PROCEDURE FOR RECORD KEEPING AND TEAM DIARY MANAGEMENT FOR COMMUNITY NURSING

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<th>Issue History</th>
<th>Issue Version</th>
<th>Purpose of Issue/Description of Change</th>
<th>Planned Review Date</th>
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<tr>
<td>May 09</td>
<td>Two</td>
<td>To promote safe and effective record keeping and diary management for all staff working in community nursing</td>
<td>2013</td>
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Named Responsible Officer:- Service Improvement Team and Locality Nurse Managers

Approved by:- Clinical Policy Group

Date: May 2010

Section: Professional Standards

Impact Assessment Screening Complete

Date: May 2010

Full Impact Assessment Required Y/N

UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM NHS WIRRAL WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION
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## CONSULTATION

- Clinical policy group
- Nurse Managers
- Service Improvement Group
RECORD KEEPING PROCEDURE FOR COMMUNITY NURSING

INTRODUCTION

NHS Wirral is committed to high standards of record keeping, to ensure safe, effective high quality nursing care for its service users. The Nursing and Midwifery Council (2007) state that:

Record keeping is an integral part of nursing, midwifery and specialist public health nursing; it is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.

AIM

- To outline the procedures for record keeping for all staff working in community nursing teams.
- To provide specific guidance relating to community nursing, that builds on existing NHS Wirral Health Records Policy and NHS Wirral Code of Conduct for handling personal and identifiable information.
- To inform existing and new community nursing staff with detailed information relevant to Community Nursing and Specialist Nursing Teams.

TARGET GROUP

All staff working in community nursing teams including bank staff and nursing students will comply with this procedure. Record keeping standards will be audited yearly.

RESPONSIBILITIES OF STAFF

Community nurses are responsible for the maintenance and safety of health records, this is established and defined by law. As an employee, any records created are public records and the principles of record keeping will apply to all documentation. A full copy of the NHS Wirral Health Records Policy and NHS Wirral Code of Conduct for Handling Personal Information are both available on the NHS Wirral internet site.

DOCUMENT CONTROL

Team leaders are responsible for ensuring that their teams are using the most current versions of nursing documentation. Old versions of forms referring to previous names of organisations should be destroyed.

TRAINING

All clinical staff attend Essential Learning Training every two years. During local induction staff are provided with an overview of NHS Wirral Policies and Procedures.
RELATED POLICIES
Please refer to relevant NHS Wirral policies and procedures

CALDICOTT PRINCIPLES
Please refer to NHS Wirral Code of Conduct for issues relating to safeguarding personal and identifiable information.

CONSENT

Please refer to NHS Wirral consent policy for full details. Consent forms are available on NHS Wirral intranet

‘Valid Consent’ is a patient’s agreement for a health professional to provide care. To demonstrate capacity individuals should be able to:-
1. Understand information about the decision to be made
2. Retain the information in their mind long enough to make a decision
3. Use or weigh that information as part of the decision making process
4. Communicate their decision (e.g. by talking or sign language)

For consent to be valid;
- Consent must be given voluntarily and freely by an appropriately informed person who has the capacity to consent to the intervention in question
- Consent must be given without pressure or undue influence being exerted on the person to either accept or refuse treatment

Evidence of valid consent must always be documented within the patient’s care plan, which is reviewed every six months or earlier if the patient health needs change. Patients can reconsider their agreement to consent to treatment or care interventions at any time.

Reference guide to consent for examination or treatment provides a comprehensive summary of the current law on consent and 12 key points on consent. Copies available from:-
www.dh.gov.uk

PATIENTS WITHOUT CAPACITY TO CONSENT

It should be noted that if an adult does not have the capacity to provide valid consent (either temporarily or permanently) then no other person can consent on their behalf – this includes the patient’s General Practitioner (GP).
Please refer to NHS Wirral Mental Capacity Act Toolkit for further information

BEST INTERESTS – CONSENT FORM 4

Health care can be given in the patients best interests. To establish best interests it is essential that the views of all persons involved in the patient’s care are sought. This would include carers and relatives, the patient’s GP and other relevant professionals, agencies or advocates. It may also be necessary to seek advice from the Service
Manager or the Safeguarding Team. In some cases the Service Manager may need to consult with the NHS Wirral solicitors for specific legal advice.

WRITTEN CONSENT FORMS
It is rarely a legal requirement to obtain written consent in community nursing. A written consent form is however required for taking a photograph e.g. for monitoring wound care, this form is available on intranet.

SAFE STORAGE OF RECORDS IN CLINIC BASES AND WHILST TRAVELLING
Staff must take all reasonable efforts to safeguard confidential client records and personal identifiable information, including:-

- Patient identifiable information, including nursing records, community nursing weekly information sheets, diaries etc. should not be left unattended in cars.
- Patient records should be returned either to base or patient/client home by the end of the working day. In the event of working out of hours all staff should ensure that all patient/client information should not be left in their car overnight and kept secure in their own home out of view from family and friends.
- Records must be carried in a nursing bag at all times.
- Patient identifiable information should not be left anywhere where it could be viewed by a member of the public.
- Records must be stored in a secure room and filed appropriately when not in use.
- Personal identifiable information should not be visible to the general public at reception areas.
- No information technology equipment to be used to store patient information unless it has been supplied and approved for safety by Wirral Health Information Systems (WHIS) and the Service Manager, using all recommended passwords and encryptions e.g. portable devices such as pen drives must be encrypted.
- All employees with access to personal identifiable information have a duty to safeguard that information under the NHS Wirral Code of Conduct.

ADDITIONAL NOTES FOR STORING COMMUNITY NURSING RECORDS
- The base notes should be filed in front of the patient held record and then secured in a blue folder.
- Community nursing patient records should not be removed from the blue community nursing folder on discharge.
- Health records in yellow A4 NHS Wirral ‘Your Care Record’ ring-binders should be removed from the file and plastic pockets and bound together in a blue community nursing folder using treasury tags and stored in chronological order.
- The date of discharge/date of death should be marked clearly on the Assessment Form in both the patient held record and in the base notes.
- Patient’s name, date of discharge/death should be written clearly on the top right hand side of the community nursing blue folder using either permanent marker or an adhesive label.
- The record should be boxed for long-term storage.
- Any problems with this system to be discussed with nurse managers and an incident form completed.
ADDITIONAL INFORMATION

Bank nurse work sheets
Any work delegated to bank nurses must be documented on the designated bank nurse work sheet. The bank nurse must complete the comments section for each patient to give feedback to the team and ‘sign off duty’ in the space provided. These sheets should then be stored alphabetically by the nurses surname at base for future reference, and retained for three years.

Bed Rail Risk Assessments/Bed Rail Fitting
Bed rail assessments/bed rail fitting can only be carried out by a nominated bed rail assessor following training and assessment of competency by a member of the Service Improvement Unit.

Blood Glucose Monitoring Meter Documentation
Ensure that each book has the serial number of the meter written inside the quality control book. Once the book is complete the quality book needs to be stored at base for eleven years.

Community Equipment
When ordering community equipment a standard stock order form should be completed and faxed to the community equipment service. A copy of the original request to be filed in the base notes. Any advice given on use, care and maintenance of equipment must be documented in the patient’s health records.

Community nursing care for children under the age of 16 years
On arranging the first home visit, ascertain whether the child’s parent/guardian will be present. No nurse should be visiting children under the age of 14 years if the parent/appropriate guardian is not present.

Fraser competence can be sought from older children e.g. 15 – 18 year olds and documented in their health records. Permission must still be sought from the parent if they are not to be present at the visit to confirm they can access the family home. This discussion must be documented in the health records.

Nurses working with children and young people should be confident and competent in providing the fundamental aspects of care (Nursing and Midwifery Council, 2008). Any procedure that a nurse is requested to undertake for a child or young adult that they are not competent to carry out must be discussed with the referring clinician. The locality nurse manager must also be informed when the referral is received.

Community ‘Patient Medicines Administration Chart’
The Patient Medicines Administration Chart is to be completed for all prescribed medications which require administration by a member of the Community Nursing Team. Patient Medicines Administration Charts are valid for 6 months and require updating after that date.

Reference Standard Operating Procedure for Medicine Administration in Community Nursing.
Nursing / Residential Homes
Medication administered to patients in nursing and/or residential homes must be recorded in the patients medicines administration record (PMAR) as well as NHS Wirral documentation to reduce risk of medication error.

Disposal of prescribed controlled drugs form
Refer to Standing Operating Procedure for destruction of patients controlled drugs in the community.

Immunisations
Comply with the relevant Patient Group Directive (PGD).

Liverpool Care of the Dying Pathway for the Dying Phase (LCP)
- Once a patient has died the LCP should be stored at the front of the nursing documentation for auditing purposes and retained in base for 12 months. The records of patients who have been on an LCP should be stored separately in the file at base, for ease of access when the records are audited. Patients’ health records should be filed chronologically by date of death.
- The LCP Post Pathway Analysis Form must be completed following the death of a patient to monitor the outcome and/or variances of the delivery of palliative care services; and a copy of the post pathway Analysis Form must be filed in the records. The task of completing the Post Pathway Analysis Form can be delegated to another member of the team to transcribe the details from the LCP. Please return the form to Audit Support, Service Improvement Unit.
- For further guidance please refer to Clinical Protocol for Liverpool Care of the Dying Pathway on the NHS Wirral intranet site.

Inter-Agency Referrals
Copies of any referral made, including telephone referrals, must be documented and secured within the base notes. Telephone referrals should be followed up by completing the appropriate inter-agency referral form within the same working day if possible (or at least within 24 hours).

Key safe
Nurses must not write patients key safe numbers in their diaries in case the diary is mislaid. Nurses may store the key safe number and date of birth of the patient in their mobile phone provided the mobile phone has a pin number to lock it. Alternatively the nurse can text themselves the key code number provided that the phone can be locked.

Mobile Phone
Please refer to mobile phone policy.

Non Medical Prescribing - Record Keeping
Refer to the Non Medical Prescribing Procedure.
Record of Patient Care in Clinics / GP Surgeries
Nursing care provided in GP surgeries is to be recorded onto the GP records or the GP computer system. Recording health care on a computer should adopt the same standards of practice as hand written records. Therefore, any entry needs to be clearly identifiable and evidence patient consent. This system needs to be in agreement with the relevant Locality Nurse Manager.

If the patient is seen both in the home and at the surgery, a full care plan using NHS Wirral documentation should be used for the home.

Risk Assessments
Please refer to health and safety policies.
There are some specific risk assessments available on the NHS Wirral intranet. Refer to the NHS Wirral intranet as this list is not exhaustive.

Taking the patient health records out of the home
If the patient’s home health records are taken out of the home, it is best practice to return the records the same day. However, if the health professional is unable to return records the same day they must be returned within 24 hours to maintain safe continuity of health care.

Patients who are catheterised or patients who may require additional visits from out of hour services must have their records returned the same day in order to maintain continuity of care. If the health professional has been unable to fully complete the records the rationale must be fully documented and the line manager informed of the situation.

Telephone Calls
All patient related telephone contact, including health advice, must be evidenced in the patient’s record. Any health related advice or patient related discussions should be documented in the base notes on the communication sheet. The patient’s health record should also be updated if any aspect of care is affected as the result of a telephone conversation.

Messages:-
- Messages should be documented on a carbonated message book and the top copy of the message filed in the patient’s base notes
- Message books must be kept for three years and then shredded or disposed of in confidential waste.
- Messages taken by members of the team must be signed, dated and timed and counter signed by the senior nurse on duty when read as an acknowledgement the message has been seen and actioned before it is filed.

Work Diaries
Please refer to retention policy
Do not record any patient clinical information in your diary as this forms part of a patient’s record.
GENERAL PRINCIPLES
Follow NHS Wirral Record Keeping policies

- Each sheet included within a patient’s plan of care must be clearly labelled with the patient’s full name, date of birth and National Health Service (NHS) number.
- Each sheet should be secured within an appropriate folder (blue community nursing folder or yellow A4 NHS Wirral ‘Your Care Record’ ring-binder).
- Every entry in the patient’s record must have the date (day, month, year) and time (24 hour clock) of the intervention recorded
- The practitioner’s printed name, signature and designation must be recorded on every entry made.
- If the date and time of an event / intervention differs from when the records are written up, this must be clearly recorded in the documentation.
- When reports / results / letters or other incoming documentation relating to patient care are received, practitioners must print their name and designation, sign and date before filing to acknowledge that they have received and read the referral, results etc
- All verbal communication relating to a patient’s care from other members of the multi-disciplinary team must be documented on the communication sheet and filed in the base records. This information must also be shared with the community nursing team at handover meetings.

PATIENTS WITH SIMILAR NAME
To avoid medication or treatment errors the same system must be used across all teams, in the following way:-

- Document on Page 2 beneath patients full name on the Initial Assessment Community Nursing Documentation that there is a patient with the same name e.g. Ann Smith 11.5.1940 (*patient with a similar name)
- Document in the same format in the work allocation diary
- Document in the same format on master copy of patient caseload profile at base.

When allocating patients in the team diary document patient’s full name and date of birth or NHS Number to clarify which patient is being referred to

INITIAL ASSESSMENT COMMUNITY NURSING DOCUMENTATION

- The initial assessment documentation is for the first contact with all patients regardless of the clinical need. If the patient is on the caseload after 4 weeks, the community nurse must discuss the patient’s needs with the team leader (or senior practitioner) to gain approval to continue to use this documentation. If the patient is on the caseload for longer than 6 weeks, consider the clinical need to complete a Comprehensive Nursing Overview.
- The initial assessment clearly indicates which patients will require the completion of a Comprehensive Nursing Overview.

COMPREHENSIVE NURSING OVERVIEW
A comprehensive nursing overview must be completed within ten days of the patient being admitted onto the nursing caseload as indicated.

The comprehensive nursing overview must be updated at least 6 monthly or earlier if there is a change to the patient’s condition and/or treatment.
MANUAL HANDLING
If the patient is over 25 stone (158kg) then please refer to the Manual Handling Policy for Extremely Heavy patients, and where necessary complete forms (1) and (2) from Health and Safety Policy 5 and seek advice from manual handling advisor.

MISSING HEALTH RECORDS
Any health records that are missing or mislaid must be reported to the locality nurse manager and an incident form completed. The staff must then commence a new set of health records for the patient. The new records should indicate why these have been generated.

NEW EPISODES OF CARE
If a patient is readmitted to the community nursing caseload within 12 weeks, the previous assessment documentation can be used, provided that the nurse updates the record accordingly. If the patient is deemed to be at risk of developing a pressure ulcer, a new initial nursing assessment must be completed.

CLINICAL INCIDENTS
Any incidents relating to record keeping must be reported following the NHS Wirral Incident Reporting Policy

REFERENCES
www.doh.gov.uk/ipu/confiden


Nursing and Midwifery Council (2007): Guidelines for Record keeping www.nmc-uk.org


Mental Capacity Act Tool Kit (2005) www.dh.gov.uk
PROCEDURE FOR COMPLETION OF TEAM WORK DIARIES (Community Nursing)

AIM
Patient safety will be promoted by utilising a standard framework for the appropriate and safe delegation of clinical duties to nursing staff within the community nursing team. The procedure outlines the layout of team work diaries to ensure visits are not omitted or duplicated.

DOCUMENTS/INFORMATION REQUIRED
- Caseload profile folder/s
- 2 page a day A4 Diary (for larger teams 2 diaries may be required) i.e. 1 for master list of patients and 1 for work allocation
- Separate diary for non registered staff master list and work allocation
- Black ink pen
- Ruler

PROCEDURE
The Master Patient List this should be completed by 2 staff in a quiet environment with no disturbances. Both members of staff must review the list to ensure that all entries are legible.

If the Master Patient List is completed by 1 member of staff the list must be checked by a second member of staff prior to work allocation.

Patient’s full name must be entered.

Once the Master Patient List is completed the transcriber and the checker must print and sign their name, and record the date and time at the end of the Master Patient List.

If additional patient visits are required, these must to be entered onto the Master Patient List and the date and time of entry recorded.

MASTER PATIENT LIST (See Appendix 2 for page lay out)
- The Master Patient List from the caseload profile must include any new patients or any additional visits.
- The page must be laid out from left to right and include the patient’s full name, dependency level, and any messages if relevant.
- If a clinic is to be delegated to a member of the team, the name of the nurse facilitating the clinic must be identified on the Master Patient List.
PATIENTS REQUIRING MORE THAN ONE VISIT A DAY
If a patient requires more than one visit in any given day, individual visits must be identified separately on the Master Patient List and each visit clearly allocated to a nurse specifying the reason for the visit.

PATIENTS WITH SIMILAR NAME
To avoid medication or treatment errors the same system must be used across all teams, in the following way:-
- Documented on Page 2 beneath patients full name on the Initial Assessment Community Nursing Documentation that there is a patient with the same name e.g. Ann Smith 11.5.1940 (*patient with a similar name)
- Document in the same format in the work allocation diary
- Document in the same format on master copy of patient caseload profile at base.

When allocating patients in the team diary document patients full name and date of birth or NHS Number.

WORK ALLOCATION (See Appendix 3 for page layout)
- Rule page to make approximately 9 boxes (one box per staff member on duty). Each box must have the staff member’s full name above and hours of duty i.e. 09.00-17.00.
- For members of staff who are not on duty, the reason for this must be identified i.e. day off, training etc in a separate section at the bottom of the page.
- The Lead Nurse on duty must be clearly identified in the diary.
- Patient allocation must be checked daily prior to staff commencing visits.
- Members of staff who have been allocated visits on the way into base must telephone the Lead Nurse on duty to confirm there has been no change to the allocation prior to undertaking any visits.
- As a patient is allocated to a nurse the patients name is to be written in the box identified for that nurse. Once this is complete, the patient’s name on the left hand side should be ticked to show that the visit has been allocated.
- Staff attending clinics i.e. leg ulcer clinic, dressing clinic must be identified in the relevant nurses work allocation box.
- Any amendments to the Master Patient List (including cancelled visits, a visit being altered to a different day, hospital admissions, appointments etc) must be documented on the list and the rationale for the alteration stated.
- Any reallocation of visits must be communicated immediately to the relevant staff member by the lead nurse.
- When allocating visits the nurse delegating the visit must ensure that the nurse is confident and competent to carry out the clinical care.

ALLOCATION OF WORK AT WEEKENDS
All members of staff must follow this procedure when allocating work Monday to Friday and at the weekends to ensure safe and effective practice.

ALTERNATIVE DIARY WORK ALLOCATION
Should the above model not be feasible for a Nursing Team, the team leader must raise this formally with their Service Manager and a suitable alternative put in place.
that adheres to the principles of patient safety as stipulated in this procedure. The team must to be able to evidence how they have shared the alternative model within their team formally in writing.

**TEAM MEETINGS**

Each team should have a system in place for:
- a minimum daily hand over meeting with all staff, to discuss/share relevant information re planned patient visits
- a weekly team meeting with all staff on duty, to discuss all patients on the caseload profile and any actions required

**PERSONAL WORK DIARIES**

Record keeping policy must be followed:-
- All entries must be legible
- Order of visits must be identified
- Patient information must be kept to a minimum
- Any meetings, courses and annual leave etc must be recorded
- Personal work diaries must be stored at base when on annual leave and must be accessible

**PERFORMANCE MANAGEMENT**

Line managers will audit work diaries at management supervision and work diaries may be subject to audit at any time.

**CLINICAL INCIDENTS**

Any related incidents or near misses arising from carrying out this procedure which may involve a clinical error must be reported following the NHS Wirral Incident Reporting Policy

**SPECIALIST ADVICE**

In the event of any problems or difficulties in carrying out the procedure, discuss with the Team Leader/Senior Nurse.
<table>
<thead>
<tr>
<th>Day</th>
<th>Date (Already in Diary)</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Joe Brown</td>
<td>A</td>
<td>Take Documentation</td>
</tr>
<tr>
<td>√ Irene White</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>William Smith</td>
<td>A</td>
<td>No Visit - In Hospital</td>
</tr>
<tr>
<td>√ Irene Jones</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>√ Ivor Jones</td>
<td>D</td>
<td>NEW PATIENT SEE FAX</td>
</tr>
<tr>
<td>√ David Jackson</td>
<td>B</td>
<td>Visit before 1300 - OPD Appointment</td>
</tr>
<tr>
<td>Sophie Carrington</td>
<td>C</td>
<td>Discharged from Caseload</td>
</tr>
<tr>
<td>√ Edith Wood</td>
<td>B</td>
<td></td>
</tr>
</tbody>
</table>

**Tick once Allocated**

- Additional Visits
  - √ Dean Smith (Date + Time)
  - √ Roger Taylor (Date + Time)

**PM Visits**

<table>
<thead>
<tr>
<th>Day</th>
<th>Date (Already in Diary)</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>√ Joe Brown</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>√ Irene Jones</td>
<td>C</td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>√ Leg Ulcer Clinic 1400 - 1700</td>
<td></td>
<td>Transcriber and Checker</td>
</tr>
<tr>
<td>√ Dressing Clinic at Surgery 1100 - 1300</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Transcriber</td>
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<td>Print</td>
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<td></td>
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<td>Sign</td>
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### APPENDIX 3

RIGHT PAGE OF DIARY or WORK ALLOCATION DIARY

(This May be 2 Pages)

*Day + Date (Already in Diary)*

<table>
<thead>
<tr>
<th>Pauline Richmond 0900 - 1700</th>
<th>Annie Hills 0900 - 1700</th>
<th>Gordon Brown 0900 – 1700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Nurse</td>
<td>Joe Brown – Take Documentation</td>
<td>Irene Jones</td>
</tr>
<tr>
<td>Irene White</td>
<td>Dean Smith</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roger Taylor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leg Ulcer Clinic 1400 – 1700</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tony Blair 0900 - 1700</th>
<th>Jackie Smith 0900 - 1700</th>
<th>Jo Wood 0900 - 1700</th>
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</thead>
<tbody>
<tr>
<td>Dee Waters Shadowing 0900 – 1400</td>
<td>Dressing Clinic 1100 – 1300</td>
<td>Leg Ulcer Clinic 1400 – 1700</td>
</tr>
<tr>
<td>Ivor Jones 4/11/23 – NEW PATIENT</td>
<td>PM Joe Brown</td>
<td>Reallocated to A Hills</td>
</tr>
<tr>
<td>Leg Ulcer Clinic 1400 - 1700</td>
<td>PM Irene Jones</td>
<td><em>(Date + Time + Signature)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barbara Roberts 0900 - 1300</th>
<th>Dee Waters 0900 - 1400</th>
</tr>
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<tbody>
<tr>
<td>David Jackson (Before 1300hrs)</td>
<td>New Staff Member Shadowing Tony Blair</td>
</tr>
<tr>
<td>Edith Wood</td>
<td>Rose Black – Senior Practitioner – Day Off</td>
</tr>
<tr>
<td></td>
<td>Samantha Jones – Essential Learning Day 2</td>
</tr>
<tr>
<td></td>
<td>Jo Wood – Sick Leave</td>
</tr>
</tbody>
</table>