SCHEDULE 3

Regulation 19(1)(a)

RECORDS TO BE KEPT IN A RESIDENTIAL CARE HOME IN RESPECT OF EACH RESIDENT

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