Standard:	Guidelines for Reporting and Documentation
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GUIDELINES for REPORTING and DOCUMENTATION
for Midwives Practicing in Newfoundland and Labrador

Introduction

Documentation is an important component of the midwife's practice and is integral in the provision of safe, ethical and quality midwifery care. Documentation refers to any written or electronically generated information about a client that describes client status or the care or services provided to that client (Potter & Perry, 2010). Quality documentation and reporting are necessary to enhance efficient and individualized client care (Potter, Perry, Ross-Kerr & Wood, 2009). Regardless of the format used to document, or the setting in which care is provided, the client's record is a formal, legal document that details the client's care and progress that may be used for risk management and optimizing the quality of midwifery care. Documentation must follow the requirements of the Personal Health Information Act (PHIA) (2010).

Purposes of Documentation

1. Provides a method of communication, by recording events in a chronological order, at the time of their occurrence, so as to preserve accuracy.

    a. The records contain information required for surveillance for provincial and national data bases;
    b. The records contain information required for research;
    c. Students use records for educational purposes while maintaining confidentiality;
    d. Records may be used for legal purposes.

2. Facilitates the coordination of care provided by a team of health professionals.

3. Promotes a high standard of care.

4. Promotes accuracy in the provision of care and reduces the possibility of error.

5. Demonstrates accountability that midwives competently assess, plan, implement and evaluate the outcomes of their care using knowledge, skills and judgment in accordance with the College of Midwives of Newfoundland and Labrador's Standards and Competencies for Practice.

6. Provides quality assurance by having records available for audit. Records are audited to:

    a. Monitor interventions and measure them against established standards;
    b. Monitor the practice of individuals, their skills, judgment and knowledge, and ensure that there is compliance with the College of Midwives' policies and

standards;

c. Assess that there is adherence to the College of Midwives' philosophy and Code of Ethics.

7. Promotes continuity of care for the midwifery team.

8. Facilitates evidence-informed practice and clinical decision support. The client record can be an important data source for midwifery and other health research and can provide information related to interventions and evaluation of client outcomes.

Principles of Documentation

1. The client care record should include information to identify the following:

- The client
- The midwife or other care provider
- Date and time of interaction/intervention
- Issues being addressed
- Plan of care
- Care provided
- Clinical reasoning for the choice of care
- Client's response and/or outcome of the interventions
- Future plans

2. The midwife must record a complete account of her assessment of the client's needs, including:

- Identified issues and concerns
- Assessment findings
- Diagnosis
- Plan of care
- Intervention(s) provided
- Evaluation of the client care outcomes

3. The midwife must document the following aspects of care:

- Relevant objective information related to client care
- Time when assessments, observations or interventions were completed
- Follow up of assessments, observations or completed interventions
- Administration of medications and IV fluids

- Education/teaching activities provided to the client and/or family
- Any adverse event or outcome

4. The person obtaining information and providing the care records it in the appropriate place. Entries are signed or initialed so that the person may be identified. When initials have been used, the document should have a place for the full name to be written so as to identify the care provider.

5. Midwives are expected to complete documentation that is clear, timely, accurate, relevant, unambiguous, comprehensive, complete, legible, chronological and reflective of relevant observations. Only accepted abbreviations may be used. Written documentation on paper must be in blue or black permanent ink. If an electronic method is being used it must be saved and backed up in a secure system and if the equipment is in an accessible place it must be "locked down".

6. If an error in documentation is made it must be corrected as per the employer's policy. Corrective products should not be used. There should be no empty lines between entries or spaces in the documentation.

Legal Matters

Client records may be accessed for quality assurance auditing purposes without the consent of the client (Health Professions Act, 2010, 23.4). However, in other circumstances the client must provide informed consent for the disclosure of client information outside the team of care providers. Client records are legal documents that may be submitted as evidence in a trial or inquiry and can be used to resolve questions or concerns about accountability and the provision of care.

1. All relevant information and care given by a person should be recorded at the time of occurrence by that person.

2. The absence of documentation infers that "nothing was done".

3. Recording by a third party (other than the person who carried out the procedure) is considered by courts of law to destroy the accuracy and diminish the credibility of the record.

4. Courts of law use records to reconstruct events, establish times and dates, and resolve conflicts in testimony.

5. Defense lawyers use records to establish that the care given and actions taken were "reasonable and prudent" for a midwife in the circumstances. Conversely, prosecution

lawyers use the records to attempt to show that the care provided failed to meet the standards of a reasonable and prudent midwife.

Access and Ownership

1. The documents belong to the agency or midwifery practice.

2. Only professionals involved with the care of the woman and baby have a right of access to the record. The assessors appointed by the quality assurance committee of the Council of Health Professionals may access client records without the consent of the client (Health Professions Act 2010, 23.4). Professionals may be required by law to disclose the information.

3. The woman has a right to read the information in her chart and to carry a copy of her own prenatal record.

Information Technology and Computer-Held Records

Midwives may be using information technology to record the assessment, planning, implementation and evaluation of care. The same basic principles that apply to manual records must be applied to computer-held records. There is no need to keep manual duplicates of computer-held records. These records do not replace the need to communicate with the team of health professionals involved in the care of the woman and/or her baby. Local guidelines should be followed regarding the information accessed by the woman. Ways should be established to determine the date and time of entries, and identification of persons who make entries. Any changes or additions that are made should be done in such a way that the original information is still visible and accessible.

Records Completed by the Midwife

Records should be stored in a safe appropriate place for the length of time approved by the College of Midwives, and then disposed of as directed by the College of Midwives in accordance with legislation.

The Records include, but are not limited to, the following:

1. Prenatal documents: Newfoundland and Labrador Prenatal Record, and a chart containing the consent form, complete history and physical examination of the woman and results from screening and laboratory tests.

2. Intrapartum documents: Intrapartum history, partogram or other labour and birth record, summary of labour and birth and printout if electronic monitoring is used.

3. Neonatal documents: Neonatal history and physical examination including Apgar scores, consent form, progress reports, screening and laboratory tests results, detailed gestational age assessment when appropriate, weight and growth chart, six week physical examination findings, and a copy of the transfer information to the community health nurse.

4. Postpartum documents: Postpartum progress reports, results from screening and laboratory tests, the final postpartum examination findings, including any family planning decisions, history, summary of the postpartum and admission and discharge documents.

The primary midwife is responsible for submitting:

1. The information required by Vital Statistics for all births.

2. The midwifery surveillance form with information required by the College of Midwives for:

    a. The Newfoundland and Labrador Centre for Health Information (NLCHI);
    b. The Canadian Institute of Health Information (CIHI);
    c. Other specific midwifery data.

The midwife will also have other records such as record of births, records for the care of mother and/or baby when care is transferred to a physician, community health nurse, or nurse practitioner.

Confidentiality and Privacy of Midwifery Records

A midwife must safeguard the records for women and their infants by making secure arrangements for both paper and electronic records. The Privacy of Health Information Act (PHIA) (2008) has established a comprehensive set of rules for the collection, use and disclosure of personal health information that the midwife must follow. As a custodian of personal health information, the midwife must provide for the secure storage, retention and disposal of records to minimize the risk of unauthorized access to or disclosure of personal health information. The midwife must also protect against theft, loss, unauthorized use, copying or modification of records. Records must be retained, transferred and disposed of in a secure manner. According to PHIA, in the event that personal health information is lost, stolen, disposed of or disclosed in an unauthorized manner (with limited exceptions), then the custodian i.e. the midwife must notify the individuals concerned and comply with the process outlined in the Act (PHIA, 2008, Part II).

If a midwife has to cease practicing she/he will notify the College and Council of Health

Professionals of this. If the midwife is unable to arrange transfer of care for her/his clients, with their permission, to another midwife or health professional she/he will notify the College and transfer all client records to the College, or to a specific agency, if appropriate. The midwife should obtain a receipt for any records returned to the College or agency.

Hospital or Birthing Centre Birth

When a birth occurs in a hospital or birthing centre the midwife documents the care she provides, consistent with institution policies and procedures, and the requirements of the College of Midwives. The primary caregiver, whether midwife or physician, completes the obstetrical birth record and the Registration of Birth. The midwife completes the postpartum referral form which is forwarded to the appropriate community health office.

The midwife and second attendant (e.g. second midwife, registered nurse) document events as they occur and the care each provides. Copies of labour records started prior to hospital admission are included in the permanent record.

Important Points

1. Record keeping is an integral part of midwifery practice.

2. Good record keeping is a mark of the skilled and safe practitioner.

3. Records should not include abbreviations, jargon, ambiguous phrases or irrelevant statements.

4. Written records should be explained to the woman and questions answered.

5. By auditing client records the midwife can assess the standard of care and identify areas for improvement and continuing education.

6. The midwife must ensure that the person who made the entry in a record can be easily identified.

7. Clients have the right of access to records held about them and their babies.

8. Clients may hold a copy of their own records as far as it is appropriate.

9. Each health professional's contribution to records should be seen as of equal importance.

10. Midwives have a duty to protect the confidentiality of the client and her baby's records.

11. Confidentiality of information held about the client and baby is just as important in computer-held records as in all other records.

12. When using records for research, confidentiality should be maintained, and the research should be approved by the local research ethics committee.

13. The midwife must use professional judgment to decide what should be recorded.

14. Records should be written clearly and in such a manner that the text cannot be erased. Whiteout must not be used.

15. Records should be factual, consistent and accurate.

16. The midwife knows that any entries made in a client's or baby's record may be scrutinized at some point for quality assurance purposes.

17. Good record keeping helps to protect the welfare [well-being] of women and babies.

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