

**NORTHERN IRELAND**

**Personal Child Health  
Record (PCHR)**

**PROFESSIONAL  
GUIDANCE ON RECORD  
COMPLETION**



**REVISED VERSION**

**1<sup>st</sup> SEPTEMBER 2010**

<b>CONTENTS</b>	<b>PAGE</b>
<b>PCHR Introduction and Purpose</b>	<b>3</b>
<b>Introducing the Record to Parents</b>	<b>3</b>
<b>Parental and Professional Contribution</b>	<b>5</b>
<b>Guidance on Completion of Routine Screens and Contacts for:</b>	
<b><i>Newborn Assessment and Examination</i></b>	<b>6</b>
<i>(PCHR Pages 20 and 21)</i>	
<b><i>Community Midwife's Discharge</i></b>	<b>11</b>
<i>(PCHR Page 23)</i>	
<b><i>New Baby Review by Health Visiting Team</i></b>	<b>17</b>
<i>(PCHR Pages 25-27)</i>	
<b><i>6-8 Week Review by Health Visiting Team</i></b>	<b>25</b>
<i>(PCHR Page 28 and CHS56 Additional page)</i>	
<b><i>8 Week Examination by General Practitioner</i></b>	<b>31</b>
<i>(PCHR Page 29 and CHS56 Additional page)</i>	
<b><i>14-16 Week Review by Health Visiting Team</i></b>	<b>35</b>
<i>(PCHR Page 30 and CHS60 Additional page)</i>	
<b><i>6-9 Month Contact by Health Visiting Team</i></b>	<b>40</b>
<i>(PCHR Page 31 and CHS60 Additional page)</i>	
<b><i>1 and 2 Year Health Reviews by Health Visiting Team</i></b>	<b>43</b>
<i>(PCHR Pages 32 and 33 and CHS60 Additional page)</i>	
<b><i>Immunisation</i></b>	<b>49</b>
<i>(PCHR Page 7)</i>	
<b>Guidance On Completion of Non-Routine Contacts</b>	<b>51</b>
<i>(PCHR Pages 35-40) This includes contacts with Maternity and Neonatal Services, Hospital Inpatient Admissions, Accident and Emergency, the GP, doctors other than GPs and other Health and Social Care Professionals (e.g. Dentists, Speech &amp; Language Therapists, Orthoptists, Social Services)</i>	
<b>Special Circumstances</b>	
<b>- Recording Sensitive Information</b>	<b>54</b>
<b>- Translations for Ethnic Minorities</b>	<b>54</b>
<b>- Literacy</b>	<b>54</b>
<b>- Child Protection</b>	<b>54</b>
<b>- Children on the Child Protection Register</b>	<b>55</b>
<b>- Looked After Children / Adoption</b>	<b>55</b>
<b>- Non-Availability of Records</b>	<b>56</b>
<b>- Lost Records</b>	<b>56</b>
<b>- Mortality</b>	<b>56</b>
<b>- Confidentiality</b>	<b>57</b>
<b>- Legal Guidance</b>	<b>57</b>
<b>Appendix 1 – Summary of the Preschool Universal Programme</b>	
<b>Appendix 2 – Child Health System Contact Information</b>	

## **Introduction**

The N. Ireland Personal Child Health Record (PCHR) has been in place for children born since 1<sup>st</sup> January 1995.

The latest version, being introduced for children born from 1<sup>st</sup> October 2010, accommodates the 'Healthy Child, Healthy Future' Child Health Promotion Programme (see Appendix 1 for preschool summary) and the record has been developed in line with recommendations coming out of both local and national review of PCHR content and structure.

The PCHR continues to be handed over to parents at time of birth. The screening and routine review section of the revised record allows for the capture of the outcomes of the new screening programme and the book also contains the new UK WHO growth charts for 0 – 4 years. These charts have been calibrated to monitor development of both breast and formula fed infants.

Parental information about posture, large and fine movements, speech, hearing and vision development have also been reformatted in order that each can be more easily referenced according to the age of the child. Otherwise, the record provides a signpost for parents to the most up-to-date health promotion and education information contained in the 'Birth to Five' book issued to parents by midwifery staff and available on the internet to view at <http://www.publichealth.hscni.net>.

The PCHR gives recognition to the key role of the parent in the health and care of their child and is very much in line with the ethos of health and care professionals working openly with parents.

## **Purpose of the Record**

- To increase partnership between parents and professionals;
- To improve communication between professionals working with the child;
- To capture information which will assess health outcomes and inform future developments; and,
- To provide parents with health and risk assessment information relevant to their child.

## **Introducing the Record to Parents**

1. Parents should be made aware of the PCHR during the antenatal period.

2. Following delivery the midwife should explain the purpose and content of the record to the parent at handover, emphasising the following points:
  - This is the child's main health record and should be kept safe.
  - It should be taken with the child whenever attending:
    - any Child/Community Health Clinic;
    - the health visitor;
    - the family doctor;
    - the hospital emergency department;
    - the hospital outpatient department;
    - the dentist;
    - the eye clinic or orthoptist;
    - any allied health professional; or,
    - if the child is admitted to hospital.

**Professionals should note that they reinforce the importance of the PCHR by asking the parent to provide it for them to use at consultations.**

This is the child's record and it is for the parent to write in as well as professionals.

3. Parents should be assured that health and social care staff support an open attitude regarding the health and well being of their child.
4. In practice, the recording of sensitive information has not been found to be a problem. In the majority of cases where a professional is concerned about a child's development, so is the parent. Therefore, the information needs to be shared.
5. It is important that the parent is made aware of other records in operation, e.g.
  - NIMATS
  - Child Health System
  - General practice systems
  - Family Health Needs Assessment System
  - Community systems
  - Manual records (GPs, HVs)

## Parental Contribution

1. Parents should be encouraged to write in the PCHR.
2. Their contribution should always be acknowledged and read carefully. Experience from other areas has shown that professionals tend to read records very quickly and parents think that their input has been ignored.
3. Parents should be encouraged to write in whatever style they prefer. However, it is important that there is common understanding between the professional and the parent.

## Professional Contribution

1. Much depends on the record being asked for and completed by **ALL** professionals with whom the child comes into contact.
2. Always record a summary of the consultation and any action taken.
3. Professionals should share any concerns they may have about the child's health, growth and/or development with parents and should always discuss and agree what they are going to record beforehand.
4. Information should be written in a language that is clear, legible and understood by the parents. When medical terms are unavoidable, they should be translated for the parent and **ABBREVIATIONS SHOULD BE AVOIDED**.
5. Professionals should **NOT** record information that does not pertain to the child, e.g. details of contraception should be recorded in the professional file.
6. The PCHR should NOT be used to document or communicate domestic violence disclosure to other professionals. Professionals should refer to local Domestic Violence Enquiry protocols.
7. **Black ball-point pen** should be used when recording information.

**PCHR**

**Completion of  
Newborn  
Assessment and  
Examination  
Information**

**Hospital Midwives  
and Doctors**

**Pages 20 and 21**

## Newborn Assessment (Part 1) – Page 20

All areas of this page should be completed using a black ball-point pen and those carrying out newborn assessment should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover of the PCHR is inserted behind all 4 copies of the page, otherwise NCR pages relating to other examinations/reviews in the booklet will be defaced.

Please affix identification labels to each of the 4 copies of the page, otherwise complete child's identification as follows:

<b>Child's Identification</b>	
<b>Surname</b>	Please enter using BLOCK CAPITALS.
<b>Forename</b>	Enter if known.
<b>Health + Care Number</b>	Enter in full.
<b>Date of Birth</b>	Enter in DDMMYY format.
<b>Child's Hospital Number</b>	Enter in full.
<b>Sex</b>	Please circle one. NB Indeterminate sex should be recorded as Male
<b>Address</b>	Enter in full, providing postcode.
<b>GP</b>	Please enter GP's name in full.
<b>Code</b>	Please enter GP's cipher number.

<b>Growth Measurement and Feeding</b>	
<b>Date of Risk Factor Assessment</b>	Please enter in DDMMYY format.
<b>Birthweight</b>	Please record in grams.
<b>Current Weight</b>	Please record in grams.
<b>Number Born</b>	Enter the number of children born this pregnancy, i.e. '1' for singleton, '2' for twins etc.
<b>Birth Order</b>	If this is a multiple birth please record the order of this child's birth, i.e. Triplet 2 should be recorded as '2'. For singleton births please record '1'.
<b>Head Circumference</b>	Please record in centimetres, if indicated (to one decimal place).
<b>Length</b>	Please record in centimetres, if indicated (to one decimal place).

<b>Growth Measurement and Feeding (cont'd)</b>	
<b>Breastfeeding</b>	Please circle as appropriate. Total Partial Not At All  NB reporting should not reflect method of feeding, i.e. expressed breast milk given via bottle should be recorded as Total or Partial breastfeeding.
<b>Child's Surname (if different)</b>	Enter using BLOCK CAPITALS, if the child's surname is different from mother's.

<b>Significant Antenatal / Infant / Parental/ Family History Information</b>
Please record any relevant information pertaining to history in this section and if there are any maternal concerns regarding the child's health.

<b>Risk Factors</b>
<p>Please circle (Y)es, (N)o or (U)nknown against each of the risk factors within each of the risk categories.</p> <p><b>Where a risk factor is identified the examiner should provide details of action taken in the free text area of Part 2 (page 21) entitled 'DETAILS OF ACTION TAKEN / REQUIRED (including referral) / COMMENTS' and MUST ensure that the appropriate action is taken as follows:</b></p> <p><b><u>Vision</u></b> Refer to paediatric ophthalmology for assessment.</p> <p><b><u>Hips</u></b> Refer for Ultrasound scan where risk exists and examination is normal. If the examination is abnormal refer for expert examination (which should include USS) as per local policy.</p> <p>Family history includes 1<sup>st</sup> and 2<sup>nd</sup> degree relatives.</p> <p><b><u>Tuberculosis</u></b> Refer to the BCG service, advising if mother is HIV positive, or if mother's HIV status is unknown. If a member of the child's household or family circle is suspected of having TB, or has/had TB in the past 5 years, advice must be sought from the Duty Room, Health Protection Division, Public Health Agency (tel: (028) 905539 94/97 or email: pha.dutyroom@hscni.net).</p> <p>See current professional guidance on TB incidence worldwide at:  <a href="http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/">http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/</a></p> <p><b>The current definition of high incidence is an annual rate of 40 cases or greater per 100,000 population (WHO – April 2009).</b></p>



<b>Risk Assessor / Examiner Information</b>	
<b>Name</b>	Please print your name in BLOCK CAPITALS.
<b>Status</b>	Indicate status e.g. Midwife, SHO.
<b>Signature</b>	Please sign here.
<b>Code</b>	Please provide your Examiner code here. <i>(Ignore until further notice)</i>

## **Newborn Examination (Part 2) – Page 21**

Please complete identification details as per guidance for Part 1 (Page 20)

<b>Consent / Examiner Information</b>	
<b>Examiner Code</b>	Please provide your Examiner code here. <i>(Ignore until further notice)</i>
<b>Examiner Status</b>	Indicate status e.g. Midwifery Sister, SHO.
<b>Examiner Signature</b>	Please sign here.
<b>Place of Examination</b>	Please record hospital where exam was carried out, if home write 'Home'.
<b>Consent to Examination</b>	Please circle as appropriate.
<b>Date of Examination</b>	Record in DDMMYY format.
<b>Time of Examination</b>	Record using 24-hour clock.

<b>Examination Outcomes</b>
<p>The exam should be carried out as per professional guidance and documented as follows:</p> <p><b>Heart Rate</b> Please record heart rate per minute.</p> <p><b>Respiratory Rate</b> Please record respiratory rate per minute.</p> <p><b>Passed Meconium:</b> Please circle as appropriate.</p> <p><b>Passed Urine:</b> Please circle as appropriate.</p> <p>Circle <b>ONE</b> outcome against each of the components listed within the Cephalo-caudal examination.</p>

## **Examination Outcomes (cont'd)**

### **Outcomes of Examination:**

'S' where examination is satisfactory.

'R' where child is referred or examination is not satisfactory.

'N' where examination is not carried out.

**Where a Hips risk has been identified, e.g. Family History (Relative Treated for DDH) and the hips examination is satisfactory, please record hips examination as (S)atisfactory.**

### **Details of Action Taken / Required:**

It is important that other professionals providing services are aware of any action taken or required (including referral) so please ensure that these details are clearly recorded in the 'DETAILS OF ACTION TAKEN / REQUIRED (including referral) / COMMENTS' area of this page.

### **Is an interpreting service required?**

Please circle **Yes** / **No** as appropriate.

### **If yes, which language**

Provide details of language required (including Sign Language).

## **DISTRIBUTION OF PAGES 20 AND 21 ON COMPLETION**

**Please remove the first, second and third copies of both pages from the PCHR and distribute (stapled together) as follows:**

- 1st copies (white) - child's hospital file
- 2nd copies (green) - HV (via the Child Health Office as per local protocol)
- 3rd copies (yellow) - GP as per local protocol

The fourth copies (white) remain in the PCHR.

Maternity Units should consider distributing GP and HV copies of the Newborn Assessment and Examination (pages 20 and 21 of the PCHR) along with maternal neonatal discharge forms (CHS3a and CHS3b), which should also **be stapled together** when mother and child are discharged at the same time).

**PCHR**

**Completion of  
Community Midwife's  
Discharge  
Information**

**Community  
Midwifery Staff**

**Page 23**

## Community Midwife's Discharge – Page 23

All areas of this page should be completed using a **black ball-point pen** and examiners should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover of the PCHR is inserted behind all 3 copies of the page, otherwise NCR pages relating to other examinations/reviews in the booklet will be defaced.

Please affix identification labels to each of the 3 copies of the page, otherwise complete child's identification as follows:

<b>Child's Identification</b>	
<b>Surname</b>	Please enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from the mother's.
<b>Forename(s)</b>	Please record in full (if known).
<b>Health + Care Number</b>	Enter in full.
<b>Address</b>	Enter in full, providing postcode.
<b>Sex</b>	Please circle one.  N.B. Indeterminate sex should be recorded as Male.
<b>Date of Birth</b>	Enter in DDMMYY format.
<b>GP</b>	Please enter GP's name in full.
<b>GP's Code</b>	Please enter GP's Cipher number.
<b>HV Name</b>	Please enter (if known).

**In the event of any change of circumstances, i.e. change of address, change of name etc., please contact the Child Health System Bureau Office (contact information in Appendix 2). Any change will be updated on the Child Health System and the family health visitor will be informed.**

<b>Newborn Bloodspot Test, Vitamin K and Feeding</b>	
<b>Parental Consent obtained</b>	<p>Circle Yes or No as appropriate.</p> <p>Where a parent declines all or part of the newborn bloodspot screening programme, details should be recorded in the Discharge Note area of page 23. The midwife should complete the bloodspot card as normal, recording the detail of the test(s) declined in the top right-hand corner of the bloodspot card and the card should be forwarded to the Biochemistry laboratory (as normal). <b>It is important that contact is made with the GP to advise of decline.</b> Please refer to the Bloodspot Consent Policy in the Northern Ireland Bloodspot Screening Programme Professional Handout (Revised April 2009).</p>
<b>First Sample Taken</b>	Please circle Yes or No as appropriate.
<b>Date First Sample Taken</b>	Please record the date that the test was taken in DDMMYY format.
<b>Preterm CHT Test Required</b>	<p>Please circle <b>Yes</b> if the First Sample was taken prior to the child reaching 36 weeks equivalent gestation, (35 weeks + 7 days), otherwise circle <b>No</b>.</p> <p>Equivalent gestation = weeks and days gestation at birth + days of age (Date of birth = Day 0).</p>
<b>Preterm CHT Test Due On</b>	<p>Please record the date that the Preterm CHT test is due to be taken in DDMMYY format.</p> <p>The test must be taken at 36 weeks equivalent gestation.</p>
<b>Preterm CHT Test Taken</b>	Record when the Preterm CHT test was taken in DDMMYY format, if carried out prior to discharge from Community Midwifery.
<b>Vitamin K Date(s) Given</b>	<p>Please review Vitamin K information provided in the Neonatal Discharge form (CHS3b) and record details of 1<sup>st</sup> administration as well as any further Vitamin K doses you have provided.</p> <p><b><i>N.B. Dosage is dependant on administration route and feeding method.</i></b></p> <ul style="list-style-type: none"> <li>○ <b><i>Intramuscular/Intravenous</i></b> 1 dose at birth, regardless of feeding.</li> <li>○ <b><i>Oral (formula fed)</i></b> 2 doses, 1<sup>st</sup> at birth and 2<sup>nd</sup> at 1 week.</li> <li>○ <b><i>Oral (breast milk fed)</i></b> 3 doses, 1<sup>st</sup> at birth, 2<sup>nd</sup> at 1 week and 3<sup>rd</sup> at 1 month.</li> </ul>

<b>Newborn Bloodspot Test, Vitamin K and Feeding (cont'd)</b>	
<b>Vitamin K Route(s)</b>	Provide route of administration.  (I)- intramuscular or intravenous (O)- oral
<b>Further Vitamin K required</b>	Please circle Yes or No as appropriate.
<b>Breastfeeding at Discharge from Community Midwife</b>	Please circle as appropriate. Total Partial Not At All  NB reporting should not reflect method of feeding, i.e. expressed breast milk given via bottle should be recorded as Total or Partial breastfeeding.

<b>Jaundice</b>	
<b>Infant Ever Jaundiced</b>	Please circle Yes or No as appropriate.
<b>SBR done</b>	Please circle Yes or No as appropriate.
<b>Latest SBR Test Date And Results</b>	Please record the date of the latest test taken and provide results for total, indirect and direct bilirubin counts in mmol/l.  Please indicate in Discharge Note if an SBR result is outstanding.
<b>Jaundiced at Community Midwife Discharge</b>	Please circle Yes or No as appropriate.
<b>Repeat SBR Required</b>	Please circle Yes or No as appropriate.
<b>Date Repeat Required</b>	Provide in DDMMYY format.  Please indicate in Discharge Note if you have/will arrange to take the test.

<b>Assessment of Risk Factors</b>
<p><b>Child's Risk Factors Reviewed:</b> Please circle as appropriate.</p> <p>Please go to risk factor assessment information on the Newborn Risk Factor Assessment page (page 20 of the PCHR) and review risk factors with mother.</p> <p><b>New Risk Factor(s) Identified?</b> Please circle as appropriate.</p> <p>If a new risk factor is identified and the child has not already been referred the following action should be taken by the Community Midwife:</p>

## Assessment of Risk Factors (cont'd)

### Hearing

Once notified, the Child Health System, will automatically identify children (**up to 6 months of age**) with hearing risk factors to Community Audiology Services for 8 month Audiology Assessment.

**N.B.** Hearing Risk Factor Assessment is available from the Newborn Hearing Screening (page 22).

Family History (1<sup>st</sup> degree relative) of Hearing Loss **EXCLUDES** a family history of “glue ear”.

### Hips

Refer for Ultrasound scan where risk is identified and examination is normal. If the examination is abnormal refer for expert examination (which should include USS) as per local policy.

Family History includes 1<sup>st</sup> and 2<sup>nd</sup> degree relatives.

### Vision

Refer to Paediatric Ophthalmology for assessment.

### Tuberculosis

Refer to the BCG service, advising if mother is HIV positive, or if mother's HIV status is unknown. If a member of the child's household or family circle is suspected of having TB, or has/had TB in the past 5 years, advice must be sought from the Duty Room, Health Protection Division, Public Health Agency (tel: (028) 905539 94/97 or email: pha.dutyroom@hscni.net).

See current guidance on TB incidence worldwide at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/>

N.B. In addition to TB risk factors identified in the PCHR, moved in infants, born in a high incidence country, should be referred to the BCG service.

**The current definition of high incidence is an annual rate of 40 cases or greater per 100,000 population annually (WHO – April 2009).**

Please record any new risk factor you have identified and action taken by you in the 'Discharge Note'. The health visitor will report your findings to the Child Health System.

<b>Additional Information</b>	
<b>Additional Support Required</b>	This relates to parents who may need additional support over and above the normal routine contact.  Please circle Yes or No as appropriate.  The discharging midwife should make contact with the health visitor as per local policy, providing written information.
<b>Is an interpreting service required?</b>	Please circle Yes or No as appropriate and record language.
<b>Family Contact Tel No</b>	Please record mother's telephone number.

<b>Discharge</b>	
<b>Discharge Note</b>	Please record any further information relevant to the child in this area of the form.
<b>Last Weight</b>	Please record last weight taken in grams.
<b>Date Last Weighed</b>	Please record in DDMMYY format.
<b>Date of Discharge</b>	Please record in DDMMYY format.
<b>Midwife's Name</b>	Please record using BLOCK CAPITALS.
<b>Midwife's Signature</b>	Please sign.
<b>Contact Telephone Number</b>	Please provide the telephone number at which you may be contacted during working hours.

### **DISTRIBUTION OF PAGE 23 ON COMPLETION**

**Please remove the first copy only from the PCHR and action as follows:**

1<sup>st</sup> copy (white) - Community Midwife's File

The 2<sup>nd</sup> copy (green) will be removed by the health visitor, following the community midwife's discharge and the 3<sup>rd</sup> copy (white) remains in the PCHR.



**PCHR**

**Completion of New  
Baby Review  
Information**

**Health Visiting Team**

**Pages 25, 26 and 27**

## New Baby Review (Part 1) – Page 25

All areas of the form should be completed using a black ball-point pen and reviewers should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover is inserted behind all 3 copies of the page, otherwise NCR pages relating to other examinations/reviews in the red book will be defaced.

Please affix CHS identification labels to all 3 copies of this page, otherwise complete as follows:

Child's Identification	
<b>Surname</b>	Enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from mothers.
<b>Health+Care Number</b>	Enter the child's H+C number in full.
<b>CHS System Number</b>	Enter in full, as provided on the Birth Notification label.
<b>Address</b>	Please complete providing postcode.
<b>Sex</b>	Please circle as appropriate.
<b>Date of Birth</b>	Enter using DDMMYY format.
<b>GP</b>	Enter name in full and provide cipher code (if known).
<b>HV</b>	Enter name in full and provide HV caseload number.

Please use a CHS8 to notify any change to your local CHS Office, should any pre-printed information on the ID label have changed.

Feeding and Choice of Treatment Centre	
<b>Date of Risk Factor Assessment</b>	Please record using DDMMYY format.
<b>Ethnicity</b>	Please record according to Ethnic Group codes provided on page 43 of the PCHR following parental enquiry. <b>N.B.</b> <b>A - White</b> relates to UK (white). <b>M - Northern European</b> (white) relates to Austria, Belgium, Ireland, France, Germany, Netherlands, Scandinavia, Switzerland etc, and any other European family origins, e.g. Australia, North America, South Africa.

<b>Feeding and Choice of Treatment Centre (cont'd)</b>	
<b>Ethnicity (cont'd)</b>	<b>N - Southern/Other European</b> (white) includes Sardinia, Greece, Turkey, Cyprus, Italy, Portugal, Spain and other Mediterranean countries, Albania, Czech Republic, Poland, Romania, Russia etc. <b>O - Other Non European</b> (other) relates to North Africa, South America, Middle East.
<b>Number Born</b>	Please record the number born this pregnancy, i.e. '1' for singleton, '2' for twins.
<b>Birth Order</b>	If this is a multiple birth please record the order of this child's birth, i.e. Triplet 2 should be recorded as '2'.
<b>Breastfeeding</b>	Please circle one outcome to report breastfeeding status.  NB reporting should not reflect method of feeding, i.e. expressed breast milk given via bottle should be recorded as Total or Partial breastfeeding.
<b>Forename(s)</b>	Please provide in BLOCK CAPITALS.
<b>Choice of Treatment / Examination Centre</b>	Please record GP. Where appropriate identify the branch surgery.
<b>Family HV</b>	Please record the name of the Family HV if you, the examiner, are not the named Family HV.
<b>Child's Surname (if different)</b>	Enter using BLOCK CAPITALS if child's surname is different from the mother's.

<b>Update of Risk Factors</b>
<p><b>Is the previous Assessment Record available?</b></p> <p>Please refer to the Newborn Risk Factor Assessment (page 20 of the PCHR) and the discharge note area of the Community Midwife's Discharge (page 23).</p> <p>If the previous Assessment Record is not available circle <b>No</b> and then undertake a full Risk Factor Assessment, recording outcomes on the Risk Factor area of this page (page 25).</p> <p>If the previous Risk Factor Assessment is available and completed circle <b>Yes</b>.</p> <p><b>If the previous Risk Factor Assessment is available have any Risk Factors changed?</b></p> <p>Where the previous Risk Factor Assessment is available please review and establish if any Risk Factors have changed.</p> <p>If Risk Factors have not changed circle <b>No</b> and <b>do not</b> complete the risk factor area of the page.</p>

## **Update of Risk Factors (cont'd)**

If Risk Factors have changed circle **Yes** and then complete the risk factor area of the page identifying **ONLY** new risk factors. Include any new risk factors identified by the community midwife.

### **N.B.**

*Where a risk factor is identified the reviewer should provide details of action taken in the free text area entitled “Comments / Details And Action Taken/Required (including referral)” in Part 2 (page 26 of the PCHR) and MUST ensure that the appropriate action is taken as follows:*

### **Hearing**

Once notified, the Child Health System, will automatically refer children (**up to 6 months of age**) with hearing risk factors to Community Audiology Services for 8 month Audiology Assessment.

**N.B.** Hearing Risk Factor Assessment is available from the Newborn Hearing Screening (page 22).

Family History (1<sup>st</sup> degree relative) of Hearing Loss **EXCLUDES** a family history of “glue ear”.

### **Hips**

Refer for Ultrasound scan where risk is identified and examination is normal. If the examination is abnormal refer for expert examination (which should include USS) as per local policy.

Family History includes 1<sup>st</sup> and 2<sup>nd</sup> degree relatives.

### **Vision**

Refer to Paediatric Ophthalmology for assessment.

### **Tuberculosis**

Refer to the BCG service, advising if mother is HIV positive, or if mother's HIV status is unknown. If a member of the child's household or family circle is suspected of having TB, or has/had TB in the past 5 years, advice must be sought from the Duty Room, Health Protection Division, Public Health Agency (tel: (028) 905539 94/97 or email: pha.dutyroom@hscni.net).

See current guidance on TB incidence worldwide at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/>

N.B. In addition to TB risk factors identified in the PCHR, moved in infants, born in a high incidence country, should be referred to the BCG service.

**The current definition of high incidence is an annual rate of 40 cases or greater per 100,000 population annually (WHO – April 2009).**

Reviewer's Information	
Reviewer's Name	Please print your name in BLOCK CAPITALS.
Signature	Please sign.
Reviewer's Code	Please enter your Examiner code.

## New Baby Review (Part 2) – Page 26

Please affix CHS identification labels to all 3 copies of this page, otherwise complete as guided for Part 1 (page 25) of the New Baby Review.

Review Details	
Consent to Review	Please circle as appropriate.
Location of Review	Please circle 'Home' otherwise record location.
Date of Review	Enter using DDMMYY format.

Growth Measurement	
Please record length in centimetres; weight in grams (to one decimal place); and, head circumference in centimetres (to one decimal place).	
Plot on 'Centile Chart' at the back of the PCHR and record 'centiles alongside measurements.	

Review
<p>The physical review should be carried out as per Healthy Child, Healthy Future Guidance on New Baby Review and documented on page 26 as follows:</p> <p>Please circle <b>ONE</b> outcome against each of the components of the review.</p> <p>S – Satisfactory  O – Observe  T – Treatment  R – Referred  N – Not Examined</p> <p><b><i>Where a risk is identified (in Part 1, page 25), e.g. Family History (Relative Treated for DDH) and examination is satisfactory, please record examination as (S)atisfactory.</i></b></p> <p><b>Further Vitamin K Required:</b>  Please review details of Vitamin K already given (refer to Neonatal Discharge Form and Community Midwife's Discharge (page 23 of PCHR) and circle as appropriate.</p> <p><b>N.B. Dosage is dependant on the administration route and feeding method.</b></p>

## Review (cont'd)

- **Intramuscular/Intravenous**  
1 dose at birth, regardless of feeding.
- **Oral (formula fed)**  
2 doses, 1<sup>st</sup> at birth and 2<sup>nd</sup> at 1 week.
- **Oral (breast milk fed)**  
3 doses, 1<sup>st</sup> at birth, 2<sup>nd</sup> at 1 week and 3<sup>rd</sup> at 1 month.

### **Bloodspot Test Taken:**

Please refer to Community Midwife Discharge (page 23) and circle as appropriate. If test has not been carried out please arrange for test to be taken as soon as possible, following your Trust's Bloodspot Repeat and 2<sup>nd</sup> Test Request Protocol.

**N.B. Details of Preterm CHT testing are provided on both the Neonatal Discharge form as well as the Community Midwife's Discharge (page 23).**

### **If BCG required, has it been given:**

Refers to Neonatal BCG, please review to establish if a risk factor was previously identified and whether BCG has been given. Examiners should refer to the Neonatal Discharge form (CHS3b) for information relating to Neonatal BCG given prior to discharge from hospital and the Immunisation page in PCHR (page 7) for immunisations given post discharge. Please circle as appropriate.

### **If Yes, Date of BCG:**

If BCG was required and given, please provide date given in DDMMYY format. If required and not already given, please refer child to the local BCG service.

### **Antenatal Contact by Health Visitor:**

Please circle as appropriate.

### **Additional Support Required:**

This relates to parents who may need additional support over and above the normal routine contact. Please circle as appropriate and follow local policy re notification to other professionals.

### **CHS Recall:**

Please circle **Yes** if you would like CHS to schedule a future appointment, otherwise circle **No**.

### **Number of Weeks:**

Please record the number of weeks ahead you want the appointment to be made.

**Agencies Referred To**

Please record any agencies that the child has been referred to as a result of this examination in the boxes provided (see list of agency codes on page 43 of the PCHR). Also record any details of referral made by the Community Midwife in the Discharge Note section of page 23.

**Comments / Details of Actions Taken / Required**

It is important that other professionals providing services are aware of any action taken or required (including referral) so please ensure that these details are clearly recorded along with any other comments you may note.

**Significant Medical Conditions**

Please record any significant diagnosis made to date in this area of the page. This information, which will be coded and input to CHS, should be recorded as concisely as possible.

**Reviewer's Information**

<b>Reviewer's Name</b>	Please print your name in BLOCK CAPITALS.
<b>Signature</b>	Please sign.
<b>Reviewer's Code</b>	Please enter your Examiner code.
<b>Is An Interpreting Service Required?</b>	Please circle as appropriate and where yes, identify which language.

**DISTRIBUTION OF PAGES 25 AND 26 ON COMPLETION**

**Please remove the first and second copies from the PCHR and distribute as follows:**

- 1<sup>st</sup> copies (white)** - GP (staple and send via local Child Health Office for CHS input)
- 2<sup>nd</sup> copies (green)** - HV Professional Record

The 3<sup>rd</sup> copies of pages 25 and 26 (white) remain in the PCHR.

## **New Baby Review Summary – Page 27**

Please affix CHS identification labels to both copies of this page, otherwise complete as guided for Part 1 (page 25) of the New Baby Review.

This page is included for you to provide a summary of the New Baby Review contact and discussion taken place as well as to allow you to record any advice that the child's mother may need to refer back to at a later time.

### **DISTRIBUTION OF PAGE 27 ON COMPLETION**

**Please remove the first copy from the PCHR and action as follows:**

**1st copy (white) - HV Professional Record**

The 2<sup>nd</sup> copy (white) remains in the PCHR.



**PCHR**

**Completion of 6-8  
Week Review  
Information**

**Health Visiting Team**

**Page 28 and CHS60**

## 6-8 Week Review – Page 28

All areas of the form should be completed using a **black ball-point pen** and examiners should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover is inserted behind all 3 copies of the page, otherwise NCR pages relating to other examinations/reviews in the red book will be defaced.

Please affix CHS identification labels to all 3 copies of this page, otherwise complete as follows:

<b>Child's Identification</b>	
<b>Surname</b>	Enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from the mother's.
<b>Forename(s)</b>	Enter in full.
<b>Health+Care Number</b>	Enter in full.
<b>CHS System Number</b>	Enter in full, as provided on the Birth Notification label.
<b>Address</b>	Please complete providing postcode.
<b>Sex</b>	Please circle as appropriate.
<b>Date of Birth</b>	Enter using DDMMYY format.
<b>GP</b>	Enter name in full and provide GP's Cipher code (if known).
<b>HV</b>	Enter name in full and provide HV's caseload number.

<b>Review Details</b>	
<b>Consent to Review</b>	Please circle as appropriate.
<b>Location of Review</b>	Please circle 'Home' otherwise record location.
<b>Date of Review</b>	Enter using DDMMYY format.

<b>Growth Measurement</b>
Please record length in centimetres; weight in grams (to one decimal place); and, head circumference in centimetres (to one decimal place).  Plot on 'Centile Chart' at the back of the PCHR and record 'centiles alongside measurements.

## Update of Risk Factors

### Is the previous Assessment Record available?

Please refer to the previous Risk Factor Assessments (pages 20, 22 and 25 of the PCHR) and the discharge note area of the Community Midwife's Discharge (page 23).

If previous Risk Factor Assessment information is not available circle **No** and then undertake a full Risk Factor Assessment, recording outcomes against **ALL** categories on the Risk Factor Assessment/Update Form (CHS59).

If the previous Risk Factor Assessments are available and completed circle **Yes**.

### If the previous Risk Factor Assessment is available have any Risk Factors changed?

Where previous Risk Factor Assessment information is available please review and establish if any Risk Factors have changed.

If Risk Factors have not changed please circle **No**.

If Risk Factors have changed circle **Yes** and then complete the Risk Factor Assessment Update form (CHS59), identifying **ONLY** new risk factors. Include any new risk factors identified by the community midwife.

***N.B. Where a risk factor is identified the reviewer should provide details of action taken in the free text area entitled "Comments / Details And Action Taken/Required (including referral)" and MUST ensure that the appropriate action is taken as follows:***

#### **Hearing**

Once notified, the Child Health System, will automatically identify children (**up to 6 months of age**) with hearing risk factors to Community Audiology Services for 8 month Audiology Assessment.

**N.B.** Hearing Risk Factor Assessment is available from the Newborn Hearing Screening (page 22).

Family History (1<sup>st</sup> degree relative) of Hearing Loss **EXCLUDES** a family history of "glue ear".

#### **Hips**

Refer for Ultrasound scan, as per local policy, where risk is identified.

Family History includes 1<sup>st</sup> and 2<sup>nd</sup> degree relatives.

#### **Vision**

Refer to Paediatric Ophthalmology for assessment.

## Update of Risk Factors

### **Tuberculosis**

Refer to the BCG service, advising if mother is HIV positive, or if mother's HIV status is unknown. If a member of the child's household or family circle is suspected of having TB, or has/had TB in the past 5 years, advice must be sought from the Duty Room, Health Protection Division, Public Health Agency (tel: (028) 905539 94/97 or email: pha.dutyroom@hscni.net).

See current guidance in TB incidence worldwide at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/>

N.B. In addition to TB risk factors identified in the PCHR, moved in infants, born in a high incidence country, should be referred to the BCG service.

**The current definition of high incidence is a rate of 40 cases or greater per 100,000 population annually (WHO – April 2009).**

## Review

### **Further Vitamin K Required:**

Please review details of Vitamin K already given (refer to Neonatal Discharge Form and Community Midwife's Discharge (page 23 of PCHR) and circle as appropriate.

**N.B. Dosage is dependant on the administration route and feeding method.**

- ***Intramuscular/Intravenous***  
1 dose at birth, regardless of feeding.
- ***Oral (formula fed)***  
2 doses, 1<sup>st</sup> at birth and 2<sup>nd</sup> at 1 week.
- ***Oral (breast milk fed)***  
3 doses, 1<sup>st</sup> at birth, 2<sup>nd</sup> at 1 week and 3<sup>rd</sup> at 1 month.

### **Bloodspot Results Given:**

Please ensure that parent has been informed about the bloodspot screening test results and that a copy of the results has been inserted into the PCHR (after page 23). If you have not received copies of laboratory test results please contact your CHS Manager **IMMEDIATELY** (see Appendix 1 for contact information).

### **Breastfeeding at 6 Weeks:**

Please circle as appropriate.

N.B. reporting should not reflect method of feeding, i.e. expressed breast milk given via bottle should be recorded as Total or Partial breastfeeding.

### **Additional Support Required:**

This relates to parents who may need additional support over and above the normal routine contact. Please circle as appropriate and follow local policy re notification to other professionals.

**Review (cont'd)**

**CHS Recall**

Please circle **Yes** if you would like CHS to schedule a future appointment, otherwise circle **No**.

**Number of Weeks**

Please record the number of weeks ahead you want the appointment to be made.

**Hips**

IF, BY LOCAL ARRANGEMENT WITH THE GP, YOU CARRY OUT THE 8-WEEK HIP EXAMINATION AT THIS CONTACT YOU SHOULD RECORD THE OUTCOME OF THE TEST IN THE HIPS S O T R N SECTION OF PAGE 29. PLEASE ENSURE YOU DATE AND SIGN THAT YOU HAVE CARRIED OUT THIS EXAM IN THE COMMENTS SECTION OF BOTH PAGES 28 AND 29.

**DO NOT REMOVE PAGE 29 UNLESS IT HAS BEEN COMPLETED BY THE GP.**

**Agencies Referred To**

Please record any agencies that the child has been referred to as a result of this examination in the boxes provided (see list of agency codes on page 43 of the PCHR).

**Comments / Details of Action Taken / Required**

It is important that other professionals providing services are aware of any action taken or required (including referral) so please ensure that these details are clearly recorded along with any other comments you may note.

**Significant Medical Conditions**

Please record any significant diagnosis made to date in this area of the page. This information, which will be coded and input to CHS, should be recorded as concisely as possible.

**Reviewer's Information**

<b>Reviewer's Name</b>	Please print your name in BLOCK CAPITALS.
<b>Signature</b>	Please sign.
<b>Reviewer's Code</b>	Please enter your Examiner code.
<b>Is An Interpreting Service Required?</b>	Please circle as appropriate and where yes, identify which language.

## **DISTRIBUTION OF PAGE 28 ON COMPLETION**

**Please remove the first and second copies from the PCHR and distribute as follows:**

**1st Copy (white) - GP (via local Child Health Office)**

**2nd Copy (green) - HV Professional Record**

The 3<sup>rd</sup> copy (white) remains in the PCHR.

**A separate page (CHS56) is available in pads for use by health visitors to record outcomes of the 6-8 Week Health Review where the PCHR is not available (see guidance on page 56).**

**PCHR**

**Completion of  
8-Week Examination  
Information**

**General Practitioner**

**Page 29 and CHS56**

## 8 Week Examination – Page 29

All areas of the form should be completed using a **black ball-point pen** and examiners should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover is inserted behind all 3 copies of the page, otherwise NCR pages relating to other examinations/reviews in the red book will be defaced.

Please affix CHS identification labels to all 3 copies of this page, otherwise complete as follows:

<b>Child's Identification Details</b>	
<b>Surname</b>	Enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from the mother's.
<b>Forename(s)</b>	Enter in full.
<b>Health+Care Number</b>	Enter in full.
<b>CHS System Number</b>	Enter in full, if known.
<b>Address</b>	Please complete providing postcode.
<b>Sex</b>	Please circle as appropriate.
<b>Date of Birth</b>	Enter using DDMMYY format.
<b>GP</b>	Enter name in full and provide GP's Cipher code.
<b>HV</b>	Enter name in full and provide HV's caseload number (if known).

<b>Examination Details</b>	
<b>Consent to Examination</b>	Please circle as appropriate.
<b>Date of Examination</b>	Please record the date that the examination was carried out in DDMMYY format.
<b>Exam Centre Code</b>	Please record your examination centre code here.



### Examination and Outcomes

The examination should be carried out as per Healthy Child, Healthy Future Guidance on 8 Week Examination and documented on page 29 as follows:

#### Heart Rate

Please record heart rate per minute.

#### Respiratory Rate

Please record respiratory rate per minute.

Please circle **ONE** outcome against each of the components of the examination.

S – Satisfactory

O – Observe

T – Treatment

R – Referred

N – Not Examined

### CHS Recall

Please circle **Yes** if you would like CHS to schedule a future appointment and record the number of weeks ahead you want the appointment to be made, otherwise circle **No**.

### Agencies Referred To

Please record any agencies that the child has been referred to as a result of this examination in the boxes provided (see list of agency codes on page 43 of the PCHR).

### Comments / Details of Action Taken / Required

It is important that other professionals providing services are aware of any action taken or required (including referral) so please ensure that these details are clearly recorded.

### Significant Medical Conditions

Please record any significant diagnosis made to date in this area of the page. This information, which will be coded and input to CHS, should be recorded as concisely as possible.

### Examiner Details

**GP's Name**

Please print your name in BLOCK CAPITALS.

**GP's Signature**

Please sign here.

**GP Code**

Please provide GP Cipher number here.

## **DISTRIBUTION OF PAGE 29 ON COMPLETION**

**Please remove the first and second copies from the PCHR and distribute as follows:**

1st Copy (white) - GP records

2nd Copy (green) - HV (via the local CHS Office, for CHS input)

The third copy (white) remains in the PCHR.

**A separate page (CHS56) is available in pads for use by general practitioners to record outcomes of this 8 Week Examination where the PCHR is not available (see guidance on page 56).**

**PCHR**

**Completion of 14-16  
Week Health Review  
Information**

**Health Visiting Team**

**Page 30 and CHS60**

## 14 - 16 Week Health Review – Page 30

All areas of the form should be completed using a **black ball-point pen** and examiners should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover is inserted behind all 3 copies of the page, otherwise NCR pages relating to other examinations/reviews in the red book will be defaced.

Please affix CHS identification labels to all 3 copies of this page, otherwise complete as follows:

<b>Child's Identification Details</b>	
<b>Surname</b>	Enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from the mother's.
<b>Forename(s)</b>	Enter in full.
<b>Health+Care Number</b>	Enter in full.
<b>CHS System Number</b>	Enter in full, as provided on the Birth Notification label.
<b>Address</b>	Please complete providing postcode.
<b>Sex</b>	Please circle as appropriate.
<b>Date of Birth</b>	Enter using DDMMYY format.
<b>GP</b>	Enter name in full and provide GP's Cipher code (if known).
<b>HV</b>	Enter name in full and provide HV's caseload number.

<b>Review Details</b>	
<b>Consent to Review</b>	Please circle as appropriate.
<b>Location of Review</b>	Please circle 'Home' otherwise record location.
<b>Date of Review</b>	Enter using DDMMYY format.

<b>Growth Measurement</b>
Please record length in centimetres; weight in grams (to one decimal place); and, head circumference in centimetres (to one decimal place).  Plot on 'Centile Chart at the back of the PCHR and record 'centiles alongside measurements.

## Update of Risk Factors

### Is the previous Assessment Record available?

Please refer to previous Risk Factor Assessments (pages 20, 22, 25 and 28 of the PCHR).

If previous Risk Factor Assessment information is not available circle **No** and then undertake a full Risk Factor Assessment, recording outcomes against **ALL** categories on the Risk Factor Assessment/Update Form (CHS59).

If the previous Risk Factor Assessment is available and completed circle **Yes**.

### If the previous Risk Factor Assessment is available have any Risk Factors changed?

Where the previous Risk Factor Assessment is available please review and establish if any Risk Factors have changed.

If Risk Factors have not changed please circle **No**.

If Risk Factors have changed circle **Yes** and then complete the Risk Factor Assessment Update form (CHS59), identifying **ONLY** new risk factors. Include any new risk factors identified by the community midwife on page 23, if not previously noted.

***N.B. Where a risk factor is identified the reviewer should provide details of action taken in the free text area entitled "Comments / Details And Action Taken/Required (including referral)" and MUST ensure that the appropriate action is taken as follows:***

#### **Hearing**

Once notified, the Child Health System, will automatically identify children (**up to 6 months of age**) with hearing risk factors to Community Audiology Services for 8 month Audiology Assessment.

**N.B.** Hearing Risk Factor Assessment is available from the Newborn Hearing Screening (page 22).

Family History (1<sup>st</sup> degree relative) of Hearing Loss **EXCLUDES** a family history of "glue ear".

#### **Hips**

Refer for Ultrasound scan, as per local policy, where risk is identified and assessment review is normal.

Family History includes 1<sup>st</sup> and 2<sup>nd</sup> degree relatives.

#### **Vision**

Refer to Paediatric Ophthalmology for assessment.

## Update of Risk Factors (cont'd)

### **Tuberculosis**

Refer to the BCG service, advising if mother is HIV positive, or if mother's HIV status is unknown. If a member of the child's household or family circle is suspected of having TB, or has/had TB in the past 5 years, advice must be sought from the Duty Room, Health Protection Division, Public Health Agency (tel: (028) 905539 94/97 or email: pha.dutyroom@hscni.net).

See current guidance in TB incidence worldwide at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/>

N.B. In addition to TB risk factors identified in the PCHR, moved in infants born in, or infants living in a high incidence country for more than 3 months, should be referred to the BCG service.

**The current definition of high incidence is a rate of 40 cases or greater per 100,000 population annually (WHO – April 2009).**

## Review

The physical review should be carried out as per Healthy Child, Healthy Future Guidance and recorded on the page as follows:

Please circle **ONE** outcome against each of the components of the review.

S – Satisfactory

O – Observe

T – Treatment

R – Referred

N – Not Examined

### **Hips**

Assess for limited reduction of hips, asymmetry of leg length or deep asymmetrical deep skin creases and record outcome in SOTRN format. If any of the above conditions are identified refer for expert examination (which should include USS) as per local policy.

### **Breastfeeding at 3 months**

Please circle as appropriate. Please record breastfeeding at 6 weeks also, if not previously reported.

N.B. reporting should not reflect method of feeding, i.e. expressed breast milk given via bottle should be recorded as Total or Partial breastfeeding.

### **Additional Support Required**

This relates to parents who may need additional support over and above the normal routine contact. Please circle as appropriate and follow local policy re notification to other professionals.

### **Advised re dental registration**

Please circle **Yes** or **No** as appropriate.

**Review (cont'd)****CHS Recall**

Please circle **Yes** if you would like CHS to schedule a future appointment, otherwise circle **No**.

**Number of Weeks**

Please record the number of weeks ahead you want the appointment to be made.

**Agencies Referred To**

Please record any agencies that the child has been referred to as a result of this examination in the boxes provided (see list of agency codes on page 43 of the PCHR).

**Comments / Details of Action Taken / Required**

It is important that other professionals providing services are aware of any action taken or required (including referral) so please ensure that these details are clearly recorded along with any other comments you may note.

**Significant Medical Conditions**

Please record any significant diagnosis made to date in this area of the page. This information, which will be coded and input to CHS, should be recorded as concisely as possible.

**Reviewer's Information**

<b>Reviewer's Name</b>	Please print your name in BLOCK CAPITALS.
<b>Signature</b>	Please sign.
<b>Reviewer's Code</b>	Please enter your Examiner code.
<b>Is An Interpreting Service Required?</b>	Please circle as appropriate and where yes, identify which language.

**DISTRIBUTION OF PAGE 30 ON COMPLETION**

**Please remove the first and second copies from the PCHR and distribute as follows:**

- 1<sup>st</sup> copy (white) - local CHS Office
- 2<sup>nd</sup> copy (green) - HV Professional Record

The 3<sup>rd</sup> copy (white) remains in the PCHR.

**A separate page (CHS60) is available in pads for use by health visitors to record outcomes of the 14-16 Week Health Review where the PCHR is not available (see guidance on page 56).**

**PCHR**

**Completion of 6-9  
Month Contact  
Information**

**Health Visiting Team**

**Page 31 and CHS60**



## 6-9 Month Review – Page 31

All areas of the form should be completed using a **black ball-point pen** and examiners should ensure that details are legible through to the final NCR (no carbon required paper) copy.

Care should be taken to ensure that the flap in the back cover is inserted behind all three copies of the page, otherwise NCR pages relating to other examinations in the red book will be defaced.

Please affix CHS identification labels to all three copies of this page, otherwise complete as follows:

<b>Child's Identification Details</b>	
<b>Surname</b>	Enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from the mother's.
<b>Forename(s)</b>	Enter in full.
<b>Health+Care Number</b>	Enter in full.
<b>CHS System Number</b>	Enter in full, as provided on the Birth Notification label.
<b>Address</b>	Please complete providing postcode.
<b>Sex</b>	Please circle as appropriate.
<b>Date of Birth</b>	Enter using DDMMYY format.
<b>GP</b>	Enter name in full and provide GP's Cipher code (if known).
<b>HV</b>	Enter name in full and provide HV's caseload number.

<b>Review Details</b>	
<b>Location of Contact</b>	Please circle 'Home' otherwise record location.
<b>Date of Contact</b>	Enter using DDMMYY format.

<b>Feeding / Home Safety / Bookstart</b>
<p><b>Breastfeeding at 6 months</b> Please circle as appropriate. Please record breastfeeding status at 6 weeks and 3 months also, if not already reported.</p> <p><b>Home safety</b> Please circle as appropriate and note any advice given in the 'Summary of Contact' section.</p> <p><b>Bookstart Pack</b> Please circle as appropriate.</p>

**Summary of Contact**

This section is for you to provide a summary of the contact and discussion taken place as well as to allow you to record any advice that the child's mother may need to refer back to at a later time.

**Reviewer's Information**

<b>Reviewer's Name</b>	Please print your name in BLOCK CAPITALS.
<b>Signature</b>	Please sign.
<b>Reviewer's Code</b>	Please enter your Examiner code.
<b>Is An Interpreting Service Required?</b>	Please circle as appropriate and where yes, identify which language.

**DISTRIBUTION OF PAGE 31 ON COMPLETION**

**Please remove the first and second copies from the PCHR and action as follows:**

1<sup>st</sup> copy (white) -Local Child Health Office

2<sup>nd</sup> copy (green) -HV Professional Record

The 3<sup>rd</sup> copy remains in the PCHR.

**A separate page (CHS60) is available in pads for use to record outcomes of the 6-9 Month Contact where the PCHR is not available (see guidance on page 56).**

**PCHR**

**Completion of 1 and  
2 Year Review  
Information**

**Health Visiting Team**

**Pages 32 and 33 and  
CHS60**

## 1 and 2 Year Reviews - pages 32 and 33

All areas of these forms should be completed using a **black ball-point pen** and examiners should ensure that details are legible through to the final NCR (no carbon required paper) copies.

Care should be taken to ensure that the flap in the back cover is inserted behind all 3 copies of these pages, otherwise NCR pages relating to other examinations/reviews in the red book will be defaced.

Please affix CHS identification labels to all 3 copies of these pages, otherwise complete as follows:

<b>Child's Identification Details</b>	
<b>Surname</b>	Enter using BLOCK CAPITALS. Please note it is important to identify the child's surname, particularly where it is different from the mother's.
<b>Forename(s)</b>	Enter in full.
<b>Health+Care Number</b>	Enter in full.
<b>CHS System Number</b>	Enter in full, as provided on the large Birth label.
<b>Address</b>	Please complete providing postcode.
<b>Sex</b>	Please circle as appropriate.
<b>Date of Birth</b>	Enter using DDMMYY format.
<b>GP</b>	Enter name in full and provide GP's Cipher code (if known).
<b>HV</b>	Enter name in full and provide HV's caseload number.

<b>Review Details</b>	
<b>Consent to Review</b>	Please circle as appropriate.
<b>Location of Review</b>	Please circle 'Home' otherwise record location.
<b>Date of Review</b>	Enter using DDMMYY format.

<b>Growth Measurement</b>
Please record length/height in centimetres; weight in grams (to one decimal place); and, head circumference in centimetres (to one decimal place). Plot on 'Centile Chart at the back of the PCHR and record 'centiles alongside measurements.

## **Update of Risk Factors**

### **Is the previous Assessment Record available?**

Please refer to previous Risk Factor Assessments (pages 20, 22, 25, 28, 30 (and 32, when undertaking the Health Review at 2 Years) of the PCHR).

If previous Risk Factor Assessment information is not available circle **No** and then undertake a full Risk Factor Assessment, recording outcomes against **ALL** categories on the Risk Factor Assessment/Update Form (CHS59).

If the previous Risk Factor Assessment is available and completed circle **Yes**.

### **If the previous Risk Factor Assessment is available have any Risk Factors changed?**

Where the previous Risk Factor Assessment information is available please review and establish if any Risk Factors have changed.

If Risk Factors have not changed please circle **No**.

If Risk Factors have changed circle **Yes** and then complete the Risk Factor Assessment/Update form (CHS59), identifying **ONLY** new risk factors. Include any new risk factors identified by the community midwife.

### **N.B.**

**Where a risk factor is identified the reviewer should provide details of action taken in the free text area entitled “Comments / Details And Action Taken/Required (including referral)” and MUST ensure that the appropriate action is taken as follows:**

#### **Hearing**

Where a new hearing risk factor is identified the health visitor should refer the child to Community Audiology Services for appropriate audiological assessment.

Family History (1<sup>st</sup> degree relative) of Hearing Loss **EXCLUDES** a family history of “glue ear”.

#### **Hips**

Refer for Ultrasound scan where a new risk is identified and previous examination was normal (as per local policy).

Family History includes 1<sup>st</sup> and 2<sup>nd</sup> degree relatives.

#### **Vision**

Refer to Paediatric Ophthalmology for assessment.

#### **Tuberculosis**

Refer to the BCG service, advising if mother is HIV positive, or if mother's HIV status is unknown. If a member of the child's household or family circle is suspected of having TB, or has/had TB in the past 5 years, advice must be sought from the Duty Room, Health Protection Division, Public Health Agency (tel: (028) 905539 94/97 or email: pha.dutyroom@hscni.net).

## Update of Risk Factors (cont'd)

See current guidance in TB incidence worldwide at:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/EpidemiologicalData/TBWorldwideData/tbepiWhoTable1/>

N.B. In addition to TB risk factors identified in the PCHR, moved in infants born in, or infants living in a high incidence country for more than 3 months, should be referred to the BCG service.

**The current definition of high incidence is a rate of 40 cases or greater per 100,000 population annually (WHO – April 2009).**

**\*THE FOLLOWING GUIDANCE ON RISK FACTOR UPDATE IS APPLICABLE TO THE 2 YEAR HEALTH REVIEW ONLY\*\***

### **2 Year Vision Assessment completed?**

Please circle Yes or No and then record the outcome of the 2 Year Vision Assessment under Vision S O T R N and take appropriate action according to 2 Year Vision Assessment tool and Vision Care Pathway.

<b>RISK IDENTIFIED</b>	<b>ACTION</b>	<b>S O T R N OUTCOME</b>
Parent/sibling wore glasses or patch under the age of 8 years or if parent/sibling has squint.	Test vision and corneal reflections <i>and refer only</i> if there is unequal or reduced vision or asymmetrical corneal reflections.	Record (R)eferred were tests results are not normal. Otherwise record (S)atisfactory.
Parent suspects child has difficulty seeing.	Test vision and corneal reflections <i>and refer</i> .	Record (R)eferred.
Parent suspects child has squint.	Test vision and corneal reflections <i>and refer</i> .	Record (R)eferred.
Child born at <32wks gestation or <1500gm.	Test vision and corneal reflections <i>and refer</i> .	Record (R)eferred.
Child has neuro developmental disorder.	Refer.	Record (R)eferred.

(S)atisfactory should be recorded within SOTRN for those children found not to have any risk at assessment.

### **Extended Pneumococcal risk factors identified?**

Please refer to page 43 for risk factor groups. Circle as appropriate. If Yes, signpost parent to GP for Pneumovax (PPV) immunisation assessment.

## Review

The 1 and 2 Year reviews should be carried out as per Healthy Child, Healthy Future Guidance and documented as follows:

Please circle **ONE** outcome against each of the components of the review.

S – Satisfactory

O – Observe

T – Treatment

R – Referred

N – Not Examined

### **Breastfeeding at 12 months:**

Please circle as appropriate and record breastfeeding at 6 weeks, 3 months and 6 months, if not already reported. *Not applicable to 2 Year Review.*

### **Additional Support Required:**

This relates to parents who may need additional support over and above the normal routine contact. Please circle as appropriate and follow local policy re notification to other professionals.

### **Advised re dental registration**

Please circle Yes or No as appropriate.

### **CHS Recall**

Please circle **Yes** if you would like CHS to schedule a future appointment, otherwise circle **No**.

### **Number of Weeks**

Please record the number of weeks ahead you want the appointment to be made.

## Agencies Referred To

Please record any agencies that the child has been referred to as a result of this examination in the boxes provided (see list of agency codes on page 43 of the PCHR).

## Comments / Details of Action Taken / Required

It is important that other professionals providing services are aware of any action taken or required (including referral) so please ensure that these details are clearly recorded along with any other comments you may note.

## Significant Medical Conditions

Please record any significant diagnosis made to date in this area of the page. This information, which will be coded and input to CHS, should be recorded as concisely as possible.

<b>Reviewer's Information</b>	
<b>Reviewer's Name</b>	Please print your name in BLOCK CAPITALS.
<b>Signature</b>	Please sign.
<b>Reviewer's Code</b>	Please enter your Examiner code.
<b>Is An Interpreting Service Required?</b>	Please circle as appropriate and where yes, identify which language.

### **DISTRIBUTION OF PAGES 32 AND 33 ON COMPLETION**

**Please remove first and second copies from the PCHR and distribute as follows:**

- 1<sup>st</sup> copy (white) - local CHS Office
- 2<sup>nd</sup> copy (green) - HV Professional Record

The 3<sup>rd</sup> copy (white) remains in the PCHR.



**PCHR**

**Completion of  
Immunisation  
Information**

**GP Practice, Health  
Visiting, Maternity  
and Neonatal  
Services, A&E  
Departments,  
Paediatric Infectious  
Diseases, Children's  
Inpatient Services  
staff, BCG Services,  
Travel Clinic  
Services and School  
Health Services**

**Page 7**

## Immunisation – Page 7

This area of the PCHR provides a summary record for parents as well as professionals and should contain all immunisations given to the child, including primary course, MMR, boosters, Hepatitis B and BCG.

Recording in this area of the PCHR does NOT obviate the need to complete the usual documentation, i.e.

- the CHS3b Neonatal Discharge form (if Hepatitis B and/or BCG is given prior to discharge);
- the CHS Immunisation Clinic List (CHS6) where immunisation is provided at the general practitioner's scheduled Immunisation Clinic; or,
- the Unscheduled Immunisation Attendance Form (CHS7) for all other unscheduled immunisations carried out:
  - in hospital (Maternity (*postnatal*), NNU, Children's wards, Outpatients and A&E);
  - at the general practitioner's Immunisation Clinic;
  - by the BCG service (post discharge); or,
  - in the home.

**PCHR**

**Recording of Non-  
Routine Contact  
Information**

**GP Practice, Health  
Visiting, A&E,  
Outpatient and  
Inpatient Services,  
Dentists, Allied  
Health Professionals,  
Social Services Staff,  
Community Services  
e.g. Eye Clinic,  
Audiology Clinic**

**Pages 35-40**

## **Notes – Pages 35 - 40**

This area of the PCHR is for any health or social care professional to record details about contacts they have with the child. This area may also be used by the parent to note anything they would like to discuss with professionals.

Care should be taken to date and sign all entries you make in this area of the PCHR.

Dentists may wish to use page 18 where they can provide information on teeth charting.

**PCHR**

**Special  
Circumstances**

## **Recording Sensitive Information**

In practice, the recording of sensitive information has not been found to be a problem. In the majority of cases where a professional is concerned about a child's development, so is the parent. Therefore, the information needs to be shared.

## **Translations For Ethnic Minorities**

A regional subgroup has been established to look at translation of the new version of PCHR and will report on the areas of the PCHR that need to be translated as well as the languages that will be required for translation.

## **Literacy**

It should not be assumed that everyone is confident with reading and writing. If you suspect literacy is a problem, it is important that you do not pressurise parents into making their own written contribution and the necessary time should be taken with the parent to explain the content of the record.

- Ensure that anything that is written is legible.
- Use simple sentence structure.
- Refer to Professional Guidance on Record Keeping.

## **Child Protection**

If you are concerned that a child has suffered abuse you are obliged to keep your own professional record and to follow your local Child Protection procedures.

Parents should be informed of your concerns and any record kept should be shared with them unless:

- a) It is deemed by professionals not to be in the best interests of the child; or,
- b) The information is from a third party whose permission must be sought.

Any action taken should be noted in the PCHR, subject to parental agreement.

Reports written should always be factually correct and any opinion should be based on sound professional judgement. Professionals may need to refer to the PCHR when drafting reports or a statement for court. Information may also be retrieved from the Child Health System by authorised personnel.

**“The PCHR is the property of the Trust. The Trust has in effect given the parent permission to hold the record. Access to the record can be requested and, in theory at least, enforced by law. Health visitors will not be held liable if a PCHR is lost or otherwise unavailable. The day-to-day responsibility for keeping the record safe lies with the client.” (HVA - Guide to Introducing Parent Held Records).**

## **Children On The Child Protection Register**

This information should be contained in the PCHR if the parent agrees. It should be recorded in the details of your contacts with the child including the reason for registration. It is therefore important that records are read carefully when you are seeing a child for the first time. Health visitors **MUST** also keep details of registration in the Professional Record.

## **Looked After Children / Adoption**

Since the PCHR is the child’s main record it is important that Social Services Staff ensure that the booklet follows the child and is available to all professionals in contact with the child.

Where a child is placed in pre-adoptive foster care it is the responsibility of Social Services to retrieve the PCHR from the pre-adoptive foster parent and to pass it to the child’s current health visitor in advance of the child being placed with prospective parents.

Social Services should continue to observe the regional policy of CHS Notification at each stage of the adoption procedure using the appropriate documentation as per local policy.

**The PCHR, professional record and Child Health System record should be cleansed as per current local policies for pre adoptive and adopted children, interim to the introduction of regional records management guidance for adopted children within Health and Social Care Trusts in Northern Ireland.**

## **Non-Availability of Records**

Additional Pads of pages will be provided for the following contacts:

- 8 Week GP Examination (CHS56);
- 6-8 Week, 14-16 Week, 1 and 2 Year Health Reviews / Other (CHS60); and,
- exceptional contact following the 4 Year Record Review (CHS57 and CHS58).

If the parent does not produce the PCHR at the time of any of these contacts please complete the relevant page and provide the PCHR copy to the parent to insert into the PCHR at home.

If the parent does not produce the PCHR at a non-routine contact, e.g. an A&E visit, or an Outpatient appointment, the professional should encourage the parent to record attendance and outcome of visit in the Notes section of the PCHR (pages 35-40 of the PCHR).

## **Lost Records**

National evaluation indicates that these records are rarely lost where there has been good training in handover procedure and effective implementation. However, in the event of loss, the health visitor should issue a new record to the parent.

It is not proposed that the health visitor should reproduce the original record, but if there are concerns highlighted within the Professional Record, they will need to be identified within the duplicate record for both the parent and other professionals' information. It is also possible to produce a Child Health System record print-out, which can be inserted into the PCHR.

The health visitor should record details of the duplication, i.e. "Copy Record" and date of copy on the first page of the duplicate PCHR.

## **Mortality**

Although the record is deemed to be the property of the Trust, parents should be given the opportunity to keep the PCHR. The Professional Health Visiting Record should be filed at the local Child Health Office according to local policy.



## **Confidentiality**

Confidentiality of the PCHR lies with parents and they can share the record as they choose, including with those looking after their child (after the age of three the majority of children are looked after by someone else in addition to their parents).

## **Legal Guidance**

1. The record remains the property of the Trust who has effectively granted permission for the parent to hold it.

Access should be permitted by the parent when requested and if refused may be enforced by law. Permission to hold the record may be revoked by the Trust.

2. The day-to-day responsibility for safety of the record lies with the parent. If the parent is subsequently unable or unwilling to hand over the record for inspection, criticism cannot be levelled at the professional.
3. The parent should see any comments as they are made and at that point have the opportunity to highlight any inaccuracies or complain of bias. Defamation is thus unlikely to be a problem and any later complaints are unlikely to be viewed sympathetically.

It is important to note that comments cannot be defamatory if they are true and sharing comments with parents as they are written should avoid this difficulty. Professionals in this case would be protected unless they acted in a totally unprofessional and malicious manner.

## HEALTHY CHILD, HEALTHY FUTURE - SUMMARY OF THE PRESCHOOL UNIVERSAL PROGRAMME\*

ACTIVITY	WHEN	WHERE	BY WHOM	PCHR REFERENCE	COMMENTS
Newborn Risk Factor Assessment and Examination	Within 72 hours of birth	Maternity Unit / Home	Midwife/SHO	Pages 20 and 21	Cephalocaudal Examination and Risk Factor Assessment
Blood spot test (PKU/CHT/MCADD/CF)	Day 5	Home	Community midwife	Page 23	2 <sup>nd</sup> CHT test at 36 weeks equivalent gestation (if 1 <sup>st</sup> test taken before 36wks GA)
Assessment at Midwifery Handover	Day 10	Home	Community midwife	Page 23	Details of Vitamin K, SBR testing (if required), blood spot test, feeding, weight and risk review/update
New Baby Review	Day 10 – 14	Home	Health visitor	Page 25-27	Examination, family needs assessment (FNA), Health Promotion (HP), feeding, growth, risk review/update
Health Review	6-8 weeks	Home	Health visitor	Page 28	FNA, HP, feeding, growth, risk review/update
Examination	8 weeks	GP clinic	General practitioner	Page 29	Examination at time of 1 <sup>st</sup> immunisation ideally
Health Review	14-16 weeks	<u>Home</u>	Health visitor	Page 30	FNA, HP, feeding, growth, risk review/update
Health Contact	6-9 months	Home	Health visitor	Page 31	Home safety, HP
Health Review	1 year	Home	Health visitor	Page 32	FNA, HP, feeding, growth, risk review/update
Health Review	2 years	Home	Health visitor	Page 33	FNA, HP, feeding, growth, risk review/update
Record Review	4 years	N/A	Health visitor	CHS57 and/or CHS58 for contact/summary	May require contact following record review

\* Details of the full programme content (covering 0-19 years) available from: 'Healthy Child, Healthy Future' a Framework for the Universal Child Health Promotion Programme (CHPP) in Northern Ireland (<http://www.dhsspsni.gov.uk/healthychildhealthyfuture.pdf>)

**CHILD HEALTH SYSTEM AREA CONTACTS****Northern Area**

Gillian Weir  
Central Child Health Office  
Braid Valley Site  
Cushendall Road  
Ballymena  
BT43 6HL  
**Telephone:** (028) 2563-5352/5435  
**Email:** [gillian.weir@northerntrust.hscni.net](mailto:gillian.weir@northerntrust.hscni.net)

**Southern Area**

Valerie Doyle  
Child Health System Bureau Office  
Chestnut Building  
100 Sloan Street  
Lurgan  
BT66 8NT  
**Telephone:** (028) 38314857  
**Email:** [valerie.doyle@southerntrust.hscni.net](mailto:valerie.doyle@southerntrust.hscni.net)

**Eastern Area**

Maria Monaghan  
Child Health System Bureau Office  
Glendinning House  
6 Murray Street  
Belfast  
BT1 6DN  
**Telephone:** (028) 90821322  
(028) 90821279 (out of hours answering service)  
**Email:** [maria.monaghan@belfasttrust.hscni.net](mailto:maria.monaghan@belfasttrust.hscni.net)

**Western Area**

Jackie Hamilton  
ICT Department  
Lilac Villa  
Gransha Park  
Londonderry  
BT47 6TP  
**Telephone:** (028) 71865124 (option 3)  
**Email:** [jackie.hamilton@westerntrust.hscni.net](mailto:jackie.hamilton@westerntrust.hscni.net)