SCHEDULE 3 Regulation 20(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 patient's death
(d) (d) Patient who was treated for mental disorder during the period to which the records refer.	A period of 20 years beginning on the date of the last entry in the record
(e) (e) Patient who was treated for mental disorder during the period to which the records refer and who died whilst receiving that treatment.	A period of 8 years beginning on the date of the patient's death
(f) (f) Patient whose records relate to treatment by a general practitioner.	A period of 10 years beginning on the date of the last entry in the record
(g) (g) Patient who has received an organ transplant	A period of 11 years beginning on the date of the patient's death or discharge whichever is the earlier
(h) (h) 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 the patient's 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 the child attends or attended before admission to an establishment;

(e) where a patient has been received into guardianship under the Mental Health Act 1983, the name, address and telephone number of the guardian;

(f) the name and address of any body which arranged the patient's admission or treatment;

(g) the date on which the patient was admitted to an establishment or first received treatment provided for the purposes of an establishment;

(h) the nature of the treatment received by the patient or for which the patient was admitted;

(i) where the patient has been an in-patient in an independent hospital, the date of the patient's discharge;

(j) if the patient has been transferred to a hospital (including a health service hospital), the date of the transfer, the reasons for it and the name of the hospital to which the patient was transferred;

(k) if the patient dies whilst in an establishment or during treatment provided for the purposes of an establishment, the date, time and cause of death.

2. A register of all surgical operations performed in an establishment, 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 (restrictions on disclosure of information).

3. A register of each occasion on which a technique or technology to which regulation 41 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;

(c) the name of the person using it; and

(d) where the person using the technique or technology is not a medical practitioner, dentist or other competent person, the name of the medical practitioner, dentist or other competent person on whose direction the technique or technology was used.

4. A register of all mechanical and technical equipment used for the purposes of treatment provided by the establishment, 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 Assembly in accordance with regulation 27.

6. A record of the rostered shifts for each employee and a record of the hours actually worked by each person.

7. A record of each person employed in or for the purposes of the establishment, which shall include in respect of an individual described in regulation 18(1) the following matters—

(a) the person's name and date of birth;

(b) details of the person's position in the establishment;

(c) dates of employment; and

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