Maternity Health Records and Record Keeping

Classification:	Guideline
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Authors Division:	Women's and Children
Departments/Group this Document applies to:	All areas providing maternity and neonatal care

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Guideline to be followed by (target staff): To assist staff within Maternity Services to manage the risk associated with maternity health records and meet the required standards of record keeping.

To be read in conjunction with the following documents:
MKUH Fetal Monitoring Guideline
MKUH Health Records Policy
MKUH Corporate Records Management Policy
MKUH Transfers by Ambulance Guideline
MKUH Policy and Guidelines for Consent to Examination or Treatment
MKUH Information Governance Policy
Department of Health: Records Management Code of Practice
MKUH Data Subject Access & Individual Rights Policy
MKUH Standard Operating Procedure (SOP) Number: 1 SOP Title: Subject Access Requests

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centered care
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 17 – Good governance

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

Good record keeping is an integral part of healthcare professional practice and is essential for the provision of safe and effective care. It is part of the Nurses and Midwives Code of professional standards of practice (2018) to keep clear and accurate records, and part of good medical practice to record work clearly, accurately and legibly. Good documentary evidence will support individual accountability, aid inter-professional communication and teamwork, assist with investigation of complaints and claims, particularly in future years, and inform audit and research.

There is an expectation that records are completed at the time of the contact, interaction or event or as soon as possible and no longer than 24hrs later. All entries made in retrospect must be documented as such.

Health records can be in any format or media and need to be managed to ensure compliance with the requirements of the General Data Protection Act 2018 (GDPA) and Access to Health Records Act 1990 (AHR). The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR).

Maternity related health records need to be kept for 25 years (DOH, 2016). Access to health care records can be requested by the individual they relate to and other sources for example a person with parental responsibility.

Trust documentation standards form the basis of the record keeping standards with further specialty specific standards, and they should be used in conjunction with this guideline.

A properly kept record contains all the information needed to deliver safe care and treatment and is available to relevant staff in a timely and accessible way. This may include care and risk assessments, care plans and case notes (CQC 2021).

The Trust will ensure that evidence-based guidelines are used in the management of health records including maternity notes.

Executive Summary

Record keeping "affects everyone in the organisation" (FOI Act - 2000) and therefore is everyone's responsibility.

The Gosport Independent Panel (2018) highlighted a consistent picture of poor recordkeeping and failure to record fundamental aspects of care and monitoring. Recordkeeping was inadequate and it did not meet the expected standards of professional guidance as set out at the time.

Any document (hard copy or electronic), which records any aspect of the care of a patient or client, can be required as evidence before a court of law or before Preliminary Proceedings Committee of the Professional Councils. All NHS health care records are the property of NHS and not the health care professional or patients / clients. Health records are public records and are "owned" by the Secretary of State and must be kept in accordance with legal and professional obligations set out in the Records Management Code of Practice for Health and Social Care in addition to the following legislation and any new guidance affecting records management as it arises:

- The Public Records Act 1958
- The Data Protection Act 2018
- The Freedom of Information Act 2000

- The NHS Confidentiality Code of Practice

The retention and storage of maternity records is detailed in the NHS Records Management Code of Practice and gives guidance on how long records should be kept and what should be kept.

Definitions

1.0 Roles and Responsibilities:

All Staff

It is the responsibility of everyone to maintain health records. All staff has a legal and contractual obligation to maintain and protect confidential data. Whilst there are key individuals within the Trust who have specific responsibilities for ensuring good practice in relation to health records they are **NOT** however responsible for each individual and everybody must take responsibility for documentation of their own actions for women and babies in their care.

2.0 Implementation and dissemination of document

This policy will be placed on the Trust's intranet site and disseminated to all employees working in maternity.

3.0 Processes and procedures

A health record is defined as being any record which consists of information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of that individual. An optimal documented record is classed as one that contains all consultations and discussions which have taken place between members of the health care team and the woman/birthing person and it should be adapted and evaluated in response to the woman's/birthing peoples needs and clinical findings.

The complete physical maternity record is composed of:

- Electronic patient records
- Paper records

Multiple information systems (IT), including eCARE (electronic patient records), Badgernet and ultrasound scan systems, hold electronic formats of different parts of the health records. Entries in these IT systems may be printed and then filed in the physical record.

It is essential that records are chronological and that the entries follow a logical and methodical sequence.

4.0 Standards for Record Keeping in Maternity

4.1 Record Keeping in Maternity

Inadequate and inaccurate record keeping has been highlighted as a recurring theme in the confidential enquiries into stillbirths and deaths in infancy (MBRRACE, 2020) as a contributing factor in sub-optimal care.

Good record keeping is an integral part of practice and is essential to the provision of safe and effective contemporaneous complete record of care. Good record keeping, has many important functions (NMC 2018).

Keeping patients' medical records up to date with key information is important for continuity of care. Keeping an accurate record of the exchange of information leading to a decision in a patient's record will inform their future care and help you to explain and justify your decisions and actions. (GMC 2020)

- Continuity of care, supporting patient care and communications
- Promoting better communication and sharing of information between members of the multi-professional healthcare team
- Communication between health professionals, showing how decisions related to patient care were made and supporting effective clinical judgements and decisions
- Improving standards of care. Promoting better communication and sharing of information between members of the multi-professional healthcare team
- Audit and clinical reviews
- Data collection, supporting the delivery of services
- Contribution to the research environment
- Professional expectation and demonstration of professional accountability
- A narrative of experience for the woman/birthing person
- Addressing complaints or legal processes.

4.2 Principles of Good Record Keeping for Maternity

The principles of good record keeping apply to all types of records, including computerised records, regardless of how they are held. These can include:

- Clinical notes
- Letters to and from other health professionals
- Laboratory reports
- Radiology reports
- Printouts from monitoring equipment e.g. CTG trace, blood gas, ECG's
- Incident reports and statements
- Prescription charts

4.3 Record keeping standards

- All entries should be clear, **accurate** and **legible.**
- All entries should be in **chronological** order.
- All entries should be made **immediately** after an event or as soon as possible no longer than 24 hours later. All entries made in retrospect must be documented as such.
- Relevant, non-factual entries e.g. conclusions, opinions etc **may** be recorded All entries must be **timed, dated and signed**.
- All entries in paper format should be written in **blue or black ink only** (Entry must be 'permanent' and readable if photocopied)
- Where a **signature** is required, this must be a full *(i.e. minimum one initial plus surname*), legible* signature, **not** initials.

*If the signature is not legible, the writer's name must be printed underneath it, or stamped there with his/her name stamp.

- The **first time** that anyone writes in a woman's/birthing persons medical record regarding a particular episode of care they should print their name and grade, in capitals, under their signature.
- Any **errors** should be crossed through with a single line so that the previous entry can still be read.
  (The previous entry must not be obliterated e.g. with correcting fluid or by scribbling/pasting over.)
- All **corrections** should be timed, dated and initialed *(A signature is acceptable instead of initials).*
- Each **new page** should have either the woman's/birthing persons name and hospital number written in the designated place, or an addressograph sticker attached there.
- Clinical records should include **relevant** clinical findings, decisions made and actions agreed, and who is making the decisions and agreeing the actions, information given to women/birthing people, any drugs prescribed or other investigation or treatment
- 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
- 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
- Take all steps to make sure that records are kept secure. All documentation, correspondence, prescription charts and investigations should be filed securely in the health record in date order.
- Refer to the "Fetal Monitoring guideline" for recordkeeping in relation to cardiotocographs (CTG)
- Abbreviations can be used if it is documented in full or there is a key in the documentation to refer to.
- In the unlikely event that health records need to be altered the practitioner must document their name and job title, and sign and date the original documentation. Any alterations made, and the original record must be clear and auditable.
- Mentors should read entries made by a student midwife to ensure accuracy and clarity. Student records in this Trust must be countersigned by a registrant.
- You should take a proportionate approach to the level of detail recorded. Good medical practice states that you must include the decisions made and actions agreed – and who is making the decisions and agreeing the actions in the clinical records. This includes decisions to take no action.

4.4 Best Practice summary

- Right record (encounter)/person
- Right place
- Right time (chronology)
- Right detail – action and reasoning
- Right Log-in (are you logged in as yourself)

4.5 Clear and organised documentation

- Staff are responsible for all documentation made under their login, therefore log in details must not be shared
- Staff should make it clear within the record when they are writing or inputting data on behalf of a colleague. The record must be checked by the person conducting the care for accuracy and a note to confirm the scribing was accurate

- Student midwives should complete their own documentation and midwives should ensure they know the correct procedure to countersign all student entries on the system
- Where an error or problem has occurred within or accessing an electronic record, the member of staff accessing that record is responsible for escalating appropriately
- Staff should be aware that digital records allow for multiple staff to be documenting and therefore information will update in real time
- Where unable to document contemporaneously staff should ensure they adjust the entry and assessment time of their documentation to ensure that the chronology of the record is maintained, but clearly explain the reason for documenting retrospectively

4.6 Accurate documentation content

- Autotext, Powerforms and Tick boxes should be utilised where appropriate to support date capture and for efficiency, but free text detail should be added as required for narrative e.g. actions and reasoning behind decisions and care planning
- Where a system pulls documentation into the record automatically from previously recorded information, it is the responsibility of the staff member to check that information is correct prior to saving the documentation as the clinician will become responsible for everything recorded within that saved record (RCM Electronic Recordkeeping Guidance and Audit Tool 2021)
- Staff should review and update the appropriate risk assessments ensuring the current risk is clear within the record
- When a member of staff is unable to use the electronic record due to emergency or downtime, all paper records should be scanned and uploaded to Electronic Data Management (EDM) for completeness
- It is advised to use the BRAIN acronym for documentation of discussion. It stands for the following:

B – What are the benefits of this course of action?
R – What are the risks?
A – Are there any alternatives?
I – What are the implications of following this course of action? What does intuition tell you?
N – What happens if we do nothing?

- The use of SBAR communication tool is a structured form of communication that enables information to be transferred accurately between individuals. It can be used on admission, when escalating a concern or between staff for a change of shift

S – Situation (Identify yourself and where you are calling from, identify the patient and describe your concern)
B – Background (give the reason for admission, any significant history, medication etc)
A – Assessment (vital signs, clinical impressions and concerns)
R – Recommendation (be explicit about what you need including time frame, make suggestions, clarify expectations)

4.7 Informed Consent

- When taking verbal consent you must make sure this is recorded in the clinical notes

- Consent forms can be a helpful prompt to share key information, as well as a standard way to record a decision that can make regular review easier

- It is the health care professional's responsibility to ensure information is provided to advise of the risks and benefits associated with any form of treatment or care pathway, taking into consideration, the individual obstetric and or medical history. Use numerical data to describe risks if available. Be aware that different people interpret terms such as 'risk', 'rare', 'unusual' and 'common' in different ways.
- When making a record of the discussion (for example, in a person's clinical notes or care plan), record any decisions made along with details of what the person said was important to them in making those decisions. Offer to share this with the person.
- The health care professional must ensure the information is provided in a way which is understood and to review that the information has been understood, utilising communication aids as appropriate and taking into consideration any factors affecting communication.
- Following this, the health care professional has a responsibility to respect and support the informed decision and in the event of a concern about mental capacity, an assessment should take place prior to discussions surrounding decision making to enable the appropriate support is in place

4.8 DOCUMENTATION AND STORAGE OF CARDIOTOCOGRAPHS (CTG)

File all CTG traces in the specific CTG wallet envelope in the woman's/birthing persons notes in date order. The tracings should never be left in any area other than the woman's/birthing persons notes. Traces should be kept for 25 years.

4.9 DOCUMENTATION AND STORAGE OF CORD PH RESULTS AND REPORTS

The results of paired blood samples must be recorded in the birth notes, in addition to the printout being stapled to the notes, because the printout will fade over time.

4.10 SAFEGUARDING ISSUES

Midwives should ensure the electronic record of safeguarding information is checked for social or child protection issues when a woman/birthing person is admitted and documentation continued as required in all appropriate records. If there is a case open to Children's Services (section 17-child in need or section 47-child protection) there will be a safeguarding flag in eCARE
The confidential box within each of the booklets is also used to indicate further information is available where it would be inappropriate to document in the notes for example domestic violence.

5.0 Recordkeeping Governance

- All staff must receive appropriate training for the electronic records systems (eCARE). Each member of staff is responsible for ensuring this is maintained and updated as required when the system is updated or changed
- All staff should ensure they are up to date with their Information Governance (IG) training and are aware of how to use the electronic record to support IG
- All staff should be familiar with business continuity procedures in case of faults, cyber-attacks, or down-time
- Healthcare professionals should be aware of, and know how to use; the Trust information systems (see Information Security Policy)
- Passwords to access information systems must not be shared. Similarly, systems should not be left open to access when staff have finished using them.

- All health care practitioners are in date with Information Governance training
- All health care practitioners are familiar with business continuity procedures in case of electronic patient records downtime

5.1 Falsification of records

- Complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements by reporting to a Senir Midwife or for medical staff the CSU Lead

6.0 Storage and Retention of Maternity Notes

Records must be retained in accordance with the Human Rights Act 2000 and the Caldicott Principles 2020

Department of Health: Records Management Code of Practice gives guidance on how long records should be kept and what should be kept.

Maternity records must be stored safely and confidentially for 25 years after the birth of the last child

6.1 General Data Protection Regulations: Storage Limitations

Kept in a form which permits identification of the data subjects for no longer than is necessary for the purposes for which the personal data are processed, within the rights of the data subject.

The rights of individuals under GDPR are in the main the same as those under the Data Protection Act.

- The right to be informed
- The right of access
- The right to rectification
- The right to erasure
- The right to restrict processing
- The right to data portability
- The right to object
- The right not to be subject to automated decision-making. This includes profiling.

Information on women/birthing people accessing their medical records is detailed in the MKUH Data Subject Access & Individual Rights Policy and Standard Operating Procedure (SOP) Number: 1 SOP Title: Subject Access Requests. This information and request form is available on the Trust Intranet.

7.0 Lost Records

Should any handheld maternity health records be misplaced or lost an incident form must be completed (see incident reporting policy and procedure).

8.0 In Utero Transfers

Before transfer, a duplicate copy of any hand-held maternal records must remain within the Maternity Unit. The original records must go with the woman/birthing person to the receiving unit and a printout of the eCARE records such as drugs and observation charts, blood and any other antenatal screening results. Please refer to MKUH Transfers by Ambulance Guideline.

9.0 Disclosure

Information that can identify a person in your care must not be used or disclosed for purposes other than healthcare without the individual's explicit consent. However, you can release this information if the law requires it, or where there is a wider public interest.

Under common law, you are allowed to disclose information if it will help to prevent, detect, investigate or punish serious crime or if it will prevent abuse or serious harm to others (NMC 2015) Any request for disclosure of patient information by an investigatory authority (i.e., Police, Social Services, Inland Revenue, etc.) must be approved by the Trust Caldicott Guardian before being provided. If you receive such a request for disclosure, please contact the Information Security Facilitator.

10.0 Compliance, Monitoring and Audit

Audit plays a vital part in ensuring the quality of care that is delivered. By auditing records, standards can be assessed, areas for improvement can be identified and staff development can take place.

The maternity services will undertake audit of maternity health records using the Record Keeping Audit tool (Appendix 1):

Audits are undertaken by the multidisciplinary team throughout the year

10.1 Record Keeping Workbook

All staff will be required to complete the mandatory record keeping requirement at the commencement of employment with MKUHFT.

11.0 Data Protection

Information recorded in a woman's/birthing persons notes is confidential under the GDPR (General Data Protection Regulation [replaces the Data Protection Act 1998]) (25th May 2018) and must be protected by staff. No-one should have access to the records or information contained therein unless they are directly involved in the care of the woman/birthing person or the woman/birthing person has given permission.

Under the GDRP women/birthing people have the right to know why information about them is being collected and who it will be shared with. They have the right to access their records.

The principles for manual records also apply to electronic records. All electronic records must be uniquely identifiable ensuring that it is clear who updates each record. Staff must maintain the security of electronic records.

Records must be retained with reference to the Human Rights Act 2000 and the Caldicott Report 1997.

Maternity records must be stored safely and confidentially for at least 25 years after the birth of the last child.

12.0 Statement of evidence/references

- General Data Protection Regulations May 2018 (previously Data Protection Act 1988)
- Access to Health Records Act 1990
- Freedom of Information Act 2000
- Computer Misuse Act 2000
- Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer*
- *Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*, London: RCOG Press.
- Nursing and Midwifery Council. 2015 (Update October 2018). *The Code. Professional standards of practice and behaviour for nurses and midwives*. London: NMC. Available at: http://www.nmc-uk.org/Documents/NMC-Publications/revised-new-NMC-Code.pdf
- MBRRACE-UK. *Saving Lives, Improving Mothers' Care 2020 - Lessons to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016–18*. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2020. Available at: Reports | NPEU (ox.ac.uk)
- National Data Guardian for health and social care: The Eight Caldicott Principles (2020) The Caldicott Principles - GOV.UK (www.gov.uk) accessed on 9th October 2021
- NHSX Records Management Code of Practice for Health and Social Care (2021) Records Management Code of Practice 2021 - NHSX accessed on 9th October 2021
- General Medical Council (2020) Guidance of professional standards and ethics for doctors: Decision making and consent. Manchester: GMC 2020. Available at Decision making and consent - GMC (gmc-uk.org)
- Gosport War Memorial Hospital: The Report of the Gosport Independent Panel (2018). Available at Gosport Inquiry (independent.gov.uk)
- Royal College of Midwives (2021) Electronic Record Keeping Guidance and Audit Tool accessed on 21st February 2022
- NICE guideline 2021: Shared decision making, guidance 197 accessed on 18th April 2022

13.0 Governance

13.1 Document review history

Version number	Review date	Reviewed by	Changes made
5	June 2018	Janice Styles	Updated and reviewed
5.1			Amendment made. Approved Women's Health CIG on 03/02/2021
5.2	February 2022	Mary Plummer and Erum Khan	Amendments made and audit tool updated

13.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Melissa Davis	Head of Midwifery	January 2022	24/01/2022	Comments throughout	Yes
Natalie Lucas	Practice Development Midwife	January 2022	18/01/2022	Comments on use of SBAR	Yes
Lauren Mitchell	Consultant Midwife	January 2022	13/01/2022		Yes
Rachael Bickley	Co-Chair Maternity: MK MVP	March 2022	15/03/2022	Comments requesting maintaining BRAIN in section 4.6	Yes
				Comments asking for patient verification of verbal consent via "check back" as soon as possible.	
				Comments requesting inclusion of "Time to decide"during informed decision making (section 4.7)	
				Comments requesting inclusion of NICE guidance on shared decision making NG197	Yes
				Comments requesting inclusion of reference to guideline for patients access to medical notes. Section 6.1 and 11	Yes
				Comments suggesting clearer outlines of audit timing and responsibility section 10	

13.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Adherence of standards of record and note keeping standards and arrangement for storage of maternity records	Audit of maternity health records			

13.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and Children	Department	Maternity
Person completing the EqIA	Mary Plummer	Contact No.	
Others involved:		Date of assessment:	January 2022
Existing policy/service		New policy/service	

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All staff*

Protected characteristic	Any impact?	Comments
Age	YES NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	YES NO	
Gender reassignment	YES NO	
Marriage and civil partnership	YES NO	
Pregnancy and maternity	YES NO	
Race	YES NO	
Religion or belief	YES NO	
Sex	YES NO	
Sexual orientation	YES NO	

What consultation method(s) have you carried out?
For example: focus groups, face-to-face meetings, PRG, etc

How are the changes/amendments to the policies/services communicated?			
For example: email, meetings, intranet post, etc			
What future actions need to be taken to overcome any barriers or discrimination?			
What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA			

Appendix 1: Audit tool

Record Keeping Audit

Paper records

		Yes	No	N/A
	All paper records have a date and time for each entry	☐	☐	
	There is a printed name and signature for each health care professional	☐	☐	
	The health care professional has printed their name and grade in capitals under their signature for first entry	☐	☐	
	Any errors are crossed through with a single line so previous entry can still be read	☐	☐	
	Corrections are signed/initialled, dated and timed	☐	☐	
	All documentation is in blue or black ink	☐	☐	
	The documentation is legible	☐	☐	
	Each new paper page has either the name and MRN written in the designated place, or an addressograph	☐	☐	
	All paper records are filed in chronological order	☐	☐	
	All CTG's are stored correctly in a CTG envelope	☐	☐	
	Non-universally recognised abbreviations has been written out fully prior to the abbreviation	☐	☐	

Electronic records

		Yes	No	N/A
	Booking risk assessment completed at booking and detailed appropriate management plan documented	☐	☐	
	Appropriate named midwife and team documented at booking	☐	☐	
	Management plan reviewed and updated at every antenatal follow up with appropriate referral	☐	☐	
	Assessment of any safeguarding issues documented at booking with appropriate detail.	☐	☐	
	Infant feeding discussed appropriately between 25-36 weeks gestation	☐	☐	
	Carbon monoxide test offered at booking and 36 weeks. Results documented	☐	☐	
	Domestic abuse screening questions completed ay booking, repeated at 28 and 36 weeks	☐	☐	
	VTE risk assessment completed at booking and actioned appropriately			
	VTE assessment completed on admission, every 7 days and following the birth of the baby and actioned appropriately			
	Birth options discussed and any plans or preferences clearly documented			
	Evidence of informed consent noted throughout documentation			
	All antenatal visits have documented: • BP, SFH, urinalysis • Review of results and investigations • Information shared, advice given			

	Are student entries countersigned			
	Is it documented on the medications chart reason for non-administration or delay			
	If the sepsis alert triggers has it been completed			