SCHEDULE 3 Regulation 21(1), (3)

PART I

PERIOD FOR WHICH MEDICAL RECORDS MUST BE RETAINED

Type of patient	*Minimum period of retention*
(a) (a) Patient who was under the age of 17 at the date on which the treatment to which the records refer was concluded.	Until the patient's 25th birthday.
(b) (b) Patient who was aged 17 at the date on which the treatment to which the records refer was concluded.	Until the patient's 26th birthday.
(c) (c) Patient who died before attaining the age of 18.	A period of 8 years beginning on the date of the patient's death.
(d) (d) Patient whose records relate to treatment by a general practitioner.	A period of 10 years beginning on the date of the last entry.
(e) (e) All other cases.	A period of 8 years beginning on the date of the last entry in the record.

PART II

RECORDS TO BE MAINTAINED FOR INSPECTION

1. A register of patients, including –
   (a) the name, address, telephone number, date of birth and marital status of each patient;
   (b) the name, address and telephone number of the patient's next of kin or any person authorised by the patient to act on his behalf;
   (c) the name, address and telephone number of the patient's general practitioner;
   (d) where the patient is a child, the name and address of the school which he attends or attended before admission to an establishment;
   (e) the name and address of any body which arranged the patient's admission or treatment;
   (f) the date on which the patient was admitted to an establishment or first received treatment provided for the purposes of an establishment or agency;
   (g) the nature of the treatment for which the patient was admitted or which he received;
   (h) where the patient has been an in-patient in an independent hospital, the date of his discharge;
   (i) if the patient has been transferred to a hospital (including a hospital vested in the Department or managed by an HSS trust), the date of the transfer, the reasons for it and the name of the hospital to which the patient was transferred;
   (j) if the patient dies whilst in an establishment or during treatment provided for the purposes of an establishment or agency, the date, time and cause of his death.
2. A register of all surgical operations performed in an establishment or by an agency, including –

(a) the name of the patient on whom the operation was performed;

(b) the nature of the surgical procedure and the date on which it took place;

(c) the name of the medical practitioner or dentist by whom the operation was performed;

(d) the name of the anaesthetist in attendance;

(e) the name and signature of the person responsible for checking that all needles, swabs and equipment used during the operation have been recovered from the patient;

(f) details of all implanted medical devices, except where this would entail the disclosure of information contrary to the provisions of section 33(5) of the Human Fertilisation and Embryology Act 1990(**1**) (restrictions on disclosure of information).

3. A register of each occasion on which a technique or technology to which regulation 39 applies has been used; including –

(a) the name of the patient in connection with whose treatment the technique or technology was used;

(b) the nature of the technique or technology in question and the date on which it was used; and

(c) the name of the person using it.

4. A register of all mechanical and technical equipment used for the purposes of treatment provided by the establishment or agency including –

(a) the date of purchase of the equipment;

(b) the date of installation of the equipment;

(c) details of maintenance of the equipment and the dates on which maintenance work was carried out.

5. A register of all events which must be notified to the Regulation and Improvement Authority in accordance with regulation 28.

6. A register of each person employed in or for the purposes of the establishment, or for the purposes of the agency and each medical practitioner to whom practising privileges have been granted, including –

(a) his name and date of birth;

(b) details of his position in the establishment or agency;

(c) dates of employment; and

(d) in respect of a health care professional, details of his professional qualifications and registration with his professional regulatory body.

7. A written record of suspected, alleged or actual incidents of abuse including details of the investigation, the outcome and action taken.

8. A record of all documentation relating to the recruitment process.

9. A record of all training and professional development activities completed by staff.

10. A record of the annual appraisal for each member of staff.

(**1**) 1997 c. 37