Maternity Records Documentation

NHS University Hospitals of Leicester NHS Trust

Trust ref: C23/2016

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.

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Background:

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:

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

2. Guidance:

The Code .Professional Standards of Professional Behaviour for Nurses and Midwives 2015

- Keep clear and accurate records relevant to your practice.
- Complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event.
- 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.
- Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.
- 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.
- Take all steps to make sure that all records are kept securely

Medical Staff - Good Medical Practice (2013) Knowledge skills and performance paragraph 19-21) GMC

- Record your work clearly, accurately and legibly
- Documents you make (including clinical records) to formally record your work must be clear, accurate and legible.
- You should make records at the time of the events you are recording or as soon as possible afterwards.
- You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.

Clinical records should include;

a) Relevant clinical findings
b) The decisions made and actions agreed and who is making the decisions and agreeing the actions.
c) The information given to patients
d) Any drugs prescribed or other investigation or treatment
e) Who is making the record and when

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. **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.
- Student entries must be countersigned by a registered practitioner within the same shift period that the entry in made.
- 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.
- All antenatal screening results that are produced in paper copy format to the UHL 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) documented in notes and plotted accurately on the woman's customised GROW chart
- All observations relevant to gestation completed in antenatal section
- Document health promotion issues discussed and leaflets given or websites signposted to
- Evidence of the woman's wishes to be completed on the personalised care plan unless the woman chooses not to

Intrapartum Care:

- The Intrapartum HIE 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 within 6 hours of admission as follows;
    - Best shot
    - Infection prevention A-F
    - Maternity nutrition
    - Patient handling risk assessment
    - Repositioning and skin monitoring
    - screening for falls
    - Sskin
    - VTE
    - Waterlow
- 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 the woman is advised of the indications for intervention
- Record insertion of urinary catheter using green sticker – daily catheter care pathway
- Record insertion of IV cannula using grey sticker – BD PVAD care bundle
- Absence or presence of meconium, including amount / consistency / colour or grade

NB: Paper copies of this document may not be most recent version. The definitive version is held on InSite in the Policies and Guidelines Library

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- Documentations of all observations (Maternal & Fetal) in line with Intrapartum Care: Healthy Women and their Babies Guideline

- 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

- Where operative delivery has been undertaken, the reason for operative delivery and informed consent should be documented in the health records.

- 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 entering the information

- Document who completed electronic records if it is a person other than midwife / doctor present at birth.

- 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

Postnatal Care:

- On discharge from hospital maternity services, the Maternity Community Transfer form must be completed in full, with the name and signature of the professional undertaking the discharge. One copy of the form must be secured in the maternity hospital records and the other copy is secured to the postnatal notes.

- All discharge information should be documented in the electronic records

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- 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**

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 woman and/or her next of kin have been informed that a clinical incident has occurred.
  An apology has been expressed to the woman 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

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

NHS Litigation Authority. (2009) ***Risk Management Standards for Acute Trusts, Primary Care Trusts and Independent Sector Providers of NHS Care.*** London: NHSLA

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians & Gynaecologists, Royal College of Paediatricians and Child Health. (2007) ***Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.*** London: RCOG Press

Dimond B. (2006) ***Legal Aspects of Midwifery.*** London: Butterworth.

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.

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

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			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