Maternity Health Records

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This Guideline is to outline the expectations from documentation within the maternity services.

This guideline is for use by the following staff groups:

All Maternity Staff

Lead Clinician(s)

Vicky Taylor	Digital Midwife
Approved by *Maternity Governance Meeting* on:	20th October 2023
Approved by Medicines Safety Committee on:	N/A
Review Date: This is the most current document and should be used until a revised version is in place	20th October 2026

Key amendments to this guideline

Date	Amendment	Approved by:
September 23	Full document review	MGM

1. Introduction

Health care professionals have a legal duty to make records of the care they have delivered to patients.

Comprehensive health record keeping is integral to communication between health care professional which in turn is essential to high quality patient care. Contemporaneous, accurate and complete health records are one of the most important tools to enable continuous risk assessment processes.

This guideline is relevant to all Health Care Professionals who work within the maternity service who document or file in clinical notes and electronic patient records (EPR). The guideline details the requirements of written entries by all health care professionals and their responsibilities in relation to the maintenance of accurate, legible and contemporaneous documentation throughout the duration of the patient's pregnancy, delivery and postpartum period.

All staff must comply with the Trust policies regarding information technology, ensuring that they use their own log in for all electronic entries and ensure that information remains confidential. Passwords or pin numbers used must not be shared between staff.

2. **Background**

Worcestershire Acute Hospitals NHS Trust use BadgerNet end to end for documentation of all maternity notes. All antenatal, intrapartum and postnatal notes should be documented on this EPR.

Patients access their care records through the Badgernotes portal either through an app or by URL. They hold a unique login to ensure privacy.

CTGS are recorded and stored within BadgerNet by the use of Moxa boxes which is a device which converts the CTG signal to a Wi-Fi signal. This Wi-Fi signal can then be linked to a woman's BadgerNet record and display the CTG's electronically.

CTGs should be electronically linked to BadgerNet. If an antenatal CTG is performed it should also be printed to evidence the assessment for Dawes Redman Analysis as BadgerNet does not calculate this.

3. Basic Record Keeping Standards

3.1 Paper Records – In line with the WAHT Digital Maternity Strategy to move away from paper records, where possible records will be documented directly onto the EPR BadgerNet. However, it is acknowledged that in some circumstances paper is stull currently used. Any records documented on paper will be:

- Identifiable to the patient with name and unit or NHS number
- Legible
- Written in black ink
- Filed chronologically
- Wherever possible, contemporaneous
- In emergency situations a scribe will be nominated to keep accurate and contemporaneous records
- Signed, dated and timed using the 24 hour clock at each entry
- Include the printed name and GMC/NMC professional number of the person making the entry.
- If errors are made these will be crossed through with a single line, dated, timed and initialled.
- If retrospective entries need to be made, the time they are written and the reason for delay will be stated.

- Any charts / proformas should be printed at a high quality. Avoid photocopying which can lead to poor quality reproductions.

3.2 Electronic Records

Everyone who documents onto the EPR must do so with their individual login. This will ensure that the name of the person making the entry is identifiable.

Documentation should be recorded contemporaneously wherever possible. In the event of a delay occurring, the practitioner must ensure that the time of the entry reflects the time the care was delivered. If retrospective entries need to be made, it needs to be clear that they are retrospective, and the time that they are entered and the reason for delay must be stated.

If an error is made in the EPR, this must be edited by the practitioner who made the original record, and a clinical note entry completed detailing the changes made and the reason for this.

HCP's should 'publish' all appropriate notes from the record to the patients Badgernotes app. This will ensure that the patient can see their notes, care plans, observations and anything in relation to their pregnancy. HCP's should not, however, publish any confidential or social notes to Badgernotes.

BSOTS (Birmingham Symptom Specific Obstetric Triage System) is used on BadgerNet for all Maternity Triage documentation.

It is also used by the Neonatal Unit enabling data sharing and facilitating transfers.

3.3 All records

- All women should have an antenatal risk assessment completed at every antenatal contact.
- All women should have an Intrapartum Management Plan documented within BadgerNet.
- Alerts should be created on BadgerNet for any risks – i.e. GBS
- Health professionals must record any debrief / discussions / advice given to women and their families particularly in cases of suspected or poor outcome. The discussion should be recorded on BadgerNet.
- Clear operative delivery notes should be recorded on BadgerNet, immediately following the procedure.
- Swab and needle counts should be authorised on BadgerNet by the people who perform the counts at the time of the count taking place.
- All anaesthetic interventions, debrief and follow up should be clearly recorded in the health records, this should include anaesthetic team involvement in intra partum, high dependency or postoperative care should be documented on the relevant anaesthetic charts and on BadgerNet.
- Records should identify discharge arrangements from hospital to community care and from community midwifery care to the health visitor by using the Transfer of Care form. The professional completing these forms should 'Confirm & Save' to ensure that the forms are sent via EDT to the named GP on the BadgerNet record.
- When there is downtime or staff members are unable to access BadgerNet, paper documentation must be scanned into BadgerNet at the earliest opportunity.
- Plans for GPs should be communicated by completing a Medical Discharge note on BadgerNet. This will be sent via docman.

4. Storage arrangements

- **Cardiotocographs (CTGs):** Any printed CTG's should have the patients details clearly on the CTG print out and stored securely in a named brown envelope within the health records.
- **Anaesthetic records including epidural records:** must be secured within the appropriate pregnancy health records. These should be scanned in to BadgerNet once the patient is discharged.
- **Out of area patients with handheld records:** Any patient who is admitted from out of area who does not have maternity electronic records will require an express booking on BadgerNet. Her handheld paper maternity notes from another trust should be kept with any other paper notes whist they are an inpatient and then sent back to the original hospital upon their discharge via post – these should **NOT** be sent home with the family.

4.1 Scanning documents into Maternity Electronic Records

It is mandatory for all paper records to be scanned into the EPR and/or CLIP as appropriate.

Primary documents

These are documents generated by the Trust, for example anaesthetic review. These documents can be scanned into the maternity electronic record, the hard copy must be kept and filed in the woman's healthcare record. Scanned documents must be opened and checked for quality, ie not blurred, ensure all pages have been scanned and that the document is orientated correctly.

Secondary documents

These are documents that originate from outside the Trust i.e. from another NHS Trust or outside agency. These documents can be scanned into the maternity electronic record however the hardcopy does not need to be filed in the woman's healthcare record and can be disposed of in the confidential waste.

If clinically indicated the following paper records are used and stored in the Obstetric folder and then scanned into BadgerNet and CLIP:

- Worcestershire Obstetric Warning chart (WOW) – Used in recovery & HDU care.
- Anaesthetic charts
- Blood Transfusion Pathway
- Drug Chart
- IV Infusion Chart
- Safeguarding outcomes.

5. Intra-Uterine Transfers

Any patients who are being transferred to a different trust that does not utilise BadgerNet during their pregnancy need to have their full notes printed from BadgerNet. This should be done by accessing the 'Transfer to other healthcare provider' clinical report. There also needs to be photocopies made of any paper notes i.e. – Drug Kardex.

If a transfer is to a trust that uses BadgerNet, they can access the patient records on BadgerNet if they are a part of Single Pregnancy Record (SPR).

If SPR is not available - Send a printout of all BadgerNet notes, along with photocopies of any paper notes i.e. Drug Kardex.

An External Emergency Transfer note should be completed on BadgerNet in either case.

6. Downtime/ Business Continuity

During BadgerNet downtime, there are business continuity procedure in place.

6.1 – National Downtime issue

If there is a national issue confirmed by Clevermed, then failover can be turned on. Meaning that BadgerNet will work as normal but will save to a local cloud. Once the national issue is resolved, failover can be turned off and our local cloud will transfer all information to the national cloud.

6.2 – Local Downtime Issue

If there is a local issue, we must revert to paper notes & printed CTGs. These must be clearly labelled with patient identifiable information and then scanned in to BadgerNet once the local issue has been resolved. The Digital Midwives, #223 bleep holder, Co-ordinator and manager on call need to be made aware of this. Communications should be sent out to all staff informing them of the downtime and correct procedures.

The local issues should be reported to IT via telephone as a Priority 1

7. Electronic Record Keeping Best Practice Summary

Midwives should consider the following principles for best practice, alongside the NMC Code, and local record keeping guidelines.

Maternity staff should, as a minimum, carry out the following checks when documenting: (RCM)

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

8. Record Keeping Governance and Training

8.1 **Information Governance**

The confidential nature of health care records cannot be overstated. Health care records (electronic and hard copies) must not be left in a position where unauthorised persons have access to them. This applies to all identifiable information where a patient's name, date of birth, and/or address is displayed e.g. clinic lists, desktop computers, iPads, ward diaries and ward hand over sheets. It is especially important for healthcare professionals to be aware of the requirements of information governance when care is given outside of health care premises.

Computer screens must not be on view so members of the general public or staff who do not have a justified need to view the information can see personal data.

Any patient identifiable information that is no longer required i.e. ward handover sheets must be destroyed in the confidential waste system.

No patient identifiable information will be shared with anyone without the patient's consent unless it is authorised to do so. Authorised persons may be, for example, medical, nursing, or other professional staff who are participants in the care, diagnosis and/or treatment of the patient.

Where there is any doubt over the authority of the person asking for patient information, advice will always be sought from a manager or the Information Governance manager before disclosure takes place.

Breaches or failure to comply with information governance guidance could result in the Trust's disciplinary process and/or referral to NMC/GMC.

8.2 Training

- All staff must receive appropriate training for the EPRs at WAHT (BadgerNet & Sunrise). New staff will be allocated a session with a Digital Midwife to be trained on BadgerNet.
- All midwives must have undertaken Allscripts PAS training to gain their logins.
- 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.

9. Monitoring and Compliance

Maternity records will be subject to review of documentation standards via case reviews/audits and medical and midwifery appraisal. If documentation concerns are identified the relevant line manager will discuss with the individual concerned and plan actions necessary.

10. Maternity Abbreviations

The trust records policy states that abbreviations should be avoided. Within maternity services recognised abbreviations are commonplace please refer to approved maternity abbreviations outlined in Appendix A.

Approved abbreviations can be used it is good practice to use the abbreviation once in full within the body of the maternity records.

Appendix A

Worcestershire Maternity Services

List of acceptable abbreviations within the maternity departments

A	
Abdominal circumference	AC
Amniocentesis	Amnio
Amniotic fluid index	AFI
Antenatal	A/N
Antenatal clinic	ANC
Antepartum haemorrhage	APH
Alpha-feto-protein	AFP
Artificial feeding	AF
Artificial rupture of membranes	ARM
Asked to see patient	ATSP
Aspartate transaminase	AST
B	
Beats per minute	bpm
BD – Twice daily	BD
Bi-parietal diameter	BPD
Birth weight	BWT
Blood pressure	BP
Body mass index	BMI
Born before arrival	BBA
Breastfeeding	BF
C	
Caesarean section	C/S
Cardiotocograph	CTG
Cephalic	Ceph
Cephalo pelvic disproportion	CPD
Cervix	Cx
Chorionic villus sampling	CVS
Combined spinal epidural	CSE
Congenital dislocation of the hips	CDH
Congenital heart disease	CHD
Continuous Positive Airway Pressure	CPAP
Controlled cord traction	CCT
Culture & sensitivity	C&S
Congenital cystic adenomatoid malformation	CCAM
Cytomegalovirus	CMV
D	
Date of birth	DOB
Decreased / reduced	↓
Deep vein thrombosis	DVT
Diagnosis	Δ
Dichorionic diamniotic	DCDA
Did not attend	DNA
Dilatation & Curettage	D&C
Discussed with	D/W
Disseminated intravascular coagulation	DIC
Ductus venosus	DV
E	
Early pregnancy assessment unit	EPAU

Elective lower segment caesarean section	EL LSCS
Electronic fetal monitoring	EFM
Emergency lower segment caesarean section	Em LSCS
End diastolic flow	EDF
Estimated blood loss	EBL
Estimated date of delivery	EDD
Evacuation of retained products of conception	ERPC
Examination under anaesthesia	EUA
Expected date of confinement	EDC
Expressed breast milk	EBM
External cephalic version	ECV
F	
Fasting blood glucose	FBG
Femur length	FL
Fetal blood sampling	FBS
Female genital mutilation	FGM
Fetal growth restriction	FGR
Fetal heart	FH
Fetal heart heard regular	FHHR
Fetal heart rate	FHR
Fetal movements	FM
Fetal movements (not) felt	FM(N)F
Fetal scalp electrode	FSE
Feto maternal medicine	FMM
Forceps delivery	FD
Fresh frozen plasma	FFP
Full blood count	FBC
G	
Gamma glutamyl transferase	GGT
General anaesthesia	GA
General practitioner	GP
Genito-urinary medicine	GUM
Glucose tolerance test	GTT
Gram	g
Gravida	G
Group and save serum	G&S
Group B streptococcus	GBS
Glucose Tolerance Test	GTT
H	
Haemoglobin	Hb
Head circumference	HC
Hepatitis B	Hep B
High dependency unit	HDU
High vaginal swab	HVS
History of	HO
Hour(s)	hr
Human immunodeficiency virus	HIV
Hypoxic ischaemic encepholopathy	HIE

I	
Idiopathic thrombocytopenic puerpera	ITP
Immediately	STAT
Increased / raised	↑
Induction of labour	IOL
Insulin dependent diabetes mellitus	IDDM
Intensive care unit	ICU
Intermittent positive pressure ventilation	IPPV
Intramuscular	IM
Intra-uterine contraceptive device	IUCD
Intra-uterine death	IUD
Intra-uterine growth restriction	IUGR
Intravenous	IV
Intravenous infusion	IVI
Investigations	Ix
Invitro fertilization	IVF
In utero transfer	IUT
J	
Jehovah's Witness	JW
K	
Kiellands forceps delivery	KFD
Kilogram	kg
Kidderminster Treatment Centre	KTC
Potassium	K
L	
Large for gestational age	LGA
Last menstrual period	LMP
Left occipito-anterior	LOA
Left occipito-lateral	LOL
Left occipito-posterior	LOP
Left occipito-transverse	LOT
Left sacro-anterior	LSA
Left sacro-lateral	LSL
Left sacro-posterior	LSP
Left sacro transverse	LST
Litre	L
Liver function test	LFT
Low birth weight	LBW
Lower segment Caesarean section	LSCS
Low vaginal swab	LVS
M	
Manual removal of placenta	MROP
Maternity Day Assessment Unit	**MDAU**
Mean cell haemoglobin	MCH
Mean cellular volume	MCV
Meconium	Mec
Methicillin-resistant staphylococcus aureus	MRSA
Middle cerebral artery	MCA
Mid stream specimen of urine	MSU
Milligram or Magnesium	Mg
Minutes	Mins
Monochorionic diamniotic	MCDA
Monochorionic monoamniotic	MCMA

N	
Negative	NEG/-ve
Neonatal death	NND
Neonatal unit	NNU
Neonatal intensive care unit	NICU
Neville Barnes forceps delivery	NBFD
Nitrous oxide & oxygen(Entonox)	$N_2O + O_2$
No abnormality detected	NAD
Neural tube defect	NTD
Normal vertex delivery	NVD
Not passed meconium	NPMec
Not passed urine	NPU
Nuchal translucency	NT
O	
Observations	obs
Occipito-anterior	OA
Occipito-posterior	OP
Occipito-transverse	OT
On admission	O/A
On examination	O/E
Out patients appointment	OPA
Out patients department	OPD
Oxygen	O_2
P	
Parity	P / para
Passed meconium	PMec
Passed urine	**PU**
Past medical history	PMH
Past obstetric history	POH
Per rectum	pr
Persistent occipito-posterior	POP
Per vaginum	PV
Platelets	Plt
Positive	+ve
Postnatal	PN
Post-partum haemorrhage	PPH
Paediatrician	Paed
Pre eclampsia	PET
Pregnancy induced hypertension	PIH
Pre-labour rupture of membranes	PROM
Presenting part	PP
Preterm Pre-labour rupture of membranes	PPROM
Protein/creatinine ratio	PCR
Pulsatility index	PI
Pulmonary embolism	PE

R	
Random blood sugar	**RBS**
Respirations	resps
Rhesus factor	RhD
Right occipito-anterior	ROA
Right occipito-lateral	ROL
Right occipito-posterior	ROP
Right occipito-transverse	ROT
Right sacro-anterior	RSA
Right sacro-lateral	RSL
Right sacro-posterior	RSP
Right sacro-transverse	RST
Review	R/V
S	
Situation Background Assessment Recommendation	**SBAR**
Serum bilirubin	**SBR**
Sexually transmitted infection	STI
Small for gestational age	SGA
Sodium	Na
Special care baby unit	SCBU
Seen by	S/B
Serum alpha fetoprotein	SAFP
Spontaneous rupture of membranes	SROM
Spontaneous vaginal birth	SVB
Spontaneous vaginal delivery	SVD
Stillbirth	SB
Sudden Infant Death Syndrome	SIDS
Symphysis fundal height	SFH
Symphysis pubis dysfunction	SPD
Staff	
Consultant	Cons
Community midwife	CMW
Doctor	Dr
Supervisor of Midwives	SoM
Maternity Support Worker	MSW
Maternity Community Support Worker	MCSW
Medical Student	Med St
Midwife	MW
Nursery Nurse	NN
Specialist Registrar	Reg / ST /SpR
Senior house officer	SHO / FY
Student midwife	St Mw
T	

Temperature	**T/temp**
Termination of pregnancy	TOP
TDS	Three times daily
To come in	TCI
To keep vein open	TKVO
Toxoplasmosis, rubella, cytomegalovirus, herpes	TORCH
Transcutaneous electrical nerve stimulation	TENS
Transitional care unit	TCU
Treatment	Rx
U	
Ultrasound scan	**USS**
Urea and electrolytes	U&E
Urinary tract infection	UTI
V	
Vaginal examination	**VE**
Vaginal Birth After Caesarean	**VBAC**
Vertex	**Vx**
Venous thrombo embolism	VTE
Vitamin K	Vit K
Von Willebrand's Disease	VWD
W	
Water	H_2O
Well contracted	W/C
White cell count	WCC
Worcestershire Obstetric Warning chart	WOW
Ward Round	WR

September 2009 (Miller, 2003) **(Capsticks - Abbreviations in Clinical Practice – Dr Eve Miller LLM MBBS**

References

rcm_guidance-report_elec_record_keeping.pdf

Audit Tool

Screenshot excerpt from Audit Tool:

2022	MONTH:	Number:	
	NHS no.		
	Delivery Date		
	Type of Delivery		
	Mode of Delivery		
	Place of delivery		
	Date of Audit		
	Auditors Name		
		Yes/No	Comments
A	ANTENATAL CARE - BOOKING		
A1	Was a Smart booking form used?		
A2	Are a full set of observations completed - temp, pulse, BP, urinalysis, CO on booking or FPOC		
A3	Ethnicity		
A4	Named midwife in Care Plan		
A5	Named Lead Professional in Care Plan		
A6	Lead Professional type		
A7	Named Consultant in Care Plan		
A8	Intended Location of Delivery in Care Plan		
A9	Continuity Pathway or none		
A10	Community Team		
A11	Risk Assessment		
A12	Booking Bloods Offered		
A13	Downs Screening Offered		
A14	Booking BMI		
A15	Booking EDD		
A16	Previous obstetric history		
A17	Management Plan		
A18	Place of birth discussion		
A19	Portal access recorded		
A20	Blood Group documented		
A21	Smoking Status		
A22	CO monitoring recorded regardless of status		
A23	Health Visitor referral done		
B	ANTENATAL CARE - ALL APPOINTMENTS		

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Maternity Records Audit	Audit tool developed by digital midwives	AdHoc	Every midwife	Maternity Managers (PDR), Digital Midwives	Yearly

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All Maternity Staff
Maternity Governance Meeting Group

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting