TALKING POINT

GP records: paediatric development card

CHRISTOPHER MAYCOCK

The use of our problem-oriented record system¹ has highlighted the omission of a developmental paediatric card and encouraged us to correct this deficiency. There have been differing ideas about paediatric assessment, particularly the timing of examinations and their content, and this has been a stumbling block to general agreement about the layout of such a card. We needed, therefore, to design a card which would be sufficiently concise and flexible to accommodate these differences while providing evidence that checks, considered necessary at the time, had been performed.

The essential feature of our card is its division into general categories (fig 1). These categories of developmental assessment correspond to the main divisions of a previously agreed "template" whose main divisions are subdivided into individual tests or skills. The doctor keeps a copy of the template beside him during examinations as an aide mémoire or check list. Any future revision of the subdivisions should be simple and inexpensive, since only a few copies of the template are needed. Our present template is a slightly modified version of the development chart used in the paediatric department of the Royal Devon and Exeter Hospital. The layout of the paediatric card, which is kept permanently in each child's NHS record folder, remains unchanged.

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Description and use

The card (18 cm × 11.5 cm) is yellow and fits the ordinary NHS record envelope (fig 1). Background information is written on the top section; the remainder of the card is divided into four main columns.

Certain individual measurements or tests are listed in the first column, as well as general categories of developmental assessment such as ventral suspension, prone posture, sitting, manipulation, social behaviour and speech. The categories correspond to the main divisions of the template. Habit "milestones" refers to the child's achievement of normal milestones for bladder and bowel control, dressing, feeding, etc, whereas "behaviour" refers to positively abnormal patterns of behaviour such as breath-holding attacks, aimless overactivity, excessive fears, obsessions, etc.

The remaining three main columns are divided into boxes for recording the findings. The age of the child at each examination is written in the box at the head of the appropriate column. In the remaining boxes is space for a tick (✓), indicating normality, or a cross (X), indicating abnormality. The upper part of each of these main columns is subdivided into two narrower columns to allow not only the marking of a tick or a cross in the right-hand subdivision but also the level of development attained in the left-hand one. This encourages the doctor to assess each category carefully and also helps him to decide whether or not development is normal, bearing in mind other factors such as gestation. Recording can be simplified by bracketing together normal findings as shown in the 28-week and two-year columns.

Fig 1

a

PAEDIATRIC DEVELOPMENT CARD Front

Surname: **PAN** Forenames: **PETER** Date of Birth: **3.1.76** Sex: **M** Gestation: **34/52**

Pregnancy and Delivery: **Antepartum** Appar: **1 min 8** Birth weight: **2980g** Feeding: **BREAST only**

has no inheritance 3 mins 9 Problems: **X** Biochem screen: **P < U** 9.1.76

Age at examination → **8 weeks** **28 weeks** **52 weeks**

Weight	Actual	4800g	✓	7800g	✓	10.2kg	✓
	Percentile	40	✓	52	✓	48	✓
Head Circumference	Actual	38cm	✓	44cm	✓	47cm	✓
	Percentile	25	✓	25	✓	40	✓
Ventral Suspension		6/52	✓			48/52	✓
Prone Posture		6/52	✓			48/52	✓
Sitting (and Supine)		4/52	✓			48/52	✓
Primitive Responses		4/52	✓	24/52	✓	52/52	✓
Walking (Standing position)		4/52	✓			48/52	✓
Manipulation		4/52	✓			48/52	✓
Vision		4/52	✓			34/52	✓
Hearing		4/52	✓			34/52	✓
Social Behaviour and Speech		4/52	✓			48/52	✓
Skull face and mouth							
Eyes (squint?)							
Ears							
Heart							
Lungs							
Abdomen and herniae							
Genitalia (testes)							
Femoral pulses							
Feet							
Feet and hands							
Muscle tone							
Reflexes							
Skin							
Sense							
Genital Abnormality							
Other							
Examiner		J.S.W.		H.V.		A.E.F.	
Date		2.3.76		3.7.76		2.1.77	

b

Back

Surname: **PAN** Forenames: **PETER** Date of Birth: **3.1.1976** N.H.S. No: **ABC 123**

Address: **1000, High St**

Age at examination → **2 years** **3 1/2 years**

Weight	Actual	12.6kg	✓	16kg	✓
	Percentile	50	✓	47	✓
Height	Actual	89cm	✓	95cm	✓
	Percentile	48	✓	52	✓
Motor		2yr	✓	3 1/2 yr	✓
Manipulation		2yr	✓	3 1/2 yr	✓
Speech		2 1/2 yr	✓	3 1/2 yr	✓
Habit "milestones"		2 1/2 yr	✓	3 1/2 yr	✓
Social and Play		2 1/2 yr	✓	3 1/2 yr	✓
Behaviour			✓		✓
Vision			✓		✓
Hearing			✓		X6
Eyes (squint?)			✓		✓
Ears			✓		✓
Noise and throat			✓		✓
Teeth			✓		✓
Heart			✓		✓
Lungs			✓		✓
Abdomen and herniae			✓		✓
Genitalia (testes)			✓		✓
Muscle tone			✓		✓
Reflexes			✓		✓
C.N.S.			✓		✓
Other			✓		✓
Examiner		H.V.		C.H.M.	
Date		6.1.76		30.6.79	

Fig 2

MALE Surname: **PAN** Forenames: **PETER**

PROBLEM LIST

National Health Service Number: **ABC 123** Date of Birth: **3.1.76**

Date	* CLINICAL NOTES	ACTIVE	INACTIVE
3.1.76	1 MOTHER EPILEPTIC		
	2 NEONATAL IRRITABILITY		4.1.76
	→ SPECIAL CARE BABY UNIT		
2.3.76	3 RIGHT TALIPES EQUINO VARUS		→
3.7.76	4 EXCESSIVE CRYING		→
	(See Patient Profile)		
15.1.79	5 RECURRENT OTITIS MEDIA		→ 6
30.6.79	6 BILATERAL HEARING LOSS		

* This column has been provided for doctors to enter A, V or C at their discretion.

Do 686225 686234 12/78 AG. FORM PP8

If the second developmental assessment is performed at about 28 weeks, full hearing and vision tests will often need to be delayed for some weeks until the child can sit without support. The results of these tests (at about 36 weeks) can be recorded in brackets in the left-hand subdivision of the next (52 week) column.

Our problem-oriented record system incorporates a separate "problem list" card, so whenever a cross (X) is marked on the paediatric card the actual abnormality is written on the problem list (fig 2). In addition, the obstetrical doctor can write the problem list code number beside the cross on the paediatric card for easier cross-reference (fig 1b—3½-year column, category "hearing").

Most paediatric records have space for family and social history. We already have provision for this on our "patient profile" card, using the system described by Zander (fig 3).² If

The full record system, which could be adapted for use in A4 records, consists of five special cards, kept in strict order and "treasury-tagged," when required, to the front of the chronologically arranged continuation cards as follows: repeat prescription card; immunisation record/simple flow chart; problem list; patient profile; and paediatric development card.

Discussion

Most general practitioners already do preventive antenatal examinations in their surgeries. It should be quite natural to continue regular preventive examinations on the babies after delivery, thus cementing the relations already begun before the birth. Some practical encouragement is probably necessary if these examinations are to be generally adopted. Perhaps the

Fig 3

a

MALE Surname PAN Forenames PETER

PATIENT PROFILE

National Health Service Number Date of Birth 3.1.76

CLINICAL NOTES

1973 1943 1975 1974

HELEN JOHN MARY

PETER

Rowing in front of Peter

Adopted

★ This column has been provided for doctors to enter A, V or C at their discretion.

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Card "Patient profile"

Key to symbols

this card is completed early in each child's life and is kept up to date the doctor or health visitor may be alerted to parental difficulties at an early stage and can try to modify the development of behavioural problems.

Finally, in the top section of the front of the paediatric card there is a box for "problems" if the child already has a disease or problem or if there is a problem in the family's history before the first developmental examination. A tick or a cross is marked. In the example shown (fig 1a), the cross (X) refers to the problems of maternal epilepsy and of neonatal irritability, which are then written on the problem list (fig 2).

Completing these three cards may seem daunting. We complete the mother's "patient profile" card at her antenatal booking examination. It is easy to copy this out on the baby's "patient profile" card at the first postnatal visit, adding the baby's name to the new diagram. We also fill in background information on the front of the paediatric development card and complete the baby's problem list at this visit. The problem-oriented paediatric record is thus completed relatively painlessly before the first developmental examination.

basic framework for this advance might be provided by a record system similar to the one described. Professor Donald Court has written, "We believe that . . . a comprehensive and integrated child and family-centred service should be based in general practice with primary care teams working in effective partnership with paediatrics and allied specialties."³

I acknowledge the advice and help of Dr Winifred Burgess and Dr Richard Orme, consultant paediatricians, and also the help and co-operation of my partners, Dr Angus Forbes and Dr John Wright.

Supplies of paediatric cards and copies of the template can be obtained from Phillips & Co, 115 High Street, Crediton, Devon.

References

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