 29 March 2012 to follow up on matters arising from the monitoring visit. A subsequent follow up inspection was carried out 4 May 2012 to determine the providers' progress with required actions highlighted following 9 September 2011 inspection. A notification of a change in the Person in Charge was also dealt with on this inspection.

Summary of findings from this inspection

The purpose of this announced inspection was to interview a recently appointed nurse to the position of person in charge and to assess the progress made by the provider and staff team in relation to the issues identified in the Action Plan of the previous inspection report (9 September 2011). Requirements related to residents' protection, financial arrangements, residents personal property, staffing and recruitment, water temperatures, maintenance of records, medication management, notification of incidents and complaints procedure.

The provider, person in charge and nurse on duty facilitated the inspection process. Staff were seen interacting and assisting residents appropriately. Relatives and residents who met and spoke with inspectors were complimentary of care staff and residents said they felt safe in the centre.

Inspectors found that while actions from the last inspection had been progressed some had not been completed satisfactorily or within the timeframes provided in the providers responses to the previous inspection report. These included management of medicines, staffing and recruitment, maintenance of records, notification of incidents and the complaints procedure.
The statement of purpose needed to be reviewed in light of changes within the operation/organisational structure and services available/provided to residents within the centre.

The provider was requested to begin to address these findings during feedback and which are reported in the action plan at the end of this report.

Issues covered on inspection

To follow up on matters arising in the last inspection
This is discussed and reported within the next section.

Statement of Purpose and Function
An updated statement of purpose was not available to reflect the current staffing levels, skill mix and management arrangements within the centre.

Fit person interview following a change in the Person in Charge
Inspectors interviewed Caroline McCormack appointed as person in charge and found her to meet the requirements of the regulations.

Actions reviewed on inspection:

1. Action required from previous inspection:

Put in place all reasonable measures to protect each resident from all forms of abuse.

Put in place a policy on and procedures for the prevention, detection and response to abuse.

Make all necessary arrangements, by training staff or by other measures, aimed at preventing residents being harmed or suffering abuse or being placed at risk of harm or abuse.

Maintain a record of all incidences where a resident is harmed or suffers abuse.

Take appropriate action where a resident is harmed or suffers abuse.

This action was addressed since the last inspection.

Reasonable measures were put in place to protect residents being harmed by or suffering financial abuse. There was recorded evidence in a sample of records reviewed of financial transactions and arrangements including those which dealt with access to resident's money. The person in charge was familiar with financial arrangements in place. She stated she plans to review the policy and procedure for the prevention, detection and response to abuse.

The provider told inspectors that he would furnish the Authority with the findings of an independent financial audit that is near completion.

2. Action required from previous inspection:

Put in place written operational policies and procedures relating to residents' personal property and possessions.

Maintain an up to date record of each resident's personal property that is signed by the resident.

Provide adequate space for each resident's personal possessions and ensure that residents retain control over their personal possessions.

Ensure that where details of a residents bank accounts, pensions or post office books are held they are secure at all times.

This action was addressed.

Since the last inspection adequate procedures were put in place relating to residents' personal finances, property and possessions. Details were maintained of financial arrangements included resident or relative control over personal property.

The provider confirmed that residents' bank accounts, pension or post office books held in filing cabinet within his office were secure and locked when the office was unoccupied. Keys to the lock were available.

3. Action required from previous inspection:

Supervise all staff members on an appropriate basis pertinent to their role.

Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

This action had progressed.

On arrival to the centre, Inspectors met with staff on duty. Staff were aware of the number of residents in the centre and of the number of staff on duty. A planned and actual staff rota was available that included the provider and person in charge. However, the activity person in the centre was not rostered for duty.

A policy was in place for recruitment and appointed of staff. The person in charge told inspectors that she had received a formal induction at the commencement of her employment. Copies of nurses' professional registration certificates were available for six of the seven regular staff nurses rostered (including provider and person in charge). However, documents in line with schedule 2 including copies of professional registration certificates was not available for one part time regular nurse and other relief nurses named on the roster.

Staff told inspectors they had difficulty maintaining records as required and attributed this to the absence/lack of administration/secretarial support staff in the centre.

4. Action required from previous inspection:

Complete an audit of water temperatures for morning, afternoon and evening over a two week period and submit to the authority and confirm that a sufficient supply of piped hot and cold water, which incorporates thermostatic control valves or other suitable anti-scalding protection, is provided.

This action was addressed satisfactorily.

Inspectors were satisfied with room and water temperature was adequate and an audit of water temperatures was maintained since the last inspection.

Since the last inspection, the provider provided confirmation of servicing of the fire alarm system. The provider said weekly alarm sounding tests were carried out in the centre to ensure the system was working and staff were responsive to same.

5. Action required from previous inspection:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so as to ensure completeness, accuracy and ease of retrieval.

Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

Make the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) available to the resident to whom the records refer and made available at all times for inspection and monitoring purposes under the Act.

Put in place written policies and procedures relating to the creation of, access to, retention of and destruction of records.

Retain the records under Regulation 22 for a period of not less than seven years after the resident to whom they relate ceases to be resident in the home.

Maintain all documentation of inspections relating to food safety, health and safety and fire inspections in the designated centre.

This action had not been addressed satisfactorily.

The directory of residents was not accurate to include the recent admission of a respite resident, transfer of a resident to hospital and omitted the cause of death for one resident.

Inadequate records were found regarding resident assessments, care plans and treatment given. Incomplete records of wound charts, medical orders and controlled drug administration was found.

Medical records were inadequate in respect of a sample of residents records reviewed and details of medical reviews and investigations were insufficient.

Hand writing on medical records was difficult to read/make out by staff and inspectors.

All prescriptions of medicine such as warfarin, did not include the date of the prescription and dosage and had not been signed and dated by a medical practitioner when changes were ordered or prescribed.

Medication management practices were not reflected in the centres policy and the policy did not include practices observed. Inspectors' findings above were verified with nurses during the inspection and were to be addressed immediately.

6. Action required from previous inspection:

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

This action had not been completed satisfactorily.

Inappropriate and unsuitable practice in relation to the management of verbal drug orders and of prescription medicines was found. A policy related to Medication management was available but it did not reflect practices in place.

Practices of nurse transcribing prescriptions, recording checks, administration and omissions of medicines were unclear and not in line with professional guidelines. Ambiguous prescriptions and incomplete records relating to verbal drug orders or omission of drugs was found and discussed with the provider and nursing staff. The provider attributed poor access to the general practitioner (GP) to issues highlighted by inspectors.

7. Action required from previous inspection:

Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

This action had been completed; however, notifications of serious injury had not been reported as required.

Inspectors reviewed records of incidents/accidents occurring with residents and noted that incidents whereby residents were admitted to hospital following accidents within the centre had not been submitted by the person in charge to the Chief Inspector, as required.

8. Action required from previous inspection:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Make each resident aware of the complaints procedure as soon as is practicable after admission.

Display the complaints procedure in a prominent position in the designated centre.

Make available a nominated person in the designated centre to deal with all complaints.

Investigate all complaints promptly.

Maintain a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied.

Inform complainants promptly of the outcome of their complaints and details of the appeals process.

Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

Retain records kept under Regulation 39 for a period of not less than seven years after the complaint has been investigated and the complainant is informed of the outcome of, and of the outcome of any appeal arising from, an investigation, or seven years after the resident(*s*) to whom they relate cease(*s*) to be resident in the home, whichever is the longer.

This action was partly addressed but not been completed.

The provider and person in charge informed inspectors that there were no complaints since the previous inspection and the complaints file had no records of complaints, concerns or expressions of dissatisfaction.

A complaints policy and procedure was available. The procedure did not include the current nominated person/complaints officer or detail the independent appeals process. Despite the improvements needed in the policy and displayed procedure, residents and visiting relatives who spoke with inspectors said they felt able to approach staff and communicate any concerns they may have to them or the provider.

Report compiled by:

Sonia McCague

Inspector of Social Services
Social Services Inspectorate
Health Information and Quality Authority

15 May 2012

Chronology of previous HIQA inspections	
Date of previous inspection	**Type of inspection:**
9 September 2011	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
18 November 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☒ Announced ☐ Unannounced
10 June 2010	☒ Registration ☐ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced
8 March 2010	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
31 December 2009	☐ Registration ☐ Scheduled ☒ Follow up inspection ☐ Announced ☒ Unannounced
16 and 17 November 2009	☐ Registration ☒ Scheduled ☐ Follow up inspection ☒ Announced ☐ Unannounced

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Action Plan

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An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report *

Centre:	Mullross Nursing Home
Centre ID:	0366
Date of inspection:	4 May 2012
Date of response:	8 June 2012 and 18 August 2012

Requirements

These requirements set out what the registered provider must do to meet the Health Act, 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

1. The provider and person in charge has failed to comply with a regulatory requirement in the following respect:

The statement of purpose had not been kept under review to ensure it consists of all matters listed in Schedule 1 of the Regulations.

Action required:

Compile a statement of purpose that describes the facilities and services which are provided for residents.

Compile a statement of purpose that consists of all matters listed in Schedule 1 of the Regulations.

Make a copy of the statement of purpose available on request to residents.

Keep the statement of purpose under review.

* The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Make a copy of the statement of purpose available to the Chief Inspector. Notify the Chief Inspector in writing before changes are made to the statement of purpose which affect the purpose and function of the centre.
Reference: Health Act, 2007 Regulation 5: Statement of Purpose Standard 28: Purpose and Function

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Updated statement of purpose has been completed and copy forwarded to regional office for attention of inspector 16 August 2012.	01/06/2012

2. The provider and person in charge has failed to comply with a regulatory requirement in the following respect: Documents in line with Schedule 2, including copies of professional registration certificates, were not available for one part time regular nurse and relief nurses named on the roster. Staff told inspectors they had difficulty maintaining records as required and attributed this to the absence/lack of administration/secretarial support staff in the centre. The activity person in the centre was not rostered for duty.
Action required: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person. Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night
Reference: Health Act 2007 Regulation 16: Staffing Regulation 18: Recruitment Standard 22: Recruitment Standard 24: Training and Supervision

Please state the actions you have taken or are planning to take with timescales:	Timescale:
Provider's and Person in Charge's response: HR files updated and compliant with necessary documents now on file All necessary documentation in relation to one nurse is now on file. Copy of her registration and pin were faxed to the Health Information and Quality Authority's (the Authority) offices on the day of the inspection. I have spoken with the staff team and no one recalls ever stating that they needed administration support to maintain the nursing files and associated documentation. Staff do not have responsibility for the maintenance of HR records, as this falls within the remit of the person in charge (PIC) and the registered provider. The records maintained by the nursing team are the documentation and record keeping set for each resident and no administration support is provided for same. The activity person is now always rostered as per the duty roster for all staff.	01/06/2012

3. The provider has failed to comply with a regulatory requirement in the following respect:

Records were not maintained to ensure completeness, accuracy and ease of retrieval.

Inadequate records were found regarding resident assessments, care plans and treatment given.

Incomplete records of wound charts, medical orders and controlled drug administration was found.

Medical records were insufficient in respect of a sample of residents records reviewed.

Recorded details of medical reviews and investigations were insufficient.

Hand writing on medical records was difficult to read/make out.

Prescription of medicines did not always include the date of the prescription and dosage, and was not signed and dated by a medical practitioner when changes occurred.

Medication management practices were not included in the centre's policy and the policy did not include practices observed.

The directory of residents was not accurate to include the recent admission of a respite resident, transfer of a resident to hospital and omitted the cause of death for one resident.

Action required:

Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so as to ensure completeness, accuracy and ease of retrieval.

Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

Make the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) available to the resident to whom the records refer and made available at all times for inspection and monitoring purposes under the Act.

Put in place written policies and procedures relating to the creation of, access to, retention of and destruction of records.

Retain the records under Regulation 22 for a period of not less than seven years after the resident to whom they relate ceases to be resident in the home.

Reference:

Health Act 2007
Regulation 22: Maintenance of Records
Standard 32: Register and Residents' Records

Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Revised nursing record and documentation set. The nurse team in conjunction with the newly appointed PIC have revised the documentation and record keeping sett within the home. This review includes a number of changes to the record keeping process to address the issues highlighted during the inspection. The following review of practice implemented by the PIC includes: ▪ resident records are now streamlined and in new folders enabling easier access ▪ care plans and assessment documentation is revised every three months ▪ staff are aware of the importance of keeping records up to	01/06/2012

date ▪ to further enable the nurse to update care plans, the nurses have implemented a 'golden hour', setting aside designated time to revised and update the record keeping set. The PIC covers the floor during this time ▪ the DDA register is checked daily by the staff nurse on duty and signed and dated ▪ medical records are now separated from the nursing folders. There is now a locked documentation trolley for the medical notes, stored in a locked office ▪ a meeting with the GP has resulted in more thorough review of the residents medical care needs. Seven residents are reviewed every Monday. The medical records are updated on a weekly basis. A doctors' round is scheduled every week and includes all residents. The GP has again been reminded about the necessity for thorough record keeping.	

4. The provider has failed to comply with a regulatory requirement in the following respect:

Unsafe practices relating to the ordering, prescribing and administration of medicines was found.

Inappropriate and unsafe practice and management of verbal drug orders and of prescription medicines was found.

Medication management practices were not included in the policy available.

Practices of nurse transcribing prescriptions, recording checks, administration and omissions of medicines were unclear and not in line with professional guidelines.

Prescriptions were unclear and incomplete records relating to verbal drug orders leading to omission of drugs was found and attributed to poor access to the general practitioner (GP) by staff.

Action required:

Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation.

Reference: Health Act 2007 Regulation 33: Ordering, Prescribing, Storing and Administration of Medicines Standard 14: Medication Management Standard	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Reviewed the procedures for ordering storing and management of medication within the home. Policies and Procedures reviewed and revised to reflect same. Administration of medicines is recorded on the kardex as per policy and professional guidelines as laid down by An Bord Altranais. The GP now faxes all verbal changes to prescriptions until he amends in writing when he attends in person. New Procedures have been drafted in response to the issues highlighted during the course of the inspection which include: ▪ a new procedure for ordering, prescribing and administration of medication has been developed ▪ a new procedure for taking verbal drug orders has been developed and implemented ▪ the policy on the management of medication is available within the centre and was available on the day of inspection ▪ nurses do not transcribe prescriptions, this is now completed by the GP ▪ GP input to the nursing home has been discussed with the GP. He has committed to more vigilant adherence and response to the needs of the nursing home. This continues to be reviewed and plans for the use of another GP are being developed.	01/06/2012

5. The provider and person in charge has failed to comply with a regulatory requirement in the following respect: Notice to the Chief Inspector had not been provided as required.
Action required: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any serious injury to a resident.

Reference: Health Act 2007 Regulation 36: Notification of Incidents Standard 29: Management Systems	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Clarity sought on the definition of serious incident. All notifications now sent to Chief Inspector as events occur.	01/06/2012

6. The provider and person in charge has failed to comply with a regulatory requirement in the following respect:

The complaints procedure had not been updated to include the current nominated person/complaints officer and independent appeals process.

Action required:

Provide written operational policies and procedures relating to the making, handling and investigation of complaints from any person about any aspects of service, care and treatment provided in, or on behalf of a designated centre.

Ensure the complaints procedure contains an independent appeals process, the operation of which is included in the designated centre's policies and procedures.

Make each resident aware of the complaints procedure as soon as is practicable after admission.

Display the complaints procedure in a prominent position in the designated centre.

Record all complaints and the results of any investigations into the matters complained about. Ensure these records are in addition to and distinct from a resident's individual care plan.

Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Retain records kept under Regulation 39 for a period of not less than seven years after the complaint has been investigated and the complainant is informed of the outcome of, and of the outcome of any appeal arising from, an investigation, or seven years after the resident(*s*) to whom they relate cease(*s*) to be resident in the home, whichever is the longer.

Reference: Health Act 2007 Regulation 39: Complaints Procedures Standard 6: Complaints	
Please state the actions you have taken or are planning to take with timescales:	**Timescale:**
Provider's response: Complaints policy revised to include independent appeals person.	 01/06/2012

Recommendations

These recommendations are taken from the best practice described in the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the registered provider should consider them as a way of improving the service.

Standard	Best practice recommendations
Standard 8: Protection	The person in charge was to familiarise herself with all policies and procedures within the centre. **Provider's response:** She is to carry out a review of all policies.
	Ensure the policy and procedure in relation to the prevention detection and response to abuse is known by all staff to inform practice and protect residents
Standard 29: Management Systems	The person in charge had no access to internet and poor telephone connectivity resulting in limited communication and access to timely and relevant information. **Provider's response:** Ensure effective management systems are in place that support and promote the delivery of quality care services.

Any comments the provider may wish to make:

Provider's response:

Mullross Nursing Home prides itself in the quality of care provided to our residents. Satisfaction surveys from residents and their families demonstrate the good work of the staff team and the quality of life enjoyed by our residents. We intend to work with the resident at the core of our services and continue to utilise the legislation to guide and continually improve our services.

Provider's name: Stephen Buckley
Date: 1 June 2012