Document Title:	**MATERNITY RECORD KEEPING INCLUDING DOCUMENTATION IN HANDHELD RECORDS**		
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Ruth Byford	Warner Library	18th April 2019

Related Trust Policies (to be read in conjunction with)	08086 Clinical Record Keeping Standards 05098 Women's and Children's Directorate clinical governance structure policy (to incorporate risk management policy) 07011 Confidentiality and Data Protection Policy 09062 Mandatory training policy for Maternity Services (incorporating training needs analysis) 05103 Case Note Tracking Policy

Document Review History:			
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2.0	Victoria Dennett		April 2012
2.1		Equality and diversity; audit and monitoring sections	January 2010
2.2		Clarification to appendix A	February 2010
3.0	Sarah Moon		October 2012
3.1	Sarah Moon	Clarification to Appendix A	November 2012
3.2	Sarah Moon	Clarification to 13.0	January 2013
3.3	Sarah Moon	Clarification to point 7.6	May 2013
3.4	Sarah Moon	Clarification to point 7.6	June 2013
3.5	Sara Smith	Clarification to point 11.1 and 12.2	July 2013
3.6	Gemma May	Clarification to point 11.1, 12.2 and Appendix B	June 2014
4.0	Sarah Moon		10 May 2016
4.1	Angela Woolfenden	Clarification to Appendix B	13th April 2018
5.0	Jude Horscraft	Full Review	29th April 2019

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1.0 Purpose

1.1 This guideline is to enable staff to be aware of the process for initialising, accessing and storing maternity records during the full maternity episode.

1.2 The support staff in achieving high standards in maternity documentation.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix B)

3.0 Scope of the Guideline

3.1 The 'Maternity record keeping including documentation in handheld records' is a specialist document (register number 06036) and will be in addition to the current Trust policies entitled 'Clinical record keeping standards' (register number 08086) and 'Patients records on wards policy' (register number 04085) and the 'Confidentiality and data protection policy' (register number 07011). This guideline should be read in conjunction with these policies.

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4.0 Background

4.1 The Department of Health Code of Practice for Records Management requires that maternity records will be retained for a minimum period of 25 years. Maternity records must be easily retrievable from whatever format or location they are stored in. For the purposes of record keeping these records are to be considered as much a record of the child as that of the mother.

4.2 Maternity records are designed to be multidisciplinary and all professionals who see the woman during her maternity care should be encouraged to use the single set of records. This is to ensure that there is a complete and contemporaneous record of all the care the patient receives and that a full and accurate picture is provided to all care givers.

4.3 It is expected that Allied Health Professionals write directly into the maternity record when seeing a patient as an inpatient. If care then continues on an outpatient basis, regular reports should be filed in the record particularly if there is a change in treatment, or on discharge.

4.4 All staff must comply with the Clinical record keeping standards policy (register number 08086).

5.0 Initialising Maternity Records

5.1 This process is to be followed when it is known a woman wishes to have her baby at Mid Essex Hospital Services NHS Trust:

5.2 A booking letter confirming the pregnancy will be sent to the Maternity Secretaries' Office from either a patient self-referral, the general practitioner or the community midwife.

5.3 The Administration Clerk will check to see if the woman has had previous care with the Trust and has an established hospital number or lilac folder. This relates to any care and not just previous maternity care.

5.4 If the patient has previous medical/maternity records, those records will be requested and this hospital number will be used for the current pregnancy. It may be necessary for these records to be regenerated from microfilm or the digitally stored image.

5.5 If the patient has never had any previous care with the Trust, a lilac folder with a hospital number will need to be generated. This applies irrespective of whether the patient intends to have a hospital or home birth.

5.6 The lilac folder will remain in the Antenatal Clinic at Broomfield Hospital or either of the two Midwife-led Units (MLU's) based at St Peter's, Maldon; and WJC, located at St Michael's Community Hospital, Braintree where there is 24 hour access. The lilac folder will retain basic demographic information, alert information and any details which cannot immediately be married up with the handheld records. This includes any documentation from maternity services contact episode when the patient forgets to bring her handheld records with her.

5.7 Arrangements must be made to link up the documentation with the handheld records (from any previous maternity episode) as soon as possible following discharge to ensure all Information pertaining to the current pregnancy is available to the multidisciplinary team.

5.8 When the midwife books the woman for maternity care, she will prepare a set of handheld Antenatal Care Records which will remain with the patient throughout her pregnancy.

5.9 At the first antenatal booking the midwife will complete a risk assessment as to whether the patient has a 'high' or 'low' risk pregnancy and will arrange an appointment with a consultant obstetrician, if required.

5.10 The name of the lead professional will be allocated at this time and will be reviewed and amended at each contact as this may change at different times throughout the pregnancy. It should be made clear in the patient's health care records who the lead professional is as the patient may move between low and high-risk care during her pregnancy, labour and puerperium.

6.0 Handheld Records

6.1 Handheld records are produced in three booklets as follows:

- Antenatal Care Record;
- Postnatal Care Record – Maternal;
- Postnatal Care Record – Baby.

6.2 Antenatal Care Record contains the current and past medical/surgical history, health and

family support assessment, anaesthetic assessment, antenatal appointments, antenatal clinical assessments and individual care plans and antenatal inpatient records.

6.3 Pregnant patients will hold their own 'Antenatal Care Record' for the duration of their pregnancy.

6.4 The midwife should ensure that the patient's name, hospital number and NHS number are recorded on the front of each complete set of healthcare records.

6.5 It is very rare for a patient to lose her handheld records. If this does happen, staff should be alert to any possible wider issues relating to her personal circumstances. A continuation sheet must be used for recording the relevant information but cannot be entered into the handheld records. Furthermore, this continuation sheet must be kept within the lilac folder. All continuation/ additional sheets must contain the patient's name, hospital number and NHS number recorded on the front sheet only.

6.6 On admission, in labour, these records will become part of the lilac folder and will be retained by the maternity staff. If a patient is admitted in labour and has not brought her handheld records with her, her partner should be asked to either to return home to collect the records or have someone else to bring them in. In the meantime, a continuation sheet should be used and then filed securely as per order of filing schedule in the handheld records when available. (Refer to Appendix A)

6.7 New handheld records should only be generated in exceptional circumstances and only after it has been confirmed that the originals are irretrievable. These will be designated as duplicate records.

6.8 The 'Labour and Delivery Care Record' must not go home with the mother following delivery. Once the mother has gone home, the Labour Care Record will then go to the maternity administration office, Broomfield Hospital to be coded. Once the 'Postnatal Care Record – Maternal' and the 'Postnatal Care Record – Baby' has been returned from the community/ MLU's they will be coded; both 'Labour and Delivery Care Record' and 'Postnatal Care Record' will be reunited and then returned to the Health Records Centre at Broomfield Hospital.

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6.9 The standard for the order of filing must be met for any loose documentation within any of the healthcare records before it is secured in the document wallet within the lilac folder. The purpose of this is to minimise the risk of lost documentation and incomplete records. (Refer to Appendix A)

6.10 The 'Postnatal Care Record – Maternal' and the 'Postnatal Care Record – Baby' will be commenced immediately after delivery and will go home with the mother and baby for the duration of her postnatal care (if the patient is in area; refer to point 6.13). The community midwife will retain these records once the mother and baby are discharged to the care of the Health Visitor.

6.11 The Community Midwife will then return these postnatal records to the Broomfield Maternity administration office, known as the Maternity Library within 2 weeks at which time they will be coded.

6.12 After coding the ‘Labour and Delivery Care Record’ and ‘Postnatal Care Records’ are secured in the lilac folder and returned to the Health Records Centre at Broomfield Hospital.

6.13 Neonatal notes are retained by the Neonatal Unit prior to discharge home. These notes are then sent for coding and then forwarded to the Phoenix Satellite Library, at Broomfield Hospital.

6.14 For those patients who live out of area the Labour Care Record and Postnatal Care Record should be retained on discharge home to the community midwife. A copy of the patient’s labour summary should be placed in the discharge letter informing the community midwife.

7.0 Style and Content

7.1 **Style** - date, time and sign each new entry and record your name, signature and designation on page 2 of each care record in black ink. All entries should be neat, legible and use objective, precise language and avoid subjective 'casual' remarks and abbreviations that might not be understood.

7.2 The responsible midwife or professional reviewing a CTG trace should ensure that they date, sign and print their surname on each occasion.

7.3 Discharge and clinical letters for outpatients’ attendance (i.e. ones that will be sent from the hospital to other health care staff) should be timely, neat and accurate.

7.4 **Content** - remember to record all information regarding current and future care; record relevant conversations with the family or friends of the patient; record the details of the information give to patients at the time of discharge. The health professional should ensure that where verbal consent is required for procedures that this documented in the patient’s healthcare records. (Refer to the guideline for ‘Clinical record keeping standards’; register number 08086)

7.5 **Data Quality** - the patient's hospital number is always the patient's primary identifier and must be recorded on the front page of each care record booklet. In addition, the patient’s name i.e. first name followed by the surname, and the patient’s NHS number which is a unique identified should also be recorded in same manner. For any additional pages required refer to point 6.4.

7.6 **Retrospective entries** - records should always be written contemporaneously or as soon as possible after the events described. One of the greatest problems in midwifery is the fact that a midwife may be under pressure during a delivery and could also be care providing for more than one patient when in the hospital setting. This makes it impossible for her to record events at the same time as the delivery takes place; in this situation the health professional is required, prior to her documentation of events to identify this entry as ‘written in retrospect’.

7.7 There is no fixed time limit on retrospective writing but best practice as the Nursing Midwifery Council (NMC) advises is to complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event; ensuring that the

date and time of retrospective entries are recorded.

7.8 The records should be completed accurately and without falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.

7.9 As a midwife, if you delegate record keeping to pre-registration students of nursing or midwifery, you must ensure that they are adequately supervised and that they are competent to perform the task. You must clearly countersign any such entry and remember that you are professionally accountable for the consequences of such an entry.

7.10 **Errors** - draw a single line through incorrect entries; initial the error; add today's date; make a note in the margin that the entry was made in error and note what the correct entry should be; never erase or use white-out liquid.

7.11 **Other Printed Records** - printed test results are part of the patient record and should be filed at the back of the antenatal care record booklet.

7.12 **Consent Forms** - record any information you have given to the patient before they have made the decision to sign any consent form; this helps ensure that you have gained informed consent; consent forms are signed by the patient after the treatment has been discussed with the doctor; If there is clinical photography planned during surgery, include this on the consent form prior to signing.

8.0 Confidentiality and Sourcing Notes

8.1 Do not remove case notes from the hospital or send original records to other hospitals. The Medical Records Tracking System on Lorenzo must be used to track the location of the notes e.g. when case notes are taken from one area of the hospital to another.as per the Trust's Casenote Tracking Policy; register number 05103.

8.2 Refer to the Trust's Confidentiality and data protection policy (register number 07011) for detailed information about the need for confidentiality and compliance with the data protection and Caldicott Principles.

8.3. All staff to be familiar with the Information Governance Handbook.

9.0 Structure of Medical Records

9.1 It is the responsibility of all staff using maternity records to understand the structure and filing system.
(Refer to Appendix A)

9.2 All items in this case note folder must be filed in accordance with these guidelines. There should be no loose papers, every user must leave the folder with the contents secured by the binding system. Filing will be routinely audited.

9.3 Records of previous pregnancies, for in area women will be filed in a plastic wallet and located

behind the current pregnancy episode.

10.0 Alert Stickers

10.1 An **alert sticker** is the **only** sticker that may be placed on the front cover of a set of maternity records. It should highlight anything that would need to be known by the next clinical member of staff to be involved with the care of the patient. If an alert sticker is used then it is the responsibility of the person making the decision, to input the reason for the 'alert' on the inside front cover of the records. This must happen even with the older buff folders that do not have a specific printed box.

10.2 An alert sticker can be used to denote the following though this list is not exhaustive:

- Drug allergies;
- Anaesthetic allergies/problems;
- Any adverse reaction;
- The presence of a **do not resuscitate order** (order to be filed in correspondence);
- Hearing or visual impairments;
- Language issues;
- Fetal loss (tear drop sticker);
- Another member of the family with the same name/initials;
- A same gender twin;
- Any medical records elements that are known to be permanently missing (only health records staff will record these).

11.0 Staffing and Training

11.1 All midwifery and obstetric staff must attend yearly mandatory training which includes record keeping update.
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis.) (register number 09062)

11.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

12.0 Professional Midwifery Advocates

12.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

13.0 Audit and Monitoring

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13.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

13.2 As a minimum the following specific requirements will be monitored:

- Basic record-keeping standards against which the health records must be audited for all healthcare professionals;
- Basic clinical note keeping standards against which the health records must be audited for all healthcare professionals;
- Storage arrangements for:
    i. Cardiotocographs;
    ii. Anaesthetic records, including epidural records;
    iii. Fetal blood sampling results/reports;
    iv. Cord pH results/reports;
    v. Securing results/reports relating to previous pregnancies;
    vi. Antenatal screening and ultrasound results.

- Arrangements for documenting the name of the lead professional (to include the process for recording any changes to the lead professional);
- Process for ensuring a contemporaneous complete record of care;
- Frequency of audit of health records;
- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

13.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 13.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

13.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

13.5 The audit report will be reported to the monthly Directorate Governance

Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

13.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

13.7 Key findings and learning points will be disseminated to relevant staff.

14.0 Guideline Management

14.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

14.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

15.0 Communication

15.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarize themselves with and practice accordingly.

15.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

16.0 References

Information Governance Alliance (2016) Records Management Code of Practice for Health and Social Care 2016. London: Information Governance Alliance
Available at https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care

National Institute of Health and Care Excellence (2012) Antenatal Care. Quality Standard (QS22) London: NICE
Available at https://www.nice.org.uk/guidance/qs22

Nursing and Midwifery Council (2018) The Code. Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates. London: NMC
Available at https://www.nmc.org.uk/standards/code

NHS Resolution (2019) Maternity Incentive Scheme Year 2. London: NHS Resolution
Available at: https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Appendix A

Mid Essex Hospital Services NHS Trust

Women's and Children's Division
Filing for Maternity Records

The list below details the order of filing for current Maternity Care Records and lilac folders:

Antenatal Care Record		Situated at the front of the lilac notes	
Antenatal screening		Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Patient information leaflet proforma	(As appropriate)	Behind Antenatal Care Record / or within the care records	Filed chronologically and secured in the behind the Antenatal Care Record
Neonatal alert form	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Proforma for Management of Multiple Pregnancy and Birth	(As appropriate)	Behind Antenatal Care Record	Secured behind the Antenatal Care Record
Raised BMI Care record pathway	(As appropriate)	Behind Antenatal Care Record	Secured behind the Antenatal Care Record
Risk Assessment for Equipment Needed for Patient with Raised BMI Proforma	(As appropriate)	Behind Antenatal Care Record	Secured behind the Antenatal Care Record
Ultrasound reports		Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
CTG	Small envelope with CTG number, patient name, hospital number and date. Insert small brown envelope into A4 CTG storage envelope	Record the name, hospital number, EDD, sequence of order, reason for CTG, outcome and signature on the front of the A4 CTG storage envelope	Secured the A4 CTG storage envelope on the behind the Antenatal Care Record
Handover of care proforma (Antenatal)	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Maternal transfer proforma	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
In utero transfer proforma	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Labour CDC computer print out		In front of the Labour Care Record	Filed chronologically and secured in front of the Labour Care Record

Labour and Delivery Care Record		Situated behind the Antenatal episode	
Drug chart		Behind Labour Care Record	Secured behind the Labour Care Record
MEOWS chart		Behind Labour Care Record	Secured behind the Labour Care Record
HII form	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Epidural Record and observations chart	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Shoulder dystocia proforma	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Postpartum haemorrhage proforma	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Fetal Blood Sampling (FBS) results	FBS results should be placed in a small brown envelope	Secure the small brown envelope chronogically in the Labour Care Record	Chronological within the documented Labour Care Record
Cord pH results	Cord pH results results should be placed in a small brown envelope (As appropriate)	Secure the small brown envelope on the Birth Assessment page	Secured behind the Labour Care Record
Urinalysis results		Secure chronogically in the appropriate Care Record	
Operative Delivery and Theatre Care Record	(As appropriate)	Behind the Labour Care Record	Secured behind the Labour Care Record
Anaesthetic records	(As appropriate)	Integral to the Operative Delivery and Theatre Care Record	Secured behind the Labour Care Record
Consent form	(As appropriate)	Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
VTE Assessment form		Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Operative theatre times	(As appropriate)	Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Baby Delivery Record		Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Handover sheet from NNU admission	(As appropriate)	Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Handover of care proforma (postnatal)	(As appropriate)	Behind the Labour Care Record	Secured in the behind the Labour Care Record
Postnatal discharge CDC	1 copy required	In front of the Postnatal Care Record - Maternal	Secured in front of the Postnatal Care Record - Maternal
Postnatal Care Record – Maternal		Behind the Labour Care Record	Secured in the behind the Labour Care Record

Specialist referrals	(As appropriate)	Behind the Postnatal Care Record - Maternal	Secured in the behind the Postnatal Care Record - Maternal
Postnatal Care Record – Baby		Behind the Postnatal Care Record - Maternal	Secured in the behind the Postnatal Care Record - Maternal
Baby drug chart, observation and feeding charts, referral forms, immunisation forms	(As appropriate)	File chronologically: baby drug chart, observation and feeding charts, referral forms, immunisation forms	Secured in the behind the Postnatal Care Record –Baby
Newborn screening forms		Behind the Postnatal Care Record - Baby	Secured in the behind the Postnatal Care Record –Baby
Clear Folder	(Retained in the lilac folder inserted behind pregnancy episode)	Clear folder should be located behind pregnancy episode chronologically	
Mat Ad 1 (Self/ Midwife/GP referral)		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Antenatal booking CDC		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
GP referral letters		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
FAQ		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Telephone message proforma		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Yellow Alert Forms		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Early pregnancy assessment clinic	(As appropriate)	Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Previous pregnancies	Securing results/reports relating to previous	Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder) filed behind the current pregnancy episode

Appendix B

NHS
Mid Essex Hospital Services
NHS Trust

Preliminary Equality Analysis

This assessment relates to: Maternity Record Keeping Including Documentation in Handheld Records (06036)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? **(What will the change achieve?)**	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Jude Horscraft	**Job Title**	Practice Development Midwife	**Date**	April 2019