

Maternity Services Health Records Policy

Effective: January 2010

Review Date: January 2013

1. Introduction

It is of vital importance that health records for patients are completed accurately and stored correctly to ensure high quality and safe care. The basic record-keeping standards against which health records must be audited are outlined in the Clinical Record Keeping Policy.

As the Maternity Service has specific requirements in relation to record-keeping, this policy is a supplement to the Clinical Record Keeping Policy and must be read in conjunction with that policy.

This policy outlines the specific record-keeping requirements for the Maternity Service and the process whereby this will be audited and monitored.

2. Clinical note keeping standards

In addition to the standards of record keeping which must be adhered to across the Trust, there are specific requirements relating to Maternity Services clinical note keeping:

Antenatal assessment

Clinical note keeping of an antenatal assessment should include:

- A record on both the hospital and hand held notes if the woman is a high or low risk delivery, who the lead professional is and the gestation date at booking
- For women identified as being at high risk, individualised care plans should be developed and be available in both the hospital and the hand held notes
- The initial Body Mass Index (BMI) should be documented and the woman referred for Consultant led care if the BMI is over 45.

Labour ward management plan

Clinical record keeping of care in the labour ward should be particularly accurate and comprehensive including:

- Documentation on the partogram as to whether the woman is high or low risk and if high risk that the management plan has been implemented
- Vaginal examination (VE) findings should be documented including the management plan following each examination
- Bladder and pressure area care should also be clearly documented within the partogram.

Additional labour details which must be documented including:

- Accurate recording of maternal observations
- Referral for medical review
- Delivery interventions

- Time active pushing commenced
- 2nd stage action plan for slow progress
- 3rd stage details i.e. drugs given, physiological or active 3rd stage, delays etc.

Cardiotocograph (CTG)

Essential content of CTG documentation includes:

- Woman's name
- Date and time printed or handwritten at the start of the CTG
- Hospital number
- Maternal pulse at the start of the CTG
- Significant events in labour which are signed
- The CTG should be assessed and documented hourly using DRCBravado and if it is pathological or suspicious the resulting actions taken should be clearly recorded.

Operation details

If the woman undergoes an operative procedure the following details must be recorded within the clinical notes:

- List of attendees
- Volume of blood loss
- Type of sutures
- Post operative instructions
- Any complications which occurred.

Anaesthetic details

If the woman receives an anaesthetic the following details must be recorded:

- Date and time of the anaesthetic
- Type of anaesthetic
- Total amount of IV fluids
- Time in/time out of theatre
- Recovery details and recovery checklist.

Discharge arrangements

On discharge from hospital care the following should be recorded:

- Completion of discharge notification
- Any complications during care
- Receipt of leaflet on newborn babies health
- Contact details for relevant health professionals.

3. Storage arrangements

3.1 Cardiotocographs

Every woman who has a CTG (either antenatally or intrapartum) will require an approved re-sealable CTG envelope. This CTG envelope must be filed securely in the obstetric notes alongside the clinical notes. The woman should only require one CTG envelope (unless an inpatient for a considerable length of time and a second envelope is required).

3.2 Partograms

Every woman who is admitted to delivery suite in labour will need to have a partogram added to her notes (except women undergoing Elective LSCS). The partogram must be filed next to the clinical notes.

3.3 Anaesthetic records

Every woman who has an anaesthetic record whether an operation sheet and/or epidural record must have these filed in the hospital notes alongside the clinical records and partogram.

3.4 Fetal blood sampling results/reports

All FBS results must be hand written on the partogram and the printout report must be filed in the specialist re-sealable envelope for loose printouts.

3.5 Cord pH results/reports

Cord pH results must be printed out and sealed in the specialist re-sealable envelope for loose printouts. If there is an operation record the cord pH result must also be handwritten in the designated place on the front of the record.

3.6 Securing reports/results relating to previous pregnancies

Details relating to a previous pregnancy may be filed at the back of the notes used for the current pregnancy, or alternatively filed in a separate set of notes under a different volume number.

3.7 Ultrasound results

All ultrasound scan reports are printed out on A4 paper and filed in position 3 of the hospital notes (investigations).

3.8 Antenatal screening

It is the responsibility of the community midwife to ensure all results are available and securely filed into the woman's hand held record at the 16 week appointment (all low risk results). Any high risk results will have been dealt with by the antenatal screening coordinators and should be filed appropriately in the hospital notes and hand held records. Results are to be correctly placed onto the appropriate mount sheets.

4. Documenting the name of the lead professional

Following the initial booking appointment, part of the documentation process must be to include clear identification of the lead professional which will be decided once the woman has been risk assessed as either low or high risk. If low risk the woman should have a named midwife which is usually the community midwife allocated to the GP surgery. If high risk then the woman will be encouraged to deliver in a consultant led unit and this should be written clearly on the Personal Maternity Record (PMR). If the name of the lead professional changes during the pregnancy then this must be amended on the PMR, pink antenatal summary sheet and Cerner.

5. Contemporaneous complete record of care

All notes must be written contemporaneously to ensure accurate record keeping. However, in the event of an obstetric emergency the notes will be completed as soon as possible after the event and documented as a retrospective entry.

6. Audit of maternity health records

The Women's Services Directorate will participate in the Trust Record-keeping audit as detailed in the Clinical Record Keeping Policy. In addition, an annual audit will be undertaken to ensure that the storage arrangements for key pieces of patient documentation in Maternity Records are correctly implemented.

Requirement	Person responsible	Frequency	Reported to and reviewed by
Maternity health records audit	Directorate management team	Annual	CIRG
Multidisciplinary and multiprofessional audit of record keeping standards against an agreed audit tool.			