# PROCEDURE FOR RECORD KEEPING FOR HEALTH VISITING

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<th>Issue Version</th>
<th>Purpose of Issue/Description of Change</th>
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<td>To promote safe and effective record keeping for all staff working within the Health Visiting Service</td>
<td>May 2016</td>
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<td>Health Visiting Service</td>
<td>Quality, Patient Experience and Risk Group</td>
<td>May 2013</td>
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Section: Professional Standards/Information Governance

IG06 (formerly CP32)

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**UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM TRUST WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION**
### CONTROL RECORD

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<td>HV Service Managers</td>
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<td>Equality Assessment</td>
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### VERSION CONTROL RECORD

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Status – New / Revised / Trust Change
INTRODUCTION

Wirral Community NHS Trust is committed to high standards of record keeping, to ensure safe, effective high quality nursing care for its service users. The Nursing and Midwifery Council (2007) state that:

‘Record keeping is an integral part of nursing, midwifery and specialist community public health nursing practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.’

AIM

- To outline record keeping responsibilities for all staff working in the Health Visiting service.
- Provide specific guidance relating to the Health Visiting service, which builds on existing Wirral Community Trust (CT) Health Records Policy and Code of Conduct for handling personal identifiable information.
- The procedure will inform existing and new staff with all detailed information relevant to Health Visiting.
- All staff must comply with the CT Health Records Policy, which underpins this procedure.

OUTCOME

All staff working in the Health Visiting service will comply with this procedure. Record keeping standards are audited yearly.

THIS PROCEDURE SHOULD BE READ IN CONJUNCTION WITH THE FOLLOWING NHS WIRRAL POLICIES AND NMC GUIDANCE:

- Wirral CT Health Records Policy.
- Mobile Phone Policy.
- Health and Safety Policies.
- Consent Policy.
- LSCB safeguarding children’s procedures.
- Failure to Gain Access Policy.
- Incident Reporting Policy.
- Wirral CT Code of Conduct for Handling Personal Identifiable Information.
- Community Nursing Supervision Policy.
- Wirral CT Information Governance Policies.
EXAMPLES OF RELEVANT DOCUMENTATION:

- Health visiting records.
- Personal child health records (PCHR).
- Prescription sheet.
- Faxes/Memos.
- Referral Forms.
- Telephone message records.
- Diaries.
- Clinic cards.
- Photographs (only if parental consent obtained using Photography Consent Form/Communications Department).
- Computerised records – authorised usage given by Wirral CT to ensure full compliance with Information Governance standards for the NHS.

TARGET GROUP

All Health Visitors, registered and non-registered staff employed by Wirral CT, Post registration students or return to practice students as part of their curriculum objectives, working under the supervision of a named mentor.

TRAINING

All staff in the Trust are required to comply with mandatory training as specified in the Trusts mandatory training matrix. Clinical staff are also required to comply with service specific mandatory training as specified within their service training matrix.

RELATED POLICIES

Please refer to relevant Trust policies and procedures.

RECORD KEEPING TRAINING

- All community staff attend Essential Learning every two years.
- All new members of staff are inducted and informed of Wirral CT Policies and Procedures.
- Every new member of staff is allocated a preceptor for 6 months to support any identified learning needs in relation to record keeping.
- All Health Visitors and registered nurses must comply with continuing professional development in relation to record keeping standards to maintain registration with the NMC.

CONSENT

Refer to the CT Patient Information and Consent Policy.
CONFIDENTIALITY

Appropriate information sharing according to the information sharing protocol and Caldicott guidelines. If a practitioner is in doubt then seek advice from Manager and/or Caldicott Guardian.

RELEASING INFORMATION

Under no circumstances must records be released directly to any person without following the recognised procedure.

Seek advice from HV Managers for any requests, either written or verbally, from solicitors, police or the media re access to health records. It is imperative that members of staff, who are contacted by the media, contact the Communications Department as a first step.

For further information, please refer to CT Health Records Policy and the Media Policy.

SAFE STORAGE OF RECORDS IN CLINIC BASES AND WHILST TRAVELLING

Staff must take all reasonable efforts to safeguard confidential client records and personal identifiable information, including the following measures:

- Patient identifiable information, including Health Visiting records, diaries etc. must not be left unattended in cars.
- All efforts must be made to return Health Visiting records to the base at the end of the span of duty. In the event of working out of hours all staff must ensure that patient/client information is not left in their car overnight and kept secure in their own home. Line managers need to be informed of any activity out of normal working hours.
- Patient identifiable information must not be left anywhere where it could be viewed by a member of the public.
- Records must be stored in a secure room and filed appropriately when not in use.
- Personal identifiable information should not be visible to the general public at reception areas.
- No IT equipment can be used to store patient information unless it has been supplied via WHIS staff (Wirral Health Information Systems).
- All records must be carried in a bag, supplied when joining the organisation.

All employees with access to personal identifiable information have a duty to safeguard that information under the confidentiality code of conduct. Administration of patient related information must only be delegated to another team member if they are aware of their responsibilities under this code.

COMPILING RECORDS FOR STORAGE – HEALTH VISITING

When the youngest child in a family reaches the age of five the Family Health records must be sent for storage. The records for children with complex/special needs must be forwarded
to school health. The only time a Family Record is kept for longer is when a new child is born.

Records should be compiled by HV clerical support and sent for storage in the following way:-

- Request designated boxes.
- Record in the birth book the destination of the records.
- Separate records into year of birth and month of youngest child.
- File all family record cards and any “additional records” e.g. Clinic Cards together.
- Label box by name of clinic, type of record, year of birth.
- Update archive database.

DELEGATION AND SUPERVISION OF RECORD KEEPING STANDARDS

It is the responsibility of every Health Visitor, or registered nurse who delegates care to non registered staff, to have a system in place to supervise the standards of record keeping within the team. There needs to be evidence that this has taken place e.g. as part of team meetings, one to one meetings, peer review, part of personal developmental reviews and during management supervision. As a minimum standard this needs to occur every 3 months or earlier if any concerns noted with record keeping practice.

Management supervision is applicable to all grades of staff working within the Health Visiting teams. Two sets of Health Visiting records will be reviewed as part of management supervision.

All staff that deliver direct client care will use the same health record.

CRITERIA FOR CASELOAD MANAGEMENT

Wirral CT requires the filing system across the Health Visiting service to be consistent, efficient and comply with all information governance standards. This will also enable bank staff to access the records. This will form part of the annual record keeping audit. All records will be filed alphabetical by youngest child’s surname unless there is a problem with storage then Universal, Universal Partnership and Universal Partnership Plus can be filed separately.

All sections in filing cabinet are to be clearly labeled.

FAMILY HEALTH RECORD

There is only one family health record per family.

A family record is raised for each family at:-

- Antenatal contact visit:
- On transfer into Wirral CT.
- If the original record is lost; a second set must only be raised when every effort has been made to locate the original. If the original is not found a new record must be started clearly indicating that this is a replacement. Contact Line Manager and complete datix on line.
This is the only record routinely used for recording information about the family. All members of the Health Visiting team and post registration Health Visiting students should contribute to this record. There should only be one system across Wirral CT and secondary records should not be raised for any reason, as this causes problems with continuity of care. In ongoing safeguarding cases, records may become unwieldy in size. In such cases, a second family record may be commenced and clearly marked as a second volume. The commencement of the second record needs to be clearly recorded in the first record and filed together. This must be noted in the birth book as a cross reference.

**INDIVIDUAL CHILD HEALTH SECTION**

Each child will have an individual section within the Health Visiting Family Record to record information pertaining to the child and each subsequent child.

This record should contain essential health information for any contact made with family members which relates to that particular child.

The aim is to provide a record, which includes the following points:

- A concise, legible and contemporaneous record (if your writing is illegible please print clearly).
- Provide evidence of partnership working with the family / client.
- Demonstrate planned health interventions outcomes that are evidence based / best practice with review dates.
- Where the contact took place e.g. home or clinic.
- What was the purpose for the contact.
- Who was present at the contact.
- What interaction/intervention took place at the contact.
- Full name, date of birth and NHS number on each individual page.
- Parent / carers consent to health interventions with the health visiting service.
RECORDING OF CHRONOLOGICAL SIGNIFICANT EVENT

SEE APPENDIX 1.

MULTI-AGENCY RISK ASSESSMENT COMMITTEE (MARAC) – On disclosure of a domestic violence incident, complete MARAC form with person reporting incident, fax to MARAC co-ordinator and file copy in family health record.

ADDITIONS WHICH RELATE TO THE FAMILY RECORD ONLY

All hospital discharge letters, referrals to other departments or agencies etc:
- Need to be dated and signed as evidence it has been read.
- Filed in the appropriate section of the record in chronological order.
- Added to chronological events – if relevant.

All additional information needs to be held securely in place.

CLINIC CONTACT CARD

A clinic contact card is raised for each child under school age within the family on attendance at any clinic.

Clinic contact card must contain:-
- Name of child, family address, child’s date of birth, NHS number, general practitioner, birth weight, gestation and team/ Health Visitor name.
- Date and child's age at each contact in weeks for first 12 months.
- Bullet point details of observations and any advice given
- Weight in kilograms and in relation to centile chart.
- Other measurements if appropriate in metric.
- Sign and print full name and designation.

All clinic cards have the following pre-printed:
“Weight will be nude unless otherwise stated”.

Accurate recording of a child’s growth on a centile chart is a vital part of any child assessment (also consider consent issues prior to asking parents/carers to undress children prior to weighing or examination).

FILING / STORAGE

All clinic contact cards need to be “married up” with the family record when:
- The child reaches the age of five/or in full time education.
- In cases of adoption.
- The child transfers out of area.
PERSONAL CHILD HEALTH RECORD (PCHR)

This record is a summary of the child’s health care and should be completed as fully as possible at the time of the contact. Parent/carer should be encouraged to take the PCHR with them to any health appointment for the child.

Encourage parent/carer to record any health information they consider relevant to the development of their child. If parent/carer forgets to bring the PCHR, record any advice on the clinic contact card and record PCHR not available.

Health information relating to other siblings or the parents should not be recorded in this record.

In the event of a PCHR being lost, this information should be recorded in the child’s record and a new book requested from:

Health Visiting Office Telephone: 0151 514 2888.

CENTILE CHARTS FOR PCHR

- Specific Centile charts and inserts for the PCHR are available for children with Downs Syndrome. Available from the Health Visiting Office or contact direct the Downs Syndrome Association. There is a cost to this, so only a small stock is held.


- Specific centile charts are available for children with Turner’s syndrome. Available from the Community Paediatric Dietician at Wirral University Teaching Hospital NHS Foundation Trust. Telephone: 0151 678 5111.

SAFEGUARDING CHILDREN

SEE APPENDIX 2 – SAFEGUARDING GUIDELINES FOR FILING

All details regarding Safeguarding concerns must be filed appropriately and recorded in the particular child’s section of the family health record.

The particular child’s record must include:

- Safeguarding summary sheet.
- Details of key workers, organisations and agencies and telephone numbers on family health record.

Any telephone referrals to the CYPD regarding a family with safeguarding issues must always be followed by completing a multi-agency request for services form (MARS) within 24 hours, a copy of which must be kept in the appropriate section of the health record.
MISSING FAMILIES

Information and details of missing families, where there are serious safeguarding concerns are sent across Wirral Community NHS Trust, to alert all relevant staff. These lists must be checked by all staff against their caseloads and signed as seen. They must then be filed in on a designated ‘Missing Families’ folder for future reference and kept on file for 1 year.

It is the responsibility of all Health Visitors when completing transfer in and antenatal visits to families in Wirral, to reference against the ‘Missing Families’ lists for the previous 12 month period held in the Health Visiting office.

In the event of the Health Visitor identifying a missing family they must notify the Central Advise and Duty Team on 606 2006.

CENTILE CHARTS

A4 Centile Charts are required for all children who are “cause for concern”; these can be obtained from the Health Visiting Office. This is essential where a child’s growth rate is being monitored. If in doubt, guidance can be sought from the safeguarding team.

LOOKED AFTER CHILDREN (LAC) AND ADOPTED CHILDREN - REFER TO CLINICAL PROTOCOL FOR THE TRANSFER OF HEALTH VISITING RECORDS.

SEE APPENDIX 3 FOR LAC GUIDELINES FOR FILING

The Wirral adoption team will let Named Nurses for LAC know via letter when a child is placed in a pre-adoptive placement within Wirral. The Named Nurses for LAC will send a copy of the letter to the Health Visitor. The same process applies when Wirral adoption team are informed that a child from another area is placed on Wirral in a pre-adoptive placement.

It is the responsibility of the current Health Visitor to request previous Health Visiting Service records as soon as possible, after being notified. The previous Health Visitor forwards the records to the current Health Visitor and records in birth book that the child has moved to a pre-adoptive placement.

ONCE A CHILD IS ADOPTED – Refer to Clinical Protocol for the Transfer of Health Visiting Records

Once notification of adoption is received, close old records and raise new ones.

Complete two change of details forms one with old details. Where new details are requested mark with not known. The other complete with new details. Where old details are requested mark with not known.

Transfer health details to new record. Where it is felt necessary to include hospital letters: photocopy original, block out child’s previous name and write new name in. Photocopy again and put photocopy in child’s new records.
Seal old records in a brown envelope, mark with child’s original name and DoB on the front of envelope. Store old records for archiving.

Advise other health professionals of new name as appropriate.

The child will be issued with a new NHS number.

THE TRANSFER TO SCHOOL NURSE SERVICE

Please refer to the Clinical Protocol for the Transfer of Health Visiting Records Within and External to Wirral Community NHS Trust.

BIRTH BOOK

This must be kept up to date with all the relevant information, at all times.

There must be one Birth Book for each Health Visiting team. The Birth Book is the main system used to track records that have transferred within or outside of the Wirral. In cases where children in the same family have differing surnames this needs to be cross-referenced in the Birth Book.

Birth Books should be stored at the clinic base and be readily accessible. Full books should be kept for a period of 25 years. New birth books can be obtained from the Health Visiting Office.

RELEVANT INFORMATION

Parental Responsibility Order
In cases where this has been obtained, a copy needs to be requested and kept in the Family Health Record. This ensures that staff are aware of who they can share information with regarding a child's health.

Referral Forms
Multi-purpose referral forms are available for audiology, speech therapy etc. there are three copies; one for service being referred to, one for the parent and one copy as evidence the referral has been completed, this copy should be filed in the relevant section of the Family Health Record.

Team Diaries/Daily Work Plans
All staff delivering direct care to clients in the Health Visiting service must complete these to cover the forthcoming week's plan. They need to be left in a visible position in the office, with a copy for clerical support, if in a separate office. This will help colleagues to inform clients of availability to return calls and to follow Wirral Community NHS Trust Lone Worker Policy. If diary work plans are held in reception area, they need to be in a secure position as they contain full details of a client’s address. Individual diaries are to be left in base at the end of the working day. Diaries/team diaries need to include DNA and cancelled visits either by client or Health Visitor.
The plan needs to include the order of home visits and the time expected to return to base. This information is essential for complying with the ‘Lone worker Policy’ and essential should any family, colleagues or clients need to contact you in an emergency. If unable to return to base there must be an identified person to contact to inform of your safe conclusion of home visits. There needs to be a shared system in each base to facilitate this process and to share with relief and bank staff.

**Work Diaries**

Only minimal client related data to be recorded in work diaries. Diaries should be stored at base, when completed at the end of the year and kept for a period of three years. After this period diaries must be shredded, as they contain client related information.

Do not record any patient clinical information in diaries as they form part of a patient’s record.

**Telephone Calls**

All client related health advice needs to be documented directly into family record, or on the agreed client information form. Incoming messages must to be written on a Wirral CT telephone message book (which has a carbon copy) and a copy placed in the clients record. Messages left for staff must be signed, with title and dated, as evidence, it has been read. Wirral CT telephone message books must be kept for three years and then shredded.

**CLINICAL INCIDENTS**

Any incidents relating to record keeping must be reported following the Wirral Community NHS Trust incident reporting policy.

**REFERENCES**

Data Protection Act 1998


[www.doh.gov.uk/ipu/confiden](http://www.doh.gov.uk/ipu/confiden)

NHS (2003) *Essence of Care - Patient Focused Benchmarks for Clinical Governance*

Nursing & Midwifery Council (2007) Guidelines for Records and Record Keeping’

[www.dh.gov.uk](http://www.dh.gov.uk)

Wirral Code of Conduct for handling personal identifiable information (2008)
Appendix 1
Recording of Chronological Significant Event Flowchart

Always:
- Check address on all information filed is consistent with address on the records
- If changed record in appropriate section of notes and inform other agencies involved with family

A & E, Unplanned care and Therapy reports e.g., speech and language, are triaged by the Health Visitor Team Leader or delegated member of the team, when received at base and signed and dated.

For children/families that have active packages of care details are recorded on chronological significant events form and any actions taken detailed in the records. Documents are then filed by the named Health visitor.

For children/families that do not have active packages of care details are recorded on chronological significant events form by any member of the Health Visiting team. Documents are then filed and records returned to filing cabinet. However if more than one ‘Failure to Attend’ to any service recorded on chronological significant events form within a 6 month period, bring to the attention of the Health Visitors who will record actions taken in records.

For children and families that do not have active packages of care details recorded on chronological events form by the Health Visitor Support Worker, CHN or CNN. Documents are then filed and records returned to the filing cabinet.

For children/families that do not have active packages of care details are recorded on the chronological significant events form by any member of the Health Visitor team. Documents are then filed in records however, if more than one Failure to Attend’ to any service recorded on chronological significant events form within a 6 month period, bring to the attention of the Health Visitors who will record actions taken in records.

Appendix 2
Filing Guidelines for Safeguarding Children Documents in Health Visiting Records

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<tr>
<th>Safeguarding Documents</th>
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<th>Child’s Record</th>
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IG06 Procedure for Record Keeping for Health Visiting – Version 1
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<td>Team Around the Child and Support Meeting Proforma</td>
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<td>Notification of Initial Conference</td>
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<td>Report documentation for Child Protection Conference</td>
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<td>Child Protection initial Conference Minutes</td>
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<td>Outcome of conference recorded in each child’s records</td>
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<td>Child Protection Plan</td>
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<td>Core Group Minutes</td>
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<td>Child Protection Review Minutes</td>
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<td>Notification of date of Child Protection Plan ended</td>
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<td>Child in Need Plan</td>
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<td>Looked After Children Documents</td>
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<td>Safeguarding Transfer Summary Sheet</td>
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<td>Safeguarding Supervision Forms</td>
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Appendix 3

**Filing guidelines for Looked After Children documents in Health Visiting Records**
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<th>Looked After Children’s Document</th>
<th>Family Records</th>
<th>Child Records</th>
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<td>Transfer summary sheet</td>
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<td>Health Visitor Report documentation for IRO and Social Worker</td>
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<td>Immunisation record form</td>
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<td>LAC supervision documentation</td>
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