Maternity Records Documentation

University Hospitals of Leicester NHS Trust

Trust ref: C23/2016

Contents

1. Introduction and who the guideline applies to:

This guideline applies to all members of staff within the Maternity Service who document and or file in clinical case notes (including Hand Held records) and electronic records. This includes midwifery and medical students working on placement with UHL staff. The guideline details the requirements of written entries by all maternity care workers and their responsibilities in relation to the maintenance of accurate, legible and contemporaneous documentation throughout the duration of the patient's pregnancy, delivery and post partum period.

Background:

A Health Care Record is information recorded by a healthcare professional about a person for the purpose of managing their health care and can include multiple formats including paper, digital or physical, such as plaster moulds.

Record keeping is considered an important tool in the care process, and pivotal in the promotion of high quality healthcare (Dimond, 2006). The keeping of clear comprehensive records is part of the duty of care owed to the client; all healthcare professionals have a specific statutory duty in relation to records.

Additionally records may be utilised for audit purposes, service development/improvement, and to provide information for complaint resolution, incident reviews and litigation.

Related documents:

Health Records Management UHL Policy B3/2005

Patient Health Records - Documenting UHL Policy B30/2006

Being Open (Duty of Candour) UHL Policy B42/2010

Maternity Records - Destruction UHL Obstetric Guideline C12/2007

Maternity Records - Creation, Tracking, Storage UHL Obstetric Guideline C166/2008

Data Protection and Confidentiality UHL Policy A6/2003

Referral Handover of Care and Transfer UHL Obstetric Guideline C101/2008

Booking Process and Risk Assessment UHL Obstetric Guideline C16/2011

Postnatal Care UHL Obstetric Guideline C119/2011

Transfer of the Critically Ill Adult UHL C26/2003

2. Guidance:

Nurse and Midwives

Nursing and Midwifery Council (NMC)The Code Professional Standards of Professional Behaviour for Nurses and Midwives 2015 (updated 10 Oct 2018)

"10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5 take all steps to make sure that records are kept securely

10.6 collect, treat and store all data and research findings appropriately"

Medical Teams

General Medical Council (GMC) Good Medical Practice (published Aug 23, effective from Jan 2024)

Recording your work clearly, accurately, and legibly

"69 You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.

70 You should take a proportionate approach to the level of detail but patients' records should usually include: a relevant clinical findings
b drugs, investigations or treatments proposed, provided or prescribed

c the information shared with patients

d concerns or preferences expressed by the patient that might be relevant to their ongoing care, and whether these were addressed

e information about any reasonable adjustments and communication support preferences

f decisions made, actions agreed (including decisions to take no action) and when/whether decisions should be reviewed

g who is creating the record and when.

71 You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection law requirements and you must follow our guidance on Confidentiality: good practice in handling patient information."

Student healthcare professionals

- Many student health care professionals provide health care under supervision in the maternity care setting and there is clear guidance regarding the suitability of delegation of tasks and the level of supervision required.
- Student health care professionals can document in the health care records, but all entries need to be countersigned, at the time of the event, by a registered healthcare professional who has overseen the care provided.

All documentation within Maternity Case Notes must meet the standards outlined in Patient Health Records - Documenting UHL Policy (Trust Ref: B30/2006).

There are a number of requirements specific to the Maternity Service that must be complied with in addition to the standards in the above policy:

2.1 Basic Record Keeping:

The minimum standards for record keeping are as follows:

Each entry must be dated, timed (using the 24 hour clock) and signed. The person's name, designation (and bleep number where applicable) should be printed alongside the first entry Best practice also recommends using a unique identifier such as a Professional Body number (e.g. GMC / NMC) adjacent to each entry or in a signature sheet.

- Written legibly in black ink
- Alterations should be made by scoring out with a single line, through the incorrect words, and signed and dated. **Correction fluid must not be used.**
- Be contemporaneous (or as soon as circumstances allow, stating the reason for the delay and that the entry has been written retrospectively, with date and time noted), comprehensive, and written in chronological order.
- Be factual, consistent and jargon free. Abbreviations should be avoided wherever possible and should only be used where an 'approved abbreviation list' exists within specialties. Inappropriate abbreviations must not be used. If abbreviations are used then ensure that they are first written in full.
- Where an Alert sticker is used, details of the alert must be clearly recorded on front inside cover of notes or on the Alert Notification sheet

2.2 Clinical Record Keeping:

Antenatal Care:

- Any information relating to previous pregnancies is stored at the back of the current hospital record, clearly identified by a divider.
- The majority of antenatal screening results are generated electronically, and these should be checked and the results annotated in the paper records. Any results that are produced in paper copy format and all UHL ultrasound reports should be secured in either the handheld or hospital records. Additionally results are documented on the appropriate page of the handheld records and within the electronic patient records.
- Document contact details of named team / midwife
- Weight, height and BMI to be recorded at booking

- Height of uterus measured in centimetres (cm). Data will be inputted electronically into the GROW 2.0 system. Individualised growth measurement points will be generated and plotted automatically. The plot point will be a X.

- Estimated fetal weights, and individual fetal measurements generated from ultrasound Data will be inputted electronically into the GROW 2.0 system. Individualised growth measurement points will be generated and plotted automatically. The plot point will be a O.

- All observations relevant to gestation completed in antenatal section.

- Document health promotion issues discussed and leaflets given or websites signposted to.

- Evidence of the pregnant woman or pregnant person's wishes to be completed on the personalised care plan unless they choose not to have this detailed.

- UHL is currently utilising a hybrid of both written and electronic records, during a period of transition. Entries are routinely recorded in either/or the paper records and/or the electronic records. There is no expectation for these to be duplicated in both places, although reference to other documentation can aid clarity about where information can be located.

Intrapartum Care:

- The Intrapartum risk assessment must be completed on admission in labour and then 2 hourly throughout labour.

- The PPH risk assessment must be completed on admission for IOL or in spontaneous labour and reassessed 4 hourly throughout labour

- Risk assessments should be completed on NerveCentre if available. If NerveCentre is not available, complete the paper assessment chart. Risk assessments should be completed within 6 hours of admission as follows;
    - Best shot
    - Infection prevention A-F
    - Maternity nutrition and hydration
    - Patient handling risk assessment
    - Repositioning and skin monitoring
    - Screening for falls risk
    - SSKIN
    - VTE
    - Waterlow
    - Making Every Contact Count – smoking cessation (at each inpatient contact)

- There should be an appropriate record of intrapartum care as specified in 'Intrapartum Care: Healthy women and their babies' guideline. Including completion of first and second stage partograms.

- Record indications for performing vaginal examination.
- Record plans made for altered management if progress not to plan.
- Record when indications for intervention are advised.
- Record insertion of urinary catheter on NerveCentre. If NerveCentre is not available, complete green insertion sticker and paper daily catheter care pathway.
- Record insertion of IV cannula using appropriate sticker for the cannula used – BD Peripheral Vascular Access Device care pathway.
- Absence or presence of meconium, including amount / consistency / colour or grade.
- Documentations of all observations (Maternal & Fetal) in line with Intrapartum Care: Healthy Women and their Babies Guideline. Observations should be recorded on NerveCentre (if available, if not, complete paper assessment chart), to allow for electronic MEOWS score to be generated.
- Where continuous electronic fetal heart rate monitoring is indicated, documentation should be in line with Fetal Heart Rate Monitoring in Labour guideline. CTG traces should be appropriately labelled and stored in an envelope in the maternal hospital notes in the current pregnancy section.
- Confirmation that fetal heart rate auscultated by Pinard or sonicaid prior to commencement of the CTG.
- Where operative delivery has been undertaken, the reason for operative delivery and informed consent should be documented in the health records. The relevant pages detailing the assessment and procedure should be completed.
- Swab, needles and instrument counts should be signed for before and after procedures by 2 practitioners. If there is a handover of staff, or change of location, during the procedure, the count should be confirmed and signed for in accordance with the relevant GL. Please refer to the Surgical swabs instruments needles and accountable items UHL policy
- Where paired cord blood gas results are available, they should be stored in an envelope in the maternal hospital notes in the current pregnancy section and also documented within the health records. This also applies to Fetal Blood Sampling (FBS)
- Where anaesthetic has been given, including epidural analgesia, the relevant documentation must be secured in the health records.
- Where a proforma for an emergency used this should be completed in full and included in notes.

Summary of Delivery:

- Consent to administer Vitamin K
- Apgar score and details of any resuscitation required
- Initial newborn examination including the body map
- Electronic record(s) completed and signed by person completing and finalising the information
- Any further supplementary documentation must be secured within the appropriate section of the maternity hospital records and/or handheld records
- Pulse oximetry results must be documented within the notes and electronically entered on to the S4N NIPE system.

Neonatal Care

- If a baby/babies require neonatal observations in accordance with NEWTT2 guidance, all aspects of the NEWTT2 observation booklets should be completed in accordance with the relevant condition/criteria that has warranted commencement of the observations
- Any transcutanenous bilirubinometer measurements for jaundice to be plotted on the correct gestation specific chart.

Postnatal Care:

- All discharge information should be documented in the electronic records and the postnatal diaries (maternal and neonatal)
- Body map page in red child health record book must be completed

2.3 Handover of Care

- The lead professional should be documented on the handheld records, in the maternity hospital records and in the electronic records. Any change to the lead professional should be documented in the appropriate section of the records (Refer to: Booking Process and Risk Assessment UHL Obstetric Guideline and the Postnatal Care UHL Obstetric Guideline
- A midwife is responsible for all episodes of care when a woman is admitted to the maternity department. At each change of shift, the accountable midwife must date, time, sign and print their name to signify that care has been handed over. (Refer to: Referral Handover of Care and Transfer UHL Obstetric Guideline)

- Where care is handed over between ward areas, whether within maternity services or outside, this should be clearly documented in the patient records.

- Handover should be completed on NerveCentre

- Handovers to critical care or other specialist areas outside of maternity, particularly to sites with no obstetric provision, need to follow the relevant guidance and be documented in accordance with the pathway outlined.

Alerts and Annotations

- Staff should add alerts and/or annotations to the electronic patient records to ensure relevant information is available to all care providers. This is particularly useful for sensitive information to secure confidentiality.

2.4 Duty of Candour

When a clinical incident has taken place which has resulted in moderate or severe harm, as a minimum the following must be documented in the patient's medical records:

- That the service user and/or their next of kin have been informed that a clinical incident has occurred.
- An apology has been expressed to the service user for the harm that has resulted from the clinical incident (an apology is not an admission of liability) (Refer to the UHL Being Open (Duty of Candour) Policy)

- That a Datix form has been completed.

3. Training and Education:

No stand-alone training but forms part of training sessions on specific topics

4. Audit and Monitoring Arrangements

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
A review of individual cases highlighted	incident reporting system	Quality & Safety Team	ad hoc	Maternity Service Governance Group
Rolling audit of maternity records	Presented in audit work stream	Intrapartum Matrons and Audit Team	Monthly?? frequency	Women's Q&S Board

5. Supporting References

Nursing and Midwifery Council. (2009) ***Record keeping: Guidance for Nurses and Midwives.*** London: NMC (2015) The Code Professional Standards of Practice and Behaviour for Nurses and Midwives

Nursing and Midwifery Council (2024) Standards for midwives.

Nursing and Midwifery Council (2024) Standards of proficiency for registered nurses.

Care Quality Commission (2024) The Fundamental Standards

6. Key Words

Documentation records quality safety audit code duty of candour

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

Development and approval record for this document			
Original Author	L Moss – Clinical Risk and Quality Safety Coordinator		**Executive Lead: Chief Nurse**
Reviewed by:	F Ford – Matron intrapartum services		
Approved by:	Maternity Service Governance Group		**Date Approved**: January 2022

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
15.04.13	3	L Matthews and A Akkad	Storage arrangements for CTG's and FBS/cord gasses
February 2016	3	D Brookes	The Code for Nurses and Midwives (NMC 2015) updated Medical Staff - Good Medical Practice (2013Knowledge skills and performance paragraph 19-21) GMC updated Duty of Candour requirements added
September 2018	4	D Brookes and L Payne	Role of Supervisor of Midwives removed Requirement to document pulse oximetry, GROW charts and intrapartum risk assessment added
December 2021	5	F Ford	• Added related documents • Added reference to electronic records throughout • Identified adding pin number to entries is best practice • Abbreviations if not already on an approved list need to be written in full • Student entries must be counter signed by a registered practitioner within the same shift period of time of entry • Alert sticker must be clearly recorded on front inside cover • HIE score & PPH risk assessement & documentation added • NerveCentre assessments and handover added • Added inclusion of IV cannula & Urinary catheter insertion stickers • Recording of APGAR & initial assessment /resus of the newborn added including completion of body map in records and child health red book
March 2025	6	J Russell	Added; A Health Care Record is information recorded by a healthcare professional about a person for the purpose of managing their health care and can include multiple formats including paper, digital or physical, such as plaster moulds. Additionally records may be utilised for audit purposes, service development/improvement, and to provide information for complaint resolution, incident reviews and litigation Added a section on student health professionals. Made reference to electronic health records & NerveCentre Plotting on the fetal grow chart recommendations added Updated risk assessments to be completed on NerveCentre Newly added -

			Handover of care ; Handovers to critical other specialist areas outside of maternity, particularly to sites with no obstetric provision, need to follow the relevant guidance and be documented in accordance with the pathway outlined. **Alerts and Annotations** • Staff should add alerts and/or annotations to the electronic patient records to ensure relevant information is available to all care providers. This is particularly useful for sensitive information to secure confidentiality.