East London NHS
NHS Foundation Trust

ELECTRONIC RECORD KEEPING AND MANAGEMENT PROCEDURE FOR INTEGRATED HEALTH VISITING/ SCHOOL HEALTH SERVICE/FAMILY NURSE PARTNERSHIP AND SPECIALIST HEALTH VISITORS

Children and Young People Services
Community Health Newham Directorate

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Version Control Summary

Version	Date	Author	Status	Comment
1.0	2009	T. Chigodora/ M. Sakupwanya/ R. Frazer / O. Gamor	final	Record Keeping and management procedure: Paper records.
2.0	2012	T. Chigodora/ Agnes .Adentan	final	Record Keeping procedure and management for integrated health visiting and school nursing policy
3..0	August 2015	Odilia Gamor and Hazel Thomas. Contributions from Tatenda. Chigodora, O. Adebayo, M. Ogunsola. S. Tangayi, Z. Vowles, E. Bloye	Final Draft	Procedure/policy is written in line with changes from record keeping and management procedure for integrated health visiting and school health service 2012 – Version 2: to electronic records management and procedure for HV/SN/FNP and specialist HVs 2015 version 3. This represents a first version of electronic record keeping management and procedure document.

Executive Summary:

East London Foundation Trust has full electronic client record keeping systems. All paper records have now been uploaded to RiO electronic client management system fully as of November 2015. The electronic version now supersedes the paper version of records management 2012.

This policy/procedure will be uploaded to the intranet as version 3.0: this will be the first full electronic procedure written after the paper record version 2.0. This procedure/policy is written in line with changes from record keeping and management procedure for integrated health visiting and school health service 2012 – Version 2.0: to electronic records management and procedure for HV/SN/FNP and specialist HVs 2015 Version 3.0.

This policy /procedure represents version 1.0 of electronic record keeping management and procedure document incorporating all specialist health visiting services**.**

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0.0: INTRODUCTION: East London Foundation NHS Trust (ELFT) 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 (2015) states 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.*"

Health records are confidential legal documents. Individual team members are responsible for maintaining the quality of all documentation (NMC Guidelines for records and record keeping 2015)

This procedure is a result of the Trust implementation of electronic records.

This procedure must be used to guide record keeping practice by Health Visitors, School Nurses, Associate School Nurses (ASN) Community Nursery Nurses (CNNs), Immunisation Nurses, administrators, CCHIT, Students HVs/ SNs and Family Nurses (FN) (FNs also follow specific guidance from the Family Nurse Partnership Unit). Health Professionals may, in the course of their duties have to attend court, and will need to ensure their records are legible, factual and contemporaneous.
It is the duty of all the above professionals to ensure accurate documentation and good record keeping minimising risk to the clients and the Trust as a whole.

The overall purpose of this procedure is to:

- Ensure accuracy of documentation and security of RiO records to minimise RISK.
- To outline record keeping responsibilities for all staff working in the Health Visiting, School Health service and Family nurse Partnership.
- Provide specific guidance relating to the Health Visiting and School Health service, which builds on existing ELFT NHS Trust Health Records Policy and Code of Conduct for handling personal identifiable information.
- To ensure good quality record keeping & management is maintained and an effective cohesive procedure is followed by all users of this document.
- The procedure will inform existing and new staff with all detailed information relevant to Health Visiting, School Health Service and Family nurse Partnership.

All staff must comply with the ELFT Health Records Policy, which underpins this procedure. All staff working in Health Visiting, School Health Service and Family nurse Partnership must comply with this procedure. Record keeping standards will be audited quarterly.

Section 1: ASSOCIATED PROCEDURES

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

East London NHS Trust Health Records Policies

NMC (2015) - Guidance for Nurses and Midwives

Mobile Phone Policy (2009)

Health and Safety Policies (2012).

Consent Policy (2013).

London Safeguarding Children's Board (LSCB) safeguarding children's procedures (2014).

Failure to Gain Access Policy. (No Access: 2014)

Incident Reporting Policy (2014).

Information Governance Policies (2015)

Media Policy – Approval Mechanisms for Press Releases (2015)

Community Nursing Supervision Policy (2014).

Code of conduct for Handling Personal Identifiable Information (2014)

Policy for Records Management, East London NHS Foundation Trust 2010

Framework for Assessment of Children in Need and Their Families (DOH 2000)

Procedure for action with regard to missing families and children (Community Health Newham 2014)

Procedure for action with regards to no access visits, failed contact and refusal of services (Health Visiting and School Nursing) (Community Health Newham Directorate March 2015)

Procedure for the transfer of Child Health records where there are safeguarding concerns (Community Health Newham 2014)

Procedure for change of health professional- (Community Health Newham 2014).

Data Protection Act (DPA) 1998 became operative on 1st March 2000

RIO Process Maps for Health Visiting (East London NHS Trust 2009)–accessed on "N"Drive: Departmental Shared/Provider RiO User RiO /Process Maps

RiO Process Maps for School Nursing (East London NHS Trust 2009)–accessed on "N"Drive: Departmental Shared/Provider RiO User Group/Process Maps

RiO handbook for School Health and Health Visiting (and 2014)

School Health Growth Monitoring procedure (2015)

Clinical Record Keeping: National Unit Guidance for Sites (FNP National Unit, Tavistock and Portman NHS Foundation Trust, August 2015)

Supervision Record Keeping: National Unit Guidance (FNP National Unit, Tavistock and Portman NHS Foundation Trust, August 2015)

Transfer of a Client between FNP Teams: National Unit Guidance (FNP National Unit, Tavistock and Portman NHS Foundation Trust, August 2015)

1.2: RESPONSIBILITIES

The responsibility for the management and co-ordination of this procedure, sits with the Integrated Team Managers (ITMs) and the Clinical Team Leaders (CTLs) and Family Nurse Partnership Supervisor (FNP SV) Sickle Cell and Thalassaemia Manager, Child health Administration Manager..

The ITMs/ CTLs/FNPSV will ensure that all staff are aware of the correct methods for record keeping, in line with electronic record keeping and use of the RIO clinical guidance booklet.

This information will be disseminated in team meeting and supervision.

The adherence to the procedure will be monitored through record keeping audit. However where there are issues of child protection and safeguarding: the child protection supervisors will inform the CTL/ITM/FNP SV who are responsible for management of the staff member.

Any breaches of procedure will be investigated by the CTLs/ ITMs/FNP SV and non- adherence will be followed up using disciplinary procedures as appropriate.

The Health Visiting/ School Nursing/FNP records will be audited at least quarterly and more frequently by random dip sampling if indicated.

Examples Of Relevant Documentation**:**

- Electronic Health visiting records. (RiO
- Electronic School Health records.
- Personal child health records (PCHR).
- Prescription sheet/pad
- Client related emails
- Faxes/Memos.
- Electronic Referral Forms.
- Telephone message records.
- Electronic Diaries.
- Staff computerised records

Computerised records – authorised usage given by ELFT to ensure full compliance with Information Governance standards for the NHS.

1.3: TARGET GROUPS

All health Visitors (HVs), School Nurses (SN), Family Nurses, registered and non-registered staff employed by ELFT, Pre and Post registration students or Practice Teachers (PT) as part of their curriculum objectives, working under the supervision of a named mentor child health administration team.

Other Team Members:
When students document in the records of children the records must be validated by HV/SN or the PT.

1.4: SMARTCARDS AND PASSWORDS

Information systems passwords and smartcards must not be shared.
Similarly, systems must not be left open to access when you are away from your terminal. All staff must log off when they have finished using the computer.
All staff must remove their smartcards from the docking station when not at the desk.
Follow information governance policy on protecting client information.

1:5 SPECIALIST HEALTH VISITORS

All Specialist health Visitors will be responsible for adherence to this policy and in addition to any other documentation related to their practice area. It is important that whilst maintaining generic health visiting documentation; that all other aspects of documentation in the varied specialist area such as RIO progress notes are clarified not combined. RIO notes can only be combined unless a joint visit has been made therefore joint notes. It is advised that specialist notes should be highlighted for the purposes of clarification. It is important to also note that specialists' letters or notifications to other professionals must be covered with the specialist area cover note or letter head template so that this will not create confusion for other professionals. In addition the specialist practitioner should complete specialist nursing assessment and care plans as per required by the specialist area.

*****All mothers who are **HIV positive** must be referred to the Specialist Sexual Health HV. All HCPs must avoid identifying the parent or child as HIV positive but to write on the records" "mother has retroviral condition" or "baby is on anti-retroviral medication" on a need to know basis. The specialist HV must document on the generic notes for health visiting and also on the reproductive and sexual health notes where this can only be assessed by sexual health staff.

*** (*This pertains to HIV clients and national recording protocols*)**

1:6 Family Nurse Partnership Procedures:

Transfer of Family Nurse Partnership Records to the Health Visiting Service
When the child turns two or is transferred to the Health Visiting service earlier, both the mother's and child's records must be discharged from the FNP caseload with discharge reason as: "case closed" by the FNP Quality Support Officer (QSO) and comment must be entered on RiO progress notes stating "client completed programme, discharged from FNP caseload and transferred to the Health Visiting service and team transferred to must be stated.

If a client disengages from FNP/requests transfer to the Health Visiting Service before the child reaches two years both the mother's and child's records must be discharged from the caseload with discharge reason as: "transferred care to another provider (CN)" by the FNP Quality Support Officer (QSO) and comment must be entered on RiO progress notes stating "client declined further engagement with FNP, client transferred to local health visiting service stating which team transferred to.

The FN must complete the FNP transfer summary and must email and conduct a telephone handover with the CTL/HV who care is being transferred to. The FNP transfer summary is uploaded to the mother and child records.

(see also Transfer of a Client between FNP Teams: National Unit Guidance (FNP National Unit, Tavistock and Portman NHS Foundation Trust, August 2015)

Transfer of Family Nurse Partnership Records Out of Borough
• For children moving out of borough the FN must complete the FNP transfer summary and a telephone hand over of the records to the FN/HV out of borough is required.
• The QSO must complete a HQ4 upload to the documents of child and send to the Central Child Health Information Team to inform them of the transfer.
• For children on CP plan/ CIN plan or LAC the record, must be sent to the safeguarding team: follow procedure for transfer out of CP children (2014).
• The QSO must discharge the child as "moved out of area".
(see also Transfer of a Client between FNP Teams: National Unit Guidance (FNP National Unit, Tavistock and Portman NHS Foundation Trust, August 2015)

Section 2: PROCEDURE FOR RECORD KEEPING

2:1 Demographic Data:

- All staff must check demographic details of children to correspond with the spine records according to the recent date of change and edit as required.
- All children must have all their families linked with the full demographic details.
- All family members must be linked.
- The spine records must correspond with the local data whichever is the most recent.
- Each time a record is opened on RIO, the member of staff must ensure that the demographic details are up to date and view significant events.
- Health Care Professionals (HCP) must ensure that fathers and siblings records are linked and synchronised with the same addresses if appropriate.
- The HCP must ensure that all records contain essential up to date telephone information on the Local Spine so that contact can be made with family members in relation to a particular child.

2:2 Safeguarding Records/ Records Needing Alerts

- HCPs must set up Alerts on RiO appropriately.
- Alerts must be updated to reflect the child's needs when a review takes place: for example HV/SN must remove alerts when it is no longer applicable.
- The HCP must write correct date of when a child moved from Child Protection Plan (CPP) to Child in need Plan (CIN).
- All children de-registered from a plan should be entered on the progress notes and the alert altered to reflect the child's safeguarding plan.
- All children on a universal Plus (UP) caseload and Universal Partnership Plan (UPP) caseload must have a named HV/SN/FN.
- All children on a plan must be presented for supervision quarterly.

2.3: Procedure For Completing Progress Notes

- Parent / carers consent to health interventions with the service must be obtained at all first contacts.

- The date and time of contact must be captured on RiO progress notes.
- The assessment, action plans and future involvement must be recorded to include the following: by when, where and by whom.
- All open episodes of care must be timed and specific action required must be stated in the progress notes: actioned timely and closed.
- The nursing evaluation and clear outcomes must be entered on progress notes as soon after the event as possible and not more than 48-72 hours after the event.
- Demonstrate in the progress notes planned health interventions outcomes that are evidence based and best practice with review dates.
- The voice of the child must be documented
- Where the contact took place e.g. clinic, home or school setting.
- What was the purpose for the contact?
-
- Who was present at the contact?
-
- What interaction/intervention took place at the contact?
- What was observed at the contact including environmental issues identified
- The entry must be spell checked.
- All entries must be validated.
- All entries done by students must be validated within the specified time frame by their Practice Teachers and/or Mentors.
- The entry must be marked as a significant event where appropriate (e.g. referrals, receipt of Merlin notification; concern hospital letters/notifications, all child protection or child in need/care minutes).
- If a child draws a HCP attention to Female Genital Mutilation (FGM) during an assessment or contact: complete the FGM form on RiO and follow the safeguarding procedure for Triage (2014). Enter in progress notes and add to significant event.

- Each team must maintain a standardised agreed message tracking system to ensure that all messages are captured and acted upon and documented. It is the responsibility of each member of staff to check the message system on their return to base. In the case of sickness/annual leave all health visitors and school nurses must inform their clinical team leader about outstanding work and any appointments.

- The CTLs must take responsibility to re-allocate work, where the HV or SN is off sick; in the case of the school nurse, the CTL must inform schools affected. In cases of staff on long term sick the CTL must allocate safeguarding work to other team members. The CTL must respond to any urgent actions required by the affected schools and services planned for the short term and long term.

- Where a colleague takes message regarding a family/child this must be documented immediately into RiO records stating any action taken and hand over to the named HV/SN.

- All HCPs must not copy and paste emails containing/and pertaining to other service users' referrals.

- All HCPs must not copy and paste emails containing/and pertaining to other service users' referrals.

- All emails copied and pasted in client records must be related directly to that particular client/ child.

- All HCPs must avoid writing the term HIV in the progress notes on RiO.

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

1. To prevent breach of confidentiality of data

2. A concise, legible and contemporaneous record.

3. Provide evidence of the use Assessment Framework

4. Provide evidence of partnership working with the family / client.

5. Provide partnership working with other providers, stakeholders and partners.

6. Provide a chronology of sequence of events.

2.4: BOOKING AND OUT-COMING APPOINTMENTS- HVs/SNs/ASNs/CNNs:

- All appointments must be booked via the Monthly Team Planners on RiO.
- All appointments must state the location and type of appointment
- All appointments must have intended activities attached to it.
- Complete the comment box if necessary : using "crib sheets provided" for all children who the intended activities cannot be identified on RiO.
- All appointments completed or not completed must be outcome from the HCP RiO diary: to reflect the outcome of the appointment.
- When writing a report or letter for a child, the child's name must be added to the HCP diary; date and time and attach intended activities: for example "report writing" or "letter writing" and must outcome as a "non-face-to-face contact achieved".
- All completed outcomes must have a main activity and actual activities recorded before outcome is saved.
- When out-coming your diary if the contact was a non-face-to-face contact enter: "non-face-to-face" contact achieved.
- Enter all face-to-face contact as "visit achieved" or "did not attend" if mother did not attend the appointment.
- For all Telephone contacts: enter: "Telephone contact achieved" or "Telephone contact -no response".
- For all group activities enter: Activity type, location, name of group, venue, type of group including topic and number attending.
- For no access visits: enter "visit no reply" and record on progress notes and validate the usual way.

***Please note comments for booking appointments for FNP**

- FNs book appointments through their individual RiO diaries
- FNs do not allocate activities to their appointments as they record their visit allocation on the FNP Information System
- FNs do not allocate activities to their appointments as they record their visit allocation on the FNP Information System
- All FNs must enter all face-to-face contact as "visit achieved" or "attended -follow up 1 week" or "attended -follow up 2 weeks" as appropriate according to stage of programme and visit schedule or "did not attend" if mother did not attend the appointment.

2.5: NEW BIRTH VISITS

Following a new birth visit the HV/FN must complete the New birth review of the baby and templates in the child's records. All further action and plan must be documented in the progress.

Mother's assessment must be documented in the mother's records and templates on RiO in accordance with the HV operational framework policy. (HV operational Policy, 2015). All further action and plan must also be documented in the progress notes.

The HV/FN must complete the breastfeeding form on the child's records and maternal mood assessment template on the mother's record on RIO.

The HV/FN must also write the progress notes with action plans in line with the operational framework using the Framework for assessment of children and their families (2000).

All follow up contacts and outcomes must be documented on the progress notes for mother and baby.

2.6: Procedure for Completion of Parent Child Held Records (PCHR) for New birth visits and Health Review Forms

- Following new birth visits and all health reviews the HCP must complete the relevant pages in the PCHR.
  Must be clearly dated, timed and signed with name printed in black ink and with the professional role. All pages must be fully completed with the following:

  1. Child's details as appearing on label or / and current address.
  2. Mother's full details
  3. Name of the GP details,
  4. Father's details
  5. Any other siblings and their nursery/schools
  6. Comments page for the child must be completed with information on action plans, progress monitoring and any follow ups required.

- All contacts must be documented in the PCHR: how the child presented, who they attended clinic with, if any concerns were identified by the parents/guardians and if applicable any advice given must be written in the PCHR.

- When a HCP member writes in the PCHR, the HCP must ensure that a straight line is drawn to the end of the line if writing has finished mid-line.

- No information in respect of the parents must be recorded in the PCHR.

- All HCPs must avoid writing the term "HIV or Retroviral disease" in the PCHR

- White copy must remain in the PCHR
- HCP must detach and bring pink copy to base to assist HCP to enter information onto RiO.
- Information from the pink copy must be used to complete Health Review forms for the new birth visit on RiO, and the copy must then be shredded.
- For FNs: all contacts must be written in the PCHR where a significant event takes place such a developmental review using the Ages and Stages/ Ages and Stages Social and Emotional Questionnaires or growth monitoring is undertaken.
- For Health Reviews follow ASQ procedure **:** (ASQ1 & 3)
- Upload the parent questionnaire onto RiO and update progress notes.

Pease Note: The PCHR is the property of the NHS which is given to parents; however, they may be used in any investigation/ serious case review. In cases of internal review permission should be sought from the parents.

2.7: PROCEDURE FOR NEW CLIENT CONTACT

The HCP must inform Child health Administrators if the client made a self-referral to the team; and a referral must be created as a self –referral by Central Child Health Information Team (CCHIT) and request for records must be made.

If records already received, the HCP must review the records on "client's document view" in RiO to access the transfer-in notes and make a clinical risk assessment.

The HCP must check the monthly team planner to ensure the visit is booked from the planner onto their diary.

At the initial family contact, the family health assessment and child profile must be completed in PCHR and RiO using the *"*Framework for Assessment of Children in Need and Their Families" *(DOH 2000)*

Where further information is not available, this must be documented on RiO progress notes and record updated when information is obtained at subsequent contact. All family members must be linked.

2.8: GUIDANCE FOR RECORDING ITEMS PRESCRIBED BY THE HEALTH VISITOR

- All nurse prescribers are required to keep contemporaneous records that are unambiguous and legible in accordance with NMC "Guidelines for Records and Record Keeping" (2015). The adherence to the procedure must be monitored by the CTLs. However where there are issues of child protection the Child Protection Supervisors must inform the CTLs and ITMs who are responsible for management of the staff).

- HVs must record all items prescribed in the PCHR and onto the child's RiO progress notes.

- All items prescribed by the HVs must be documented in PCHR and RiO and any prescribing decision must be part of the care plan, and evidenced in the assessment of the child.

- The GP must be informed within 48 hours of all prescribed items.

- HVs must work within the local protocols agreed for the recording of prescribing information onto medical records

  .

- If prescribing information is to be faxed to a GP practice the fax cover must bear the confidentiality statement and disclaimer.

*__All prescribers should ensure that they adhere to the Trust Prescribing Policy__ .

Section 3

3.1: PROCEDURE FOR CARE PLANS AT NURSERY AND SCHOOL CONTACT

- The initial family contact must be arranged by the SENCO or responsible person for the individual school or nursery school: the family health assessment and child profile must be completed and protocol for standard care plans must be used to either update or devise a new one with information from the parents and from the hospital discharge information.

- Care Plans must be clearly reviewed with family members and signed as a working document for the school.

- At each follow up contact with the child, the health visitor or school nurse must review on a yearly basis, all care plans and also whenever there are changes before the next review date.

- All care plans must be signed and uploaded to the child's records and must be available on the "document view" with the naming convention.

- The school nurse and health visitor must record action plans in the progress notes and state what the care plan is for, and a medical alert must be added on the child's records.

- The care plan must be uploaded using the naming convention, (for example: School care plan_epilepsy)

- All entries must have the date and time of contact recorded.

- All entries must have a review date.

3.2: MIGRATION OF SCHOOL CHILDREN:

- **Arrival Lists**: Arrivals lists must be processed by the administrators. **(See RIO Process Map 'Migration-Arrivals')**

- **Reception Class Lists:** The Administrator must request lists from schools at the beginning of each term for those children who have turned five years of age the previous term and attending school in Newham. The lists must be processed by the Administrator and entered onto RiO records: the **school attended** must be entered on RiO by the administrator. The address if there is any change must be synchronised with the recent address on the spine and local RiO. The administrator must inform school nurse of the list.

- **Leavers List**: Leavers lists must be processed by the Administrator**. (See RiO Process Maps 'Migration-leavers')**
  All leavers on the UPP (Child protection plan) list must be perused and discharged to the GP by the named school nurse.
  All UP leaver's records must be perused and discharged from RiO as "transfer out".

- Migration lists will be kept in a folder by the Administrator for future reference and deleted or shredded after one year.

3.3: PROCEDURE FOR SCHOOL ENTRY HEALTH ASSESSMENT (SEHA) FORMS: (See RIO Process Maps 'Health Assessment- school entry').

The school nurse must inform school reception staff and Special Educational Needs Co-ordinators (SENCO) about the delivery of the SEHA questionnaires and teacher questionnaires and distribution to all children in reception.

All forms returned must be collected by the school nurse, perused, assessed for any further work to be done, date and sign forms as "perusal completed"

All forms perused must be entered on RiO as perused and completed and action plan to be recorded. If there are any further actions to be carried out with the child after perusal; the school nurse must refer the child to Team UP and allocate a named HCP to the child on the team caseload.

Child must be discharged from the HCP caseload as "activity completed" when action plan is completed and no further work required.
All children with no further action plans must be discharged from the HCP UPP caseload as: "activity completed"

Where further information is not available, this must be documented on RiO and record updated when information is obtained at subsequent contact.

3.4: PROCESSING OF CHILDREN OVER STATUTORY SCHOOL AGE ON RIO

- For young people aged sixteen- eighteen who have special needs, or Looked After Children or are subject to a Child Protection Plan, who remain in school, records are retained on RiO as UPP and with named HCP attached to the child by the School Nurse until they leave school.

- Once the child leaves school the records must be discharged from school health on RiO. School nurses responsible for these children must peruse and discharge the child with a referral letter to the GP informing them that the child /young person had a CP plan.

- All year eleven records for children not in school must be discharged as activity completed. The administrators must draw up a report from RiO and mark all year eleven children as school leavers.

- Records can be retrieved by searching Rio using client NHS number or client ID if required**.**

3.5 UPLOADING OF LETTERS AND REPORTS

Letters and reports must be scanned and uploaded onto RiO as soon as it has been processed – see Scanning Protocol 2014
All electronic letters received by the health visitor or school nurse must be saved and uploaded to the child's record on RiO and marked clearly on the date and time letter received and saved in chronological order.

All Reports and referrals received electronically must be saved and uploaded to the child's records; with the correct details of document and date received and saved in chorological order.

3.6: ADDRESS NOT KNOWN

The HV/SN or HCP must check RiO records on the National spine and update the records on the local spine. If address is not on the National spine then the HCP should follow the process of "address not known" state that address is not known as well as action taken to try and identify address.

3.7: Transfer in – see RiO Process Map 'Transfer in'. The administrator must date stamp and sign any paper records received, and must scan, and upload to the child's records. The administrator must ascertain the team the child belongs to and make a referral to the team. The Administrator must place the notification onto the RiO team planner after perusal and uploading completed.

- For children who have not had any contact with the School Health Service (i.e. a School Entry Health Assessment has never been commenced), the SN

- must discuss the child with a member of school staff at their next routine meeting.

- If a record is perused which shows health concerns for a child aged 0-5 yrs., a home or clinic contact should be made by the health visiting team. The outcome must be noted on RiO progress notes. If the record shows a concern for child over 5-19yrs, the SN will peruse the records and contact the parents and the school and formulate an action plan. The SN must add the child to her UP or UPP caseload.

Section 4:

4.0: TRANSFER OF HEALTH VISITING RECORDS TO SCHOOL HEALTH:

- The Health Visiting Team retains the child's records until the month in which the child turns five. The transfer should include all records pertaining to the child e.g. records from child development centre.

4.1 Universal Care pathway Records:

- When the child turns five, the child's records must be discharged from the caseload as: "discharged to school health" by the health visitor and recorded on RiO. The child must not have a health visiting referral after child turns five.
- The mother's records must remain as a virtual caseload on RiO. If the mother has been allocated a named HV with specific activity; then the HV must discharge the mother from the caseload as soon as the activity is completed.

4.2: Universal Plus (UP)/ Universal Partnership Plus (UPP) Care Pathway:

- Where the child meets the criteria for Child protection or has complex special/medical needs, the HV must have a transfer summary and a direct telephone conversation with the school nurse. For out of borough children a telephone hand over of the records to the school nurse out of borough is required. The Central Child Health Administration team must be informed of the transfer.
- For UPP children on CP plan the record must be sent to the safeguarding team: follow procedure for transfer out of CP children (2014).
- The HCP must write a discharge summary following safeguarding protocol (2014)
- The HCP must complete a HQ4 and upload to the documents of the child.
- The HCP must discharge the child as "transfer out" from the referral page.
- Child's record on RiO must be updated to reflect this handover. See RiO Process Map for 'Transfer of Records', "Procedure for the transfer of Child Health Records where there are safeguarding concerns (2014) and the Procedure for "change of health professional (2014) must be followed.

4.3: TRANSFER OF RECORDS

4.3.1: Transfer out of Universal Records–(Universal pathway records are records that do not need additional input from the universal care offer. see RiO Process Maps 'Transfer Out'). The administrator must inform the HCP by email requesting

the HCP to complete summary of transfer out. The HCP must inform the administrator when the summary is completed and the records must be transferred out. The HCP must discharge the child's referral from the caseload as "transfer out" The process must be completed within 7-10 days.

4.3.2: Universal Plus Care Package: This record pertains to an individual child receiving extra input from the school nurse and any other HCP involved with a child with a long term condition. The record will be perused and progress notes must be written before discharging or transferring to the next HCP. The HCP must discharge the referral from her caseload and transfer to the next HCP as appropriate. A needs analysis and plan of action and follow –up care will be indicated in the records.

All records to be transferred out must be discharged by the HCP doing the discharge as "transfer out of borough". Follow procedure of discharging records in the RiO booklet. **Where the child has moved address the HCP must change the address and synchronise it to the national spine.**

4.3.3: Transfer of Child Protection Records: Universal Partnership Plus: – see RiO Process Maps: "Transfer out Records", Procedure for the transfer of Child Health Records where there are safeguarding concerns (2014) and the Procedure for the change of health professional (2014) must be followed.

4.4: When a young person has left school at the end of Year 11 and continues to have a Child Protection Plan (CPP), the SN will write to the child's GP informing them that the young person has a CPP and is no longer on the SN's caseload as they have left school. The letter sent to GP should be copied to:

- Social Worker
- Parent
- Safeguarding advisor for the school nurse.
- Uploaded onto RiO child record.
- The records must be discharged from school nurse caseload

4.5: YEAR SIX SCHOOLTRANSFER LISTS:

The Administrator must check on RiO and pull the list of all Year Six transfer lists towards the end of the summer term to be processed by the SN. All children's records must be updated on RiO with the new school.

All School nurses must transfer UP and UPP children going to another school from their caseload and must conduct a verbal handover to the receiving school nurse **(See RiO Process Maps 'Transfer to secondary-UP and UPP').**

Related Policies
Refer to relevant Safeguarding Trust policies and procedures.

Section 5: CRITERIA FOR CASELOAD MANAGEMENT

ELFT requires that record keeping and documentation across the Health Visiting, School health service, FNP, and specialist health visiting services must be consistent, efficient and comply with all information governance standards. This will also enable any HCP who has access to RIO; has a "role" assigned and is able to view HV/SN records to be able to access the records. This procedure will form part of the record keeping audit.

5.1 CONSENT

Refer to the ELFT Patient Information and Consent Policy.

5.2: CONFIDENTIALITY

Appropriate information sharing must be adhered to according to the information sharing protocol and Caldecott guidelines. If practitioners are in doubt then they must seek advice from Manager and/or Caldecott Guardian.

5.3: SHARING INFORMATION

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

All practitioners must seek advice from ITMs, FNP supervisor or Senior Nurse/ Lead Nurse and General Manager for any requests, either written or verbally, from solicitors, police or the media regarding access to health records. It is imperative that members of staff, who are contacted by the media, must contact the Communications Department as a first step.

5.4: 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.

5.4.1: RECORD KEEPING TRAINING

All HCP staff must attend record keeping training as required

All new members of staff are inducted and informed of ELFT Policies and Procedures.

Every new member of staff is allocated a preceptor for 1-2 years to support any identified learning needs in relation to record keeping.

All Health Visitors, School Nurses and registered nurses must comply with continuing professional development in relation to record keeping standards to maintain registration with the NMC.

All staff must complete annual Information Governance training (mandatory requirement for Trust).0

Section 6: INFORMATION GOVERNANACE AND RECORD KEEPING

6.1: SAFE STORAGE OF ELECTRONIC/LAPTOPS 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/School Health records, Laptops/Trust Mobile Phone diaries etc. must not be left unattended in cars.

- 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 must be informed of any activity out of normal working hours.
- All practitioners must follow whereabouts procedure and must adhere to the lone working procedure and out of hour's procedure.

- Patient identifiable information must not be left where it could be viewed by a member of the public.

- Personal identifiable information must not be visible to the general public at reception areas.

- IT equipment must not be used to store patient information unless it has been supplied by ELFT (Health Information Systems).

- All Patient information must be carried in Laptops, supplied by the organisation.

- All employees with access to personal identifiable information have a duty to safeguard patient 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.

- Records must be scanned & uploaded into Rio Document as delegated.

6.2: DELEGATION AND SUPERVISION OF RECORD KEEPING STANDARDS

Management supervision is applicable to all grades of staff working within the Health Visiting, School Health teams and the FNP Service.

Two sets of Health Visiting, school health records UP or UPP caseload and FNP records will be audited as part of management one to one supervision

It is the responsibility of every Health Visitor, School Nurse or registered nurse who delegates care to students, to have a system in place to supervise the standards of record keeping within the team. All such staff must show 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 must occur every 3 months or earlier if any concerns are noted with record keeping practice.

All staff who are delivering direct client care must use the same electronic health record.

Section 7:
7.1: Communication:

- School nurse must provide schools with a weekly time table of their whereabouts, which may need to be updated by phone.
- Health visitors/FNs must complete their where- about book at every in and out of their bases. Follow the "Lone Worker Policy" (2014)
- Copy of timetable to also be available at the school nurse's base.
- All HCPs will have a work mobile.
- Health Visitor, School nurse and FNs will be provided with an ELFT laptop and would be able to access ELFT emails and RiO records.
- Nursery schools must have the named Health visitor contact details and base.
- Schools must have the school nurse and the ELFT base contact details
- School must have school nurse ELFT email addresses
- School must have clinical team leader and ITM details
- When HCPs are off sick**:** follow ELFT sickness reporting procedure by informing the clinical team leader who must inform schools affected.
- If school nurse or health visitor or FN is off sick the CTL/ FNP SV must look on RiO and inform the parent/carer, nursery, school, children's centre as applicable to all pre booked appointments can be covered or cancelled.

7.2: Accommodation:

- Work space for school nurse in each school
- Private room for school nurse to see children/parents – may be same office as where she completes documentation. This would be timetabled in advance with school and on RIO HCP diary.
- HVs must work in children's centres, health centres and nursery schools and in the community accommodation with Local authority agreement.
-
- FNs primarily work in clients homes, they may also work in children's centres, health centres, and other community locations as appropriate

7.3: Measurable Outcomes:

- School nurse in school for one session a week (morning or afternoon). This may be a clerical session, but the school nurse can pick up / respond to any urgent problems and emails while in school with their laptop.
- HV/FN will cover work that could not be done by sick/absent colleagues.

Appendix A (HQ4)

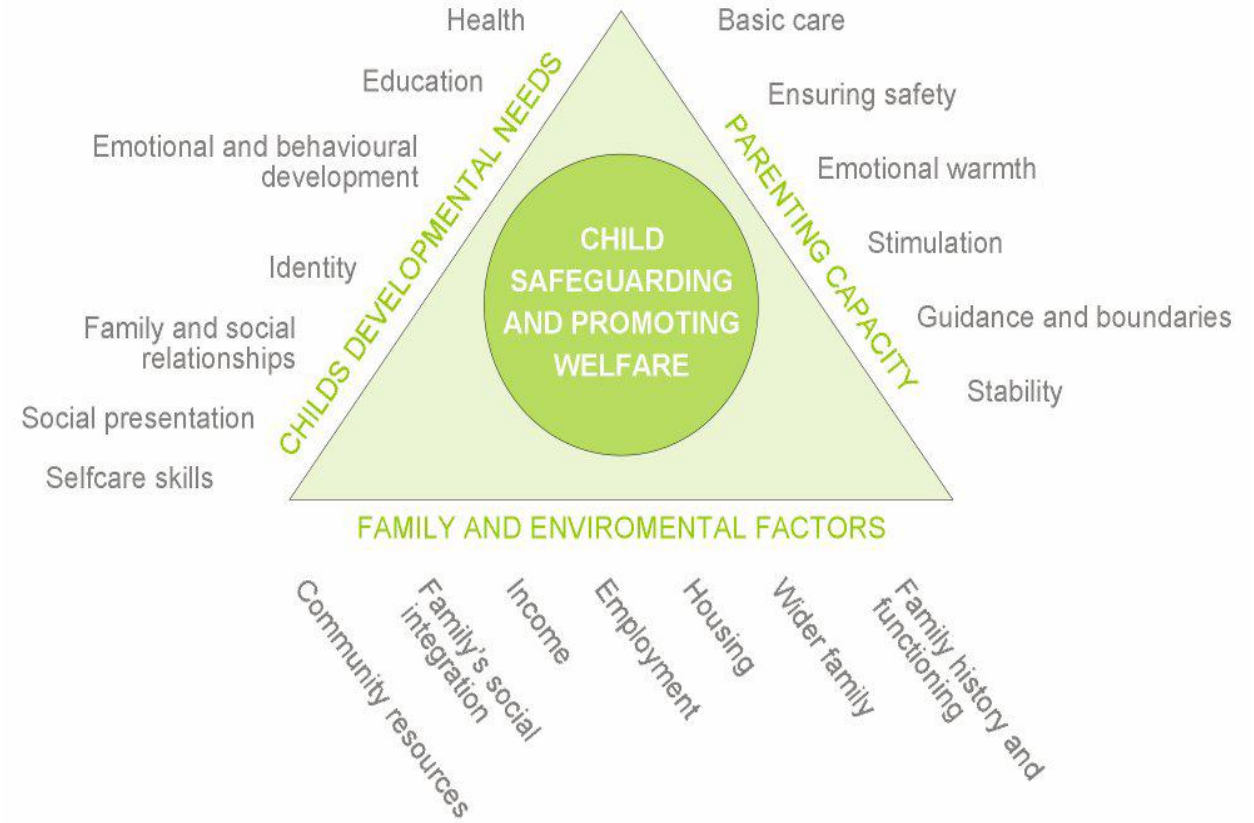
HQ4: **To be completed for all records to be transferred out of Newham Please complete in full**	
Tick as appropriate	☐ Currently subject to a Child Protection Plan ☐ Currently subject to a Child in Need Plan ☐ Currently a Looked After Child
☐ Record request ☐ Record to be transferred	
Date	
To	
Address	
From	
Address	
Name and address of Child Health Department for new health organisation (external transfers only)	

Family name	First name	Date of birth

Current information	
Address	
GP	
School Nurse / Health Visitor	
GP	
School	
Previous information	
Address	
GP	
School Nurse / Health Visitor	
GP	
School	

Appendix B

Framework for Assessment of Children in Need and Their Families (DOH 2000)



Appendix C – Consultation Document

Date: ……(sent via email)

Dear Colleague,

Re: Procedure for Management of Health Visiting and School Health Records and Record Keeping

Your comments on the attached draft document would be appreciated. Please see the attached document and either complete the form below or track changes and return to me by 25/09/2015. A copy of this request has been sent to those listed below. If you know of anyone else that should be included in this consultation process, please forward it to them and let us know. Thank you for your input.

Sincerely,

Odilia Gamor and Hazel Thomas

Consultation list:
Ian McKay, Head of Children, Young People and Women's Services
Sarah Rolfe, General Manager and Lead Nurse, C&YPS
Diane Humphries, Assistant Group Manager, C&YPS
Agnes Adentan, Named Nurse for Child Protection and the Safeguarding Children Team
Dr Fayrus Abusrewil: Named Child protection and safeguarding children doctor.
Kerry Read, Designated Nurse for Children in Care
Safeguarding Children Advisors and Paediatric Liaison Officer
Health Visiting and School Health Service:
Integrated Team Managers
Clinical Team Leaders

Name:

Job Title:		
Service:		
Comments		
Page	Section	Comment

Appendix D - DISTRIBUTION LIST

Ian McKay, Head of Children, Young People and Women's Services
Sarah Rolfe, General Manager and Lead Nurse, C&YPS
Diane Humphries, Assistant Group Manager, C&YPS
Agnes Adentan, Named Nurse for Child Protection and the Safeguarding Children Team
Dr Fayrus Abusrewil: Named Child protection and safeguarding children doctor.
Kerry Read, Designated Nurse for Children in Care
Safeguarding Children Advisors and Paediatric Liaison Officer
Health Visiting and School Health Service
Integrated Team Managers
Clinical Team Leaders
Paediatric Clinical Governance group

Appendix E

Implementation Plan Template

Procedure title: Record Keeping and Management Procedure for Integrated Health Visiting and School Nursing Service/FNP and Specialist HV services.
Lead Director: Ian McKay
Procedure lead: Odilia Gamor &Hazel Thomas
Sponsor Group: Children & Young People and Sexual Health Governance Group

Objective	Action	Lead	Timescale	Progress /Outcome	Evaluation/ Evidence
1. The procedure is properly disseminated throughout the Trust.	Document sent to the various departments within children and young people services including the Paediatric Governance group.	Odilia Gamor and Hazel Thomas	2 weeks	Disseminate procedure at locality team meetings; e mails and 121 meetings and supervision.	Record Keeping audits
2. Appropriate training is provided to staff.	To ensure that all new staff members undertake induction and all other appropriate training in order to deliver quality care services safely.	Integrated Team Managers/ Clinical Team Leaders	Training needs identified when newly recruited staff and 121, IPRs and audits.	Staff will be booked onto training when new to the Trust. All staff will understand and adhere to the criteria on electronic record keeping	Record keeping audits. Monthly dip sampling in supervision.

EQUALITY ANALYSIS TEMPLATE

A Template for Undertaking Equality Analysis of New and Existing Policies, Functions, Service Redesign, Internal Reorganisations or Restructuring Processes

November 2015

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Equality Analysis Template

Part 1: Equality Analysis Details	
Title of 'Proposal' (The term proposal covers activities such as such as policy development, policy review, service redesign and internal reorganisation or restructuring processes).	Electronic Record Keeping and Management Procedure for Integrated Health Visiting & School Health Service.
Name of directorate	Community Health Newham Children, and Young People Services
Name of manager undertaking the Equality Analysis	Hazel Thomas and Odilia Gamor
Consultation date/s with staff	November 2015
Consultation date/s with service users	None
Date Equality Analysis Completed	5th November 2015
Review date **(R reviewed least once every three years)**	November 2018

Part 2: Proposal Details

1) What are the aims of the proposal? Indicate if this is a new proposal or the review of an existing one?
(The term 'proposal' covers *activities such as such as policy development, policy review, service redesign and internal reorganisation or restructuring processes)*
The aim of this new proposal is to support staff in their day to day work, to ensure good quality electronic record keeping and management is maintained; so as to improve communication and promote safe outcomes for children and young people and their families.
The objectives of this proposal are to provide a clear process for management of electronic records and record keeping and to ensure that the procedure is fully implemented

This protocol will ensure that the evidence of care packages delivered and planned is fully documented electronically.

2) Provide a summary of the current activity to which the proposal relates e.g. policy or service structure and provision and the reasons for the changes being proposed? (State if the proposal involves relocating a service to another site; extended service hours; puts staff at risk or involves significant change)
There are no current electronic record keeping management procedure hence this proposal is a new procedure for electronic records in line with the changes from paper records to fully integrate electronic records management of care delivered and outcomes to children and young people and their families.

To ensure that all staff who have successfully been employed in the service receive orientation of the service procedures and protocol for electronic record keeping

Part 3: Equality Analysis of Staff

Protected Groups ▪ Identify the impact or potential impact on each of the following protected groups, with due regard to the three aims of the PSED (public sector equality duty).	Impact Positive or negative? or no impact?	Please describe the process of your analysis with reference to the following: ▪ Results of consultation ▪ Data or research on the protected groups that you have considered ▪ Implications for the protected groups
Age: different age groups	No	
Disability: (Consider a range of impairments, including - sensory, mental, physical and learning disability)	No	
Sex: men and women	No	
Religion or Belief: (including no belief)	No	
Sexual Orientation: people who are gay, lesbian, bisexual or heterosexual	No	
Race: including ethnicity and nationality	No	
Gender Reassignment transgender people	No	
Pregnancy and Maternity	No	
Marriage and Civil Partnership	No	

Part 4: Equality Analysis of Service Users / Patients

Protected Groups (Equality Strands) ▪ Identify the impact or potential impact on each of the following protected groups, with due regard to the three aims of the PSED (public sector equality duty).	**Impact Positive or negative? or no impact?**	**Please describe the process of your analysis with reference to the following:** ▪ **Results of consultation** ▪ **Data or research on the protected groups that you have considered** ▪ **Implications for the protected groups**
Age: different age groups	No	
Disability: (Consider a range of impairments, including - sensory, mental, physical and learning disability)	No	
Sex: men and women	No	
Religion or Belief: (including no belief)	No	
Sexual Orientation: people who are gay, lesbian, bisexual or heterosexual	No	
Race: including ethnicity and nationality	No	
Gender Reassignment: transgender people	No	
Pregnancy and Maternity	No	
Marriage and Civil Partnership	No	

Part 5: Findings from the Equality Analysis
Use this space provided below to elaborate on your decision based on the findings of the equality analysis
1. **Accept the proposal** - no evidence of discrimination and appropriate opportunities have been taken to advance equality and foster good relations Not Applicable
2. **Adjust the proposal** - take steps to remove barriers to advance equality. It may involve introducing actions to mitigate the potential effect or to look at how to deliver the proposal in a different way. It *is* lawful under Equality Law to treat people differently in some circumstances, for instance developing single sex provision where required Not Applicable
3. **Continue the proposal** - despite adverse effects or taking opportunities to advance equality provided the proposals do not unlawfully discriminate and can be objectively justified. ***(To identify whether a proposal may unlawfully discriminate due regard should be given to discrimination on the basis of the protected characteristics)*** Not Applicable
4. Stop the proposal – the policy shows unlawful discrimination and adverse effects that cannot be mitigated Not Applicable

Part 6: Equality Analysis Action Plan

Adverse Impact – Staff	Please describe the actions that will be taken to mitigate this impact
	None

Adverse Impact – Service Users	Please describe the actions that will be taken to mitigate this impact
	None

What Happens Next?

Once a plan has been put in place to mitigate against adverse impacts, the Equality Analysis should then be signed off by the Director/ Head of Service. Following this, the proposal can then be implemented. It is important to remember that Equality Analysis is not a one off process. It is important therefore, to be alert to emergent equality impacts throughout implementation.

This analysis has been checked and approved by:

Name:

Title:
(Director/ Head of Service)

Date:
Once completed the document should be sent to the Trust's Equality & Diversity Lead to quality check, who will also arrange publication on the Trust's website: Clementine.femiola@eastlondon.nhs.uk. Updated versions of a completed Equality Analysis for major proposals may be subsequently published.

References

http://www.eastlondon.nhs.uk/about_us/equality_and_diversity.asp Equality Information including examples of Equality Analysis, East London Foundation Trust

www.equalityhumanrights.com Equality and Human Rights Commission

www.stonewall.og.uk Lesbian, Gay & Bisexual Information and Research, Stonewall

www.ndti.org.uk; Achieving Age Equality in Local Mental Health Services, National Mental Health Development Unit

Nurses and Midwives Council (2015) Record Keeping: Guidance for Nurses and Midwives. London

NMC Code of Professional Practice (2014)

East London Foundation Trust School Health Service Operational policy 2014

East London Foundation Trust Health Visiting Service Operational policy 2014

East London Foundation Trust safeguarding Children's policy (2014)

Departmental Shared CHN Triage policy (Merlin Policy: March 2014) East London Foundation.

Civil Evidence Act 1995

Access to Health records 1990

Data Protection (Processing of sensitive personal data) Order 2000

Data protection Act 1988