SCHEDULE 3

Regulation 17(1)(a)

RECORDS TO BE KEPT IN A CARE HOME IN RESPECT OF EACH SERVICE USER

1. The following documents in respect of each service user—

(a) the assessment referred to in regulation 14(1);

(b) the service user's plan referred to in regulation 15(1).

2. A photograph of the service user.

3. A record of the following matters in respect of each service user—

(a) the name, address, date of birth and marital status of each service user;

(b) the name, address and telephone number of the service user's next of kin or of any person authorised to act on his behalf;

(c) the name, address and telephone number of the service user's general practitioner and of any officer of a local social services authority whose duty it is to supervise the welfare of the service user;

(d) the date on which the service user entered the care home;

(e) the date on which the service user left the care home;

(f) if the service user is transferred to another care home or to a hospital, the name of the care home or hospital and the date on which the service user is transferred;

(g) if the service user died at the care home, the date, time and cause of death;

(h) the name and address of any authority, organisation or other body, which arranged the service user's admission to the care home;

(i) a record of all medicines kept in the care home for the service user, and the date on which they were administered to the service user;

(j) a record of any accident affecting the service user in the care home and of any other incident in the care home which is detrimental to the health or welfare of the service user, 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 care home and supervising the service user;

(k) a record of any nursing provided to the service user, including a record of his condition and any treatment or surgical intervention;

(l) details of any specialist communications needs of the service user and methods of communication that may be appropriate to the service user;

(m) details of any plan relating to the service user in respect of medication, nursing, specialist health care or nutrition;

(n) a record of incidence of pressure sores and of treatment provided to the service user;

(o) a record of falls and of treatment provided to the service user;

(p) a record of any physical restraint used on the service user;

(q) a record of any limitations agreed with the service user as to the service user's freedom of choice, liberty of movement and power to make decisions.

4. A copy of correspondence relating to each service user.