



Midwifery Council

Te Tatau o te Whare Kahu

Be Safe.

PAPER

04.

DOCUMENTATION AND RECORD KEEPING

March 2018

Documentation and record keeping

Documentation and record keeping are essential to record the provision of safe and effective care for women and their babies and are an integral part of midwifery practice. Documents associated with the provision of health care will also form an important component of any practice.

Professional record keeping includes all forms of recorded communication that supports the midwifery care provided in partnership with the woman - all written and electronic health care records, audio and text, emails, laboratory reports, photos, videos or any other form of communication pertaining to a woman's care.

Maternity records in New Zealand must be retained for a minimum of 10 years following the date of the last entry. Professional responsibility requires midwives to take active steps to protect stored documents and records. Such data is vulnerable to slow deterioration and disaster.

Women receiving midwifery care should feel confident that their and their baby's health information will be documented, with their consent, in a respectful manner and also taking into consideration their cultural needs. Health care records should be confidential except when:

- women consent for them to be shared with other agencies or caregivers or
- if it is necessary to share information without consent to prevent or lessen a serious threat to the life or health of a mother or baby.

It is accepted in health practice that women have a right to access their health information and many community based midwives provide the woman with her own notes.



Be Safe

Be Safe is a series of papers highlighting safety, best practice and professional standards in midwifery.

The Midwifery Council

The Midwifery Council makes sure midwives meet and maintain professional standards of education, conduct and performance so that they deliver high quality healthcare throughout their careers. The safety of mothers and babies comes first.

Professional documentation includes

- Detailed assessments and clinical findings.
- Discussions of care and information provided with the woman.
- Discussions and consultations with health professionals, including care plans.
- Evidence of informed choice and consent.
- Care decisions with rationale.
- Any medication or treatment prescribed.
- All administrative requirements eg dates, time, identifying information.
- Name and designation of health professionals consulted and/or referred to.
- Any referrals.

Documentation should occur at the time that care is provided. Notes written in retrospect should be identified as such.

Professional record keeping/storage

All midwives are required to work within the appropriate frameworks for documentation or other communications which relate to their practice environment. Midwives are expected to ensure that health records are maintained kept and stored in accordance with relevant legislation outlined below.

Electronic record and storage systems should include:

- Pass word-protected computer-based/electronic information
- Regular maintenance of computer/other electronic equipment. Electronic data must be retrievable and readable at all times
- Regular back-ups of computer records in case of technical difficulties
- Up to date virus protection, future proofing and encryption
- Due care with portable electronic devices.

Confidentiality

- Be aware of legal requirements and guidance regarding confidentiality, and make sure your practice is in line with national and local policies.
- Be aware of the rules governing confidentiality when supplying and using data for secondary purposes.
- Follow local policy and guidelines when using records for research purposes.
- Don't discuss people in your care where you might be overheard, nor leave records, either paper or digital, where they might be seen by others.
- Don't take or keep photographs of any woman or their family which are not clinically relevant.



Other record and storage systems should include:

- An easy and accessible filing system that is lockable and protects the records from intruders and destructive sources eg fire, water, earthquake.
- Disposing of information securely eg fine shredding. NB Most shredders used in home may not provide the level of destruction required for health records.
- In the case of an unexpected event (eg the midwife becomes seriously unwell), appropriate arrangements need to be made to take responsibility for the safe transfer of the health records to maintain continuity of care.
- In the case of planned events (eg the midwife retires), appropriate arrangements are made for the records if the midwife is unable to continue to take responsibility. An option is that the woman can have her notes returned to her.
- The midwife should keep a schedule of the actions taken.
- An accurate summary should be retained where there is concern that the material on which the total health information may deteriorate before the minimum 10 years.
- In the case that the midwife dies and prior arrangements were not made for the retention of her clinical records, the Executor of the estate or Power of Attorney should endeavour to return records to the woman.
- In the case that a woman dies, the midwife may seek legal advice regarding the health care record.

Documentation should occur at the time that care is provided.

Electronic data must be retrievable and readable at all times.

Quality assurance processes

Midwives are encouraged to consider a self or peer audit of their documentational and health record management systems/storage. This will highlight areas where improvements may need to be made. Peer review of professional documentation has been shown to be the most effective method of improving clinical practise.

Relevant legislation

- Code of Health and Disability Services Consumers' Rights
- Health Information Privacy Code (1994)
- Health (Retention of Health Information) Regulations (1996)
- Health Practitioner Competence Assurance Act (2003)
- Privacy Act (1993)
- Medicines Act (1981)
- Misuse of Drugs Act (1975)

Virus protection, future proofing and encryption must be kept up to date at all times.

This content of this document may change if legislative changes render it obsolete before the review date of 2020.

What is a health record?

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

- handwritten clinical notes
- emails
- text messages
- letters and referrals to and from other health professionals
- requests for review by other health professionals
- laboratory reports
- x-rays or scans
- printouts from monitoring equipment, eg CTG machine
- incident reports and statements
- photographs
- videos
- tape-recordings of telephone conversations
- text messages



Go to www.midwiferycouncil.health.nz for more information.

Contact Us

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Tips

- Handwriting should be legible.
- All entries should be signed and dated.
- Your records should be accurate and clear.
- Records should be factual and not include abbreviations, jargon, meaningless phrases or irrelevant speculation.
- Use your professional judgement to decide what is relevant and should be recorded.
- Records should identify risks or problems and show the actions taken to deal with them.
- Communicate fully and effectively with your colleagues, so they have all the information they need about the people in your care.
- Use professional language that can be easily understood by women in your care.
- Never amend or falsify records.
- Record the narrative and rationale for decisions.

Maternity records

must be retained for a minimum of

10 years

following the date of the last entry

