3.8 Resources/Tools

3.8.8 Child Health Records

3.8.8.1 Child health records: descriptions and guidelines for use, retention and disposal

Background

The importance of accurate record keeping cannot be overemphasised. Client medical (health) records are, in general, contemporaneous records of events that have taken place and reflect the facts of health care interventions. They primarily serve as clinical records for continuity of care and good management of clients; however, they can also be useful tools in court proceedings or other investigations.

Records containing any personal or health information about individuals must be stored securely and handled to ensure confidentiality.

Community health nurses and other health personnel are required to document assessments, care and referrals undertaken for every child. Health professionals must make relevant, accurate, legible and comprehensive records of any health care provided to clients (refer to Appendix A for suggestions). To assist in this documentation, a suite of child health records are available to staff working in the field.

General principles

This tool has been developed to assist community health staff in understanding the purpose and intended processes associated with child health records. It should be noted that it is the responsibility of health services (and delegated health service staff) to manage paper-based CHS records used in child health settings. Staff need to be aware of the Patient Information Retention and Disposable Schedule Version 3 2008, which supports this document.

Role of child health staff

The following child health records are described in this document and the retention and disposal applies to paper-based versions of each:

| CHS 017 | Progress notes child health |
| CHS 035 | Child health register |
| CHS 560 | Child health record |
| CHS 560A | Temporary record for transfers & visitors |
| CHS 560B | Family health record |
| CHS 575 | Referral form 6-8 weeks motor development |
| CHS 663 | Confidential referral |
Retention of records relating to Aboriginal people

All health records created by remote community health in the Kimberley and Pilbara relating to Aboriginal and Torres Straight Islander people must be retained indefinitely.

All health records of Aboriginal and Torres Strait Islander people born prior to and including 1970 must be kept. For the child health setting, this would mean retaining any CHS 560A or 560B for mothers/family members or carers born in 1970 or earlier. Refer to Operational Directive (OD0051/07) in Appendix B for more information.

Destruction register

For future reference, and for reasons of accountability, it is essential that a register of records destroyed be maintained by the agency. The destruction register needs to be consistently and accurately maintained whenever client records are destroyed.

The register must capture details of each record that is destroyed (rather than a group of records), including description of record, date of record, date of destruction, method of destruction and authorisation for destruction. A Senior Manager must authorise the destruction of any record. Refer to Operational Directive (OD0110/08) for more information.

1. CHS 017 Progress Notes

Purpose / guidance for use

These notes can be attached as an addendum to CHS 560 or CHS 560B if additional space for progress notes is needed.

Retention and disposal

- Record to remain attached to CHS 560 or CHS 560B record and be retained securely by health service.
- Can destroy as per CHS 560 or 560B (can destroy once the client has attained the age of 25 years).

2. CHS 035 Child Health Register

Purpose / guidance for use

The register records birth notifications received at the child health centre. It is a comprehensive document pertaining to the client files held by the centre and documents transfers in and out of each centre. The register also provides data for Birth Notifications and the numbers attending scheduled contacts. It is recommended practice that after the information in the Birth Notification form has been documented in the register, it is stored in the Child Health Record Book (CHS 560).
Retention and disposal

- Retain original copy in Health Service. To be retained securely until destruction.
- Destroy once the youngest child in the register has reached the age of 25 years.

3. CHS 560 Child Health Record

Purpose / guidance for use

The child health record can be used to document individual client’s progress. It contains information on family history (genogram), indicators of need, prompts for discussion and progress notes which should be completed for each occasion of service. In some areas, it may have a UMRN number which can be registered on HCARe, or other electronic systems.

The record is linked with the parent held Personal Health Record (PHR) in respect to the universal contact schedule and ‘Assessment by community health nurse’ tear off pages. The carbon copy of these pages along with the birth and newborn pages, are to be attached to the relevant section of the CHS560.

- Birth details/Obstetric discharge summary
- Newborn discharge examination
- Assessment by the community health nurse at
  - first contact
  - 6-8 weeks
  - 3-4 months
  - 8 months
  - 18 months
  - 3 years.

Additional Progress notes pages may be added to the record as required.

It is recommended practice that the copy of the Birth Notification is stored within the CHS 560 and retained and disposed in the same manner.

Retention and disposal

- Retain original copy in the Health Service. To be retained securely until destruction.
- Destroy once the client has attained the age of 25 years.
- Records can be transferred to other area health services if a client moves. However, it is considered good practice for original records to be retained at the site where they were created. Photocopies can be used to provide other area health services with information if the client transfers. Please note: If the record contains sensitive information which may be required for future court proceedings, retain original record at health service of origin. If there is doubt about what constitutes ‘sensitive information’, staff should discuss with their line manager.
4. CHS 560A Temporary Record for Transfers In and Visitors

**Purpose / guidance for use**

The record can be used to ensure there is documentation on occasions of service for ALL clients seen by a child health nurse.

**Retention and disposal**

- Retain original copy in the Health Service. To be retained securely until destruction.
- Destroy once the client has attained the age of 25 years.

5. CHS 560B Family Health Record

**Purpose / guidance for use**

The Family Health Record (FHR) can be used to document information and interventions relevant to the parent/caregiver or the family. All material directly pertinent to the child should be recorded in the Child Health Record (CHS560).

The FHR can be commenced during the antenatal or the postnatal period to record non-child directed services provided by the nurse relating to issues including but not limited to:

- Physical health issues
- Mental health issues (psychological or psychiatric)
- Drug and alcohol / substance use
- Parental discord
- Domestic violence

(Continued over page)

- Expressed concern from a specialist, GP or other professional about a parent/caregiver where ongoing support from the nurse is required.

Should extra pages be required, staff can attach Progress Notes to the FHR.

The FHR can be placed inside the Child Health Record (CHS560) for storage but should not be attached to this record.

**Retention and disposal**

- Retain original copy in the Health Service. The current edition of the Patient Information Retention and Disposal Schedule does not list this record. As it is anticipated that this record will be identified in future editions of this schedule and until that time: record can be destroyed once the child has attained the age of 25 years.
• Records can be transferred to other community health services if a client moves. However, it is considered good practice for original records to be retained at the site where they were created. Photocopies can be used to provide other health centres with information if the client transfers.

Please note: If the record contains sensitive information which may be required for future court proceedings, retain original record at health service of origin. If there is doubt about what constitutes 'sensitive information', staff should discuss with their line manager.

• When original records or copies are forwarded, they should be posted by registered mail, to appropriate community health service staff.

6. CHS 575 Referral Form 6-8 Weeks Motor Development

Purpose / guidance for use

The referral form is used to refer babies to a physiotherapist with motor development concerns at the 6-8 week contact. It contains information about the concern from both parent and child health nurse perspective.

Retention and disposal

• Retain duplicate copy with the child health record (CHS 560) in the Health Service. The current edition of the Patient Information Retention and Disposal Schedule does not list this form. It is anticipated that this form will be identified in future editions of this schedule and until that time: record can be destroyed once the client has attained the age of 25 years.
  ▪ Send original copy to receiving physiotherapist.
  ▪ Retain duplicate copy with the child health record (CHS 560).

• Records can be transferred to other community health services if a client moves. However, it is considered good practice for original records to be retained at the site where they were created. Photocopies can be used to provide other health centres with information if the client transfers.

Please note: If the record contains sensitive information which may be required for future court proceedings, retain original record at health service of origin. If there is doubt about what constitutes 'sensitive information', staff should discuss with their line manager.

• When original records or copies are forwarded, they should be posted by registered mail, to appropriate community health service staff.

• Documentation of the referral should also be noted in the progress notes of the child health record (CHS 560), along with referral outcomes when received.
7. CHS 663 Referral from Community Health

Purpose / guidance for use
The CHS 663 is used by community health staff when making a referral to another health practitioner (internal or external) or other agency. Consent to make the referral should be sought from the parent prior to issuing the referral to the health practitioner or agency.

Retention and disposal
- Send original copy to receiving practitioner/agency (via parent).
- Retain duplicate copy with child health record.
- Retain triplicate copy with health service. This copy can remain in the pad for ease of handling and monitoring.
- Destroy once client has attained the age of 25 years.
- To be retained securely by health services until destruction.
- Records can be transferred to other community health services if a client moves. However, it is considered good practice for original records to be retained at the site where they were created. Photocopies can be used to provide other health centres with information if the client transfers.

Please note: If the record contains sensitive information which may be required for future court proceedings, retain original record at health service of origin. If there is doubt about what constitutes ‘sensitive information’, staff should discuss with their line manager.

- When original records or copies are forwarded, they should be posted by registered mail, to appropriate community health service staff.
- Documentation of the referral should also be noted in the progress notes of the child’s health record (CHS 560), along with referral outcomes when received.

8. Diary Work

Work containing information which identifies an individual client, including details of client appointments, assessments or telephone conversations should be destroyed 7 years after date of last entry.
Appendix A

Health professionals must make relevant, accurate, legible and comprehensive records of any health care provided to clients. When creating or making an entry in a client record it is recommended that:

- All documentation is filed in chronological sequence.
- Each record page is clearly identified with the client identification (name).
- All entries in the record are legible and clear.
- All entries be dated, timed, signed and include the position/office of the author. Where signatures are illegible, the surname should be printed alongside the entry and on the first occasion of entry.
- All entries are concise, accurate and relevant.
- All records are treated confidentially.
- Leaving applicable data items blank on form are avoided.
- Non-specific terms such as ‘had a good day’ be avoided.
- All entries are objective, i.e. facts only. Subjective or emotional statements and moral judgements should be avoided.
- Wherever possible, only those events the author had direct knowledge of (e.g. matters that the author saw, heard, did, said or felt) be recorded.
- Gaps not to be left between entries.
- When using ‘progress notes’, pages be clearly numbered to indicate chronological order.
- Only authorised or approved forms to be used to document client information.
- Every client encounter to be documented, including telephone conversations and failed attempts to make telephone contact.
- Wherever possible, entries should be added at the same time the event occurred or document as closely as possible to the time the event occurred. Indicate the date of the intervention and the date the notes were written.
- If additional information is added later, note ‘late entry’ with time and date of addition, and then sign.
- Avoid the practice of writing notes ahead of time.
- When a word or line or extra note is written in error, do not erase, ‘white out’ or otherwise totally obliterate the entry. Draw a single line through the entry and write ‘mistaken entry’ next to it before initialling, dating and signing the correction.
- Blue/black pen only be used for recording information.
- To protect client confidentiality when transporting health records out of the child health centre, please ensure the records are kept in a safe and secure location as per Area Health service policy e.g. transported in a locked briefcase, or sealed envelope marked confidential with a local site address.
Freedom of information

The Freedom of Information Act 1992 (WA) gives people the right to apply for access to documents held by public health services subject to certain exemptions under the Act. Individuals may apply for access to public health service records by submitting a written request to the relevant health service’s Freedom of Information officer or similar.

It is important to be aware that other processes exist whereby medical (health) records can be obtained by a court or third party, for example, by subpoena or warrant or in the discovery stage of legal proceedings. You should discuss this with your line manager as legal assistance should be sought if there are any concerns where such a request is made.

Electronic records

Client information stored electronically by health services and their staff is considered to constitute ‘records’ for the purpose of the SRA. As such, electronic records are required to be retained and disposed of in accordance with the minimum standards set by the Patient Information Retention and Disposal Schedule.

Related policies, procedures and guidelines

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<thead>
<tr>
<th>Policy Owner</th>
<th>Portfolio</th>
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<td>Director Statewide Policy Unit.</td>
<td>Birth to School Entry</td>
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References


Appendix B

Department of Health
Government of Western Australia

OPERATIONAL DIRECTIVE

Enquiries to:  Refer below  
Number:  OD 005107
Date:  06 June 2007
File No:  06-05408

Supersedes:  OP 1154/98

Subject: RETENTION OF RECORDS RELATING TO ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

On 15 December 1996, and following a major recommendation arising from The National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (Bringing Them Home), the Premier directed all State Government Departments and Agencies to cease destruction of any records, administrative or clinical in any format, relating to Aboriginal or Torres Strait Islander people.

A subsequent directive of the Premier issued in March 2003 (Circular No. 2003/02) states that "...records relating to Indigenous individuals, families or communities which concern any children, Indigenous or otherwise, removed from their families for any reason, whether held by government or non-government agencies, be brought to the attention of the Family Information Records Bureau and reflected in agency record keeping plans".

The Family Information Records Bureau (FIRB), within the Department for Community Development, is primarily interested in Aboriginal and Torres Strait Islander records that contain information prior to and including 1979, may be identified as Aboriginal or Torres Strait Islander, and provide information on family history, genealogy or cultural links.

It is acknowledged that it is not practicable to identify and retain indefinitely all records relating to Aboriginal and Torres Strait Islander people.

Health care facilities and agencies must retain Aboriginal and Torres Strait Islander administrative and patient records indefinitely for clients with a date of birth prior to and including 1979, except those patient records created by remote clinics. All patient records created by remote clinics in the Kimberley and Pilbara health districts must be retained indefinitely.

To identify and subsequently preserve records of Aboriginal or Torres Strait Islander people, facilities are advised to consider the following:

- The Indigenous status recorded on health information systems (e.g. TOPAS, HCARE, local administrative systems).
- The record is of an individual with a recognised Indigenous family name (including aliases).
- The record relates to an individual of an identified Indigenous community (e.g. clinic records).
- The record relates to care delivered by a health service (e.g. including Mission, Station and Itinerant health workers).
- The record relates to a health program that provided care to the Indigenous population (e.g. eye health).
- The record exists in an area with a high proportion of Indigenous population (e.g. Kimberley region).
- The records contains evidence of adoption, fostering or an informal arrangement of care for a child.