SCHEDULE 3

Regulation 19(1)(a)

RECORDS TO BE KEPT IN A NURSING HOME IN RESPECT OF EACH PATIENT

1. The following documents in respect of each patient –
   (a) the assessment of needs referred to in regulation 15(1)(a);
   (b) the patient's plan referred to in regulation 16(1).
2. A recent photograph of the patient.
3. A record of the following matters in respect of each patient –
   (a) the name, address, date of birth and marital status of each patient;
   (b) the name, address and telephone number of the patient's next of kin or of any person authorised to act on his behalf;
   (c) the name, address and telephone number of the patient's general practitioner and of any officer of a HSS Trust whose duty it is to supervise the welfare of the patient;
   (d) the date on which the patient was admitted to the nursing home;
   (e) the date on which the patient was discharged from the nursing home;
   (f) if the patient is transferred to another nursing home or to a hospital, the name of the nursing home or hospital and the date on which the patient is transferred;
   (g) if the patient died at the nursing home, the date and time of death;
   (h) the name and address of any HSS Trust, organisation or other body, which arranged the patient's admission to the nursing home;
   (i) a record of all medicines kept in the nursing home for the patient, and the date on which they were administered to the patient;
   (j) a record of any accident affecting the patient in the nursing home and of any other incident in the home which is detrimental to the health or welfare of the patient, the record shall include the nature, date and time of the accident or incident, whether medical treatment was required and the name of the nurses who were respectively in charge of the nursing home and supervising the patient;
   (k) a contemporaneous note of all nursing provided to the patient, including a record of his condition and any treatment or surgical intervention;
   (l) details of any specialist communications needs of the patient and methods of communication that may be appropriate to the patient;
   (m) details of any healthcare plan relating to the patient in respect of medication, specialist health care provision or nutrition;
   (n) the wishes of the patient regarding any specific arrangements at the time of death;
   (o) a record of falls and of treatment provided to the patient;
   (p) a record of incidence of pressure ulcers and of treatment provided to the patient;
   (q) a record of any restraint used in relation to the patient;
   (r) a record of any limitations agreed with the patient as to the patient's freedom of choice, liberty of movement and power to make decisions.
4. A copy of correspondence relating to each patient.