Managing Child health Records for Children who have been Adopted in Nottinghamshire County.

Background

When a child moves into a prospective adoptive placement from foster care, the child remains looked after, the birth name remains the legal name and they will have the same NHS number from birth.

When a child is legally adopted, the court process initiates the issuing of a new NHS number for that child. From that point (the granting of the adoption order), the child will have a new identity. The time span from moving into placement to the granting of the order can be anything from 6 months onwards. At that point, the child will require new child health records.

The management of paper records have traditionally meant that pertinent health information is summarised by the Health Visitor or the School Nurse for that child from the old child health record, which is then transferred to a new paper record which has a child’s new legal name and new NHS number.

Information containing the old identity, demographics and birth family information is not included within the new record. The old paper record with this information within is then sealed and filed with the new paper record. That sealed record would then only be reopened in very specific circumstances (for example, development concerns in the future that may require a paediatrician to look at the old health information), and would follow the current paper record should the child move. There would be no link between the two records other than a reference in the new records that a previous record exits.

The development of SystmOne means that a new approach is required.

Old information cannot pass from unit to unit electronically as the previous record is no longer connected to the spine. If a child remains in the same unit, the original record can be accessed but only if a worker can remember the original name or NHS number. This becomes more difficult as a child grows older.

The following guidance will aid health professionals when handling adoption records on SystmOne.
Guidance.

- Health professional finds out that a child has been legally adopted:
  1. When S1 record is opened and a large sign appears that indicates the record has an invalid NHS number and has been declared invalid by the spine.
  2. They may be informed by new parents, social worker, child health or other involved professional.

  The child will have been issued with a new NHS number.

- Health professional should contact the child health department so that they can find out the new NHS number. **Do not** put any further health entries into the old record.
- Child health will then contact the health professional to inform them that a new record has been created using the new number and create a share.
- All immunisation data will be transferred over by child health to the new record.
- All birth information and development reviews will be transferred to the new record by child health if the child was born in this area and if the development reviews were inputted onto S1 by them.
- The named health visitor/school nurse is responsible for summarising the old health history, exactly the same as would have occurred with paper records or as happens when transferring a child’s records out of area.
- A template has been adapted for professionals to use when transferring information from the old record to the new one. **This has been added to the clinical tree on every unit.** Information regarding this is included in Appendix One.
- Letters containing old names, addresses, NHS numbers **cannot** be put on the new electronic record.
- Re-create the shares and recalls that existed in the old record.
- Create relevant relationships. Adoptive parents should be known as ‘parents’ once the new record is created. The word ‘adopted’ should be avoided if possible.
- Ensure allergies and any other relevant information is transferred to new record.
- The old S1 record is printed off and placed into a sealed envelope- Child health can send copy’s of the notice that goes on the front of the sealed record if the health professional has not already received this.
- The sealed envelope can remain with any new paper record as is the current practice. If there is no new paper record then it remains at base currently. The new name for the child will need to be printed on the sealed envelope.
- Make a note on the new S1 record that previous records are available and where they are been kept. This should be recorded on the **reminders** section of the template.
- When the old record has been printed off, deduct the old S1 record. **The child at that point should only have one record on each unit.**
• If letters arrive from elsewhere with the old NHS number/details on following the granting of the adoption order, then these would have to be summarised on S1 and filed in the sealed envelope. For example, a hospital letter.
• All other involved units, for example physiotherapy, would need to contact child health or health visitor/ school nurse/GP to find out the new NHS number and then open the child up on their S1 unit under the new details.
• Each involved unit is responsible for summarising their involvement- for example a physiotherapist would summarise their involvement and place it on the new record. It is for the professional to decide the best way of achieving this. The new template should be used.
• If the child moves out of area, the old sealed record will currently follow the child.

Future Developments.

A central point to keep the old records may be required.

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Appendix One.

Record Summary for New NHS Number.

See Template below:

- Summarise past health history, development concerns and behaviour concerns.
- Record date last seen and summarise the contact. Make a comment as to whether child maintaining centiles.
- Record where paper record is to be stored.
- Tick the box to say summary has been completed.

Example:

Health:
Born 10 weeks premature and spent 7 weeks on neonatal unit.
Regular reviews by neonatologist- discharged in 2010.
Reviewed in orthoptics 2011 due to squint- now discharged.
Had an innocent murmur investigated June 2011- now discharged.

Development:
Development delay prior to placement, mainly in gross motor skills.
Had various blood tests and was reviewed by community paediatrician in January and July 2012. No cause for development delay found.

**Behaviour:**
Behaviour difficulties on placement due to past life experiences prior to placement. CAMHS involved until November 2012.

**Last seen:**
Date
Growth
Describe current state of health, development, and behaviour.
Include details of family make-up as you would for all transfer in visits.
Eg-Child has been with new family since January 2012. Child has settled in well after initial difficulties due to behaviour and development delay.

**Reminders:**
An old paper record exists for this child and is stored with the new paper record at………………..Health Centre.

**Remember-**
A brief summary only is needed as the old records are still available if more detail is required.