

Record keeping and documentation

'Next to hands-on care, the importance of keeping accurate records cannot be underestimated. Developments in technology, patient rights and benchmarking, now mean that all [midwives] must update their record-keeping skills – or risk the consequences'

(Hoban 2005)

Learning outcomes

MIDIRS has developed this content to assist midwifery students, registered practitioners and others providing care to childbearing women and/or their babies to:

- Understand the principles of good record keeping, whether these records are in electronic format or paper-based
- Keep up to date with NMC record keeping guidance (NMC 2009)
- Increase their awareness of record keeping as an integral component of individual and professional accountability
- Reflect on their existing record keeping practice and identify areas for development
- Recognise how record keeping is incorporated with other NHS responsibilities, including partnership working, CNST (Clinical Negligence Scheme for Trusts), risk management and the management of complaints
- Be able to demonstrate completion of a learning activity in fulfilment of Post Registration Education and Practice (PREP) Continuing Professional Development (CPD) Standard (NMC 2008).

NB. Issues around confidentiality, data protection, rights of access to records and disclosure of information are not covered in this section, as these have been included in new and forthcoming practice development content.



Introduction

Midwives' record keeping and standards of documentation are increasingly subject to close scrutiny. It is a significant fact that poor record keeping is one of the most common reasons for a health care professional to be removed from the Nursing and Midwifery Council (NMC) register. This dissection of health care records is supported by stringent legislation, including the Human Rights Act 1998, the Freedom of Information Act 2000 and the Data Protection Act 2003 (Dimond 2003, Dimond 2006), all of which have increased the profile of, and access to, health care records. This has happened within a culture of rising consumer expectations and a willingness (rightly so) to complain about substandard care provision, in the highly litigious areas of midwifery and obstetric practice.

Good record keeping is a fundamental aspect of midwifery practice and *'is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow'* (NMC 2009:1).

Record keeping is also a key component of professional accountability and plays an important role in clinical, educational, and administrative practices (NMC 2009). While it could be argued that in rare instances some corners may be cut in order to save time or expedite situations, record keeping is one area where this approach should never be adopted. Whatever the stresses or constraints of your daily clinical work, maintaining accurate, up to date client maternity records is integral to your midwifery practice and the care process (Day-Stirk & Steele 2001, Hoban 2003).

While it is recognised that employing NHS Trusts and PCTs often determine the way in which midwives keep maternity records, maintaining good standards of record keeping in accordance with national guidance (NMC 2009) is vital. You never know when you may need to rely on your record keeping to provide contemporaneous information about an event, substantiate and/or support the clinical decisions that you or others made, or the midwifery care that was given (Dimond 2006, Solon 2009).

'What matters in court is not truth, but proof and, when I am given a case, my first question is: 'where is the evidence?' From my perspective, cases are won and lost on the quality of the records'

(Andrew Andrews, cited by O'Malley 2009).

However, while the highly litigious nature of midwifery and obstetric practice can leave practitioners feeling afraid of having to justify their professional advice, care or treatment (Solon 2009, Fraser 2010), this should not be the main driver behind best practice in record keeping. Of more importance is the need to provide documented 'need to know' information, that the woman herself can easily access, as well as other members of the maternity care team who need to be able to monitor and review the clinical situation (Jones & Jenkins 2004). This includes the documentation of the decisions made relating to the clinical management of the pregnancy and continuity of care, whether this is to do nothing, monitor the pregnancy closely, instigate or alter a plan of care, or in an obstetric emergency, summon urgent medical assistance (Jones & Jenkins 2004, NMC 2004, NMC 2007).

NMC guidance for record keeping

It is often said that the quality of a practitioner's record keeping is a direct reflection of their approach to, and standard of, professional practice. Therefore, where a midwife always maintains neat, accurate and contemporaneous records, it is very likely that they will adopt the same meticulous approach to their midwifery practice. Similarly, where a practitioner's record keeping is 'sloppy', for example, illegible, not dated or signed, and difficult to interpret with gaps in the documented entries, this can be an indication of an equally 'sloppy' approach to care provision (Fraser 2010).

While there is no set template or single model for record keeping, the NMC maintains that there are certain criteria that provide the foundations for good records and best practice in record keeping. A number of these criteria relate to the style and content of documentation, and apply to both manually-held and electronic records, including handwritten clinical notes, letters of referral from one health care professional to another, incident reports (eg AIMS forms), interprofessional emails, printouts from fetal heart rate monitors, and laboratory reports (NMC 2009).

NMC principles of good record keeping: style and content

- Handwriting should be legible
- All entries to records should be signed. In the case of written records, the person's name and job title should be printed alongside the first entry
- In line with local policy, you should put the date and time on all records. This should be in real time and chronological order, and be as close to the actual time as possible
- Your records should be accurate and recorded in such a way that the meaning is clear
- Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation
- You should use your professional judgement to decide what is relevant and what should be recorded
- You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment
- Records should identify any risks or problems that have arisen and show the action taken to deal with them
- You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care
- You must not alter or destroy any records without being authorised to do so
- In the unlikely event that you need to alter your own or another health care professional's records, you must give your name and job title, and sign and date the original documentation. You should make sure that the alterations you make, and the original record, are clear and auditable
- Where appropriate, the person in your care, or their carer, should be involved in the record keeping process
- The language that you use should be easily understood by the people in your care

- Records should be readable when photocopied or scanned
- You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care
- You should not falsify records (NMC 2009:5-6).

Additionally:

- It is accepted as best practice in record keeping that black, indelible ink is always used when documenting entries in records. This is because the text is much clearer if documents need to be photocopied or scanned
- Any mistakes should not be corrected using Tipp-Ex. Instead, it is advisable to cross through the entry with a single line, and, in accordance with the NMC's guidance on record keeping, give your name and job title, and sign and date the original documentation (NMC 2009)
- In some areas, local policy/guidelines include a list of accepted/commonly used abbreviations eg ARM (Artificial rupture of the membranes); SROM (Spontaneous rupture of the membranes); Cx (Cervix). However, given that some abbreviations can have dual meanings, it is advisable to document the term in full text initially, followed by the accepted abbreviation which can then be used for subsequent entries
- You should not document your initials only, as a form of signature, unless this is in accordance with local policy (for example, when documenting dispensed medication on a hospital drug chart).

Contemporaneous records

The NMC guidelines for record keeping (NMC 2009) state that:

***'You should put the date and time on all records. This should be in real time and chronological order, and be as close to the actual time as possible.'* (NMC 2009:4)**

This principle refers to contemporaneous records and record keeping, where you need to document events as they occur, or as soon after, as is safe and practical. This can be a

challenge in critical situations, such as real obstetric emergencies, where clinical decisions and treatments may be undertaken simultaneously by a number of multidisciplinary health care professionals.

In these instances, it is often necessary to document actions that were taken by just recording the most basic of information. For example:

'16.30hrs – second cannula sited by Dr Thompson'

The maternity records can then be completed comprehensively at a later time once the situation has stabilised, with the delay in their completion and the reason for this, also being noted (Chapman 2003). Up to 24 hours following the event is considered to be contemporaneous, providing the most important aspects of information/key facts were recorded at the time that the event occurred.

Similarly, practitioners should not be constrained by the format of documents, for instance, adding important clinical details to a computer printout – providing that any additions are legible, timed, dated and signed – in accordance with NMC guidelines (NMC 2009) is also permissible. In some areas, preformatted sheets and electronic checklists have been developed to aid documentation, for example, in the management of shoulder dystocia. These have been found to improve the completeness of documentation relating to several critical elements, including the manoeuvres performed and the time interval between delivery of the baby's head and its body (Crofts *et al* 2008, Deering *et al* 2010).

As an accountable midwifery practitioner you need to remember that your client's maternity records can be called as evidence in a Court of Law, or may be scrutinised when investigating a complaint that is made at a local level (Solon 2003). They may also be regarded as evidence by the NMC Fitness to Practise Committee. Because record keeping can take so many forms – care plans, diaries, birth plans, emails and interprofessional referral letters – anything that makes reference to the care of the woman or her baby, may be required as evidence (NMC 2009). In considering record keeping, Courts of Law adopt the attitude that, if it is not recorded, it did not happen (Dimond 2003, Wood 2003, Lynch 2009). Therefore, practitioners need to employ their own professional judgement in determining what information is relevant and needs to be recorded in clients' maternity records (NMC 2009).

Delegating record keeping

Registered midwives need to be aware that they are professionally accountable for ensuring that any responsibilities that they delegate to health care colleagues (who are not registered practitioners) are completed to a reasonable standard. These individuals might include, for example, maternity care assistants/support workers and pre-registration student midwives who will require supervision in completing various duties until they are assessed as being competent (NMC 2004).

Record keeping is one task that registered practitioners may choose to delegate, and, as such, practitioners are required to clearly countersign any entries and be aware that they are professionally accountable for the consequences of such entries, as well as any omissions (NMC 2004, NMC 2009). For instance, if a student midwife gives direct care to a client, the student is responsible for the health care record, but this is under the overall supervision of the registered midwife who is mentoring/assessing them. This applies to students who are undertaking both the 18 month and three year programmes of midwifery education.

Electronic records

The *Information for health* strategy launched in 1998 (Burns 1998) heralded the development of a programme of computer-generated records within the NHS. However, the production, collection, storage and retrieval of most health records have actually changed very little, with the majority continuing to be produced as paper-based documents. An increasing investment in national programmes has seen the introduction of information communication technology, electronic record keeping and the infrastructures to support these within many NHS Trusts and PCTs. As such, practitioners need to be aware of, and competent in using, the information systems and tools that are available to them in their practice (NMC 2009). This helps to ensure accuracy in the inputting of data and accuracy and quality of information output, including labour and delivery records, birth notifications and discharge letters.

Reflective activities

The following activities have been developed to help consolidate knowledge and provide evidence of learning activity in fulfilment of Post Registration Education and Practice (PREP) Continuing Professional Development (CPD) Standard (NMC 2008).

Activity 1: This activity is designed to demonstrate how we should not take our record keeping for granted.

You may be required to rely on your records to support your actions, clinical decision making, and the care that you gave to a mother and/or her baby up to 25 years after the event took place:

- Write down what you were doing this time last week.
- Do you know what you were doing at this time last month?
- Can you remember what you were doing on this date last year?
- Now try and remember what you were doing five years ago...

Activity 2: This activity is designed to help you consider the maintenance and retention of health records.

The Midwives rules and standards (NMC 2004) detail the professional requirements relating to the maintenance and retention of records. Read Rule 9 – 'Records'. This rule states that all maternity records concerning the care of the woman or baby must be kept for 25 years.

- Consider the scenario of a woman asking for information from when she gave birth (i) six months ago, (ii) one year ago? What would you be able to remember?
- Make a list of the records or other documents that might be included under this requirement.
- Find out what arrangements are in place within your employing NHS Trust/PCT. Would duty rotas be included?

Activity 3: This activity is designed to introduce you to the clinical audit of record keeping.

Randomly select five sets of hand-held maternity records, in which you have recently documented entries. Using the NMC's guidance on the principles of good record keeping (NMC 2009), complete an audit of your own records. Alternatively, you and a colleague may wish to audit each other's record keeping?

Standards you may wish to focus on might include the following:

- Are all your entries legible?
- Have they all been dated and timed?
- Did you print your name and job title alongside your initial entry?
- Has black indelible ink been used throughout?

Activity 4: This exercise looks specifically at clarity of documentation.

Make a list of the abbreviations that you commonly encounter during the course of your daily practice. Can any of them be interpreted in more than one way?

Look at the examples listed below and think about how they may be interpreted?

- IUD
- SB
- PROM
- CPD
- POM

For further support and information regarding best practice in record keeping, speak with your local Supervisor of Midwives and visit the NMC website at www.nmc-uk.org

References

- Burns F (1998). *Information for health: an information strategy for the modern NHS 1998-2005*. Leeds: DH, NHS Executive.
- Chapman V (2003). Record keeping and litigation. In: Chapman V ed. *The midwife's labour and birth handbook*. Oxford: Blackwell Publishing:219-23.
- Crofts JF, Bartlett C, Ellis D *et al* (2008). Documentation of simulated shoulder dystocia: accurate and complete? *BJOG: An International Journal of Obstetrics and Gynaecology* 115(10):1303-8.
- Day-Stirk F, Steele R (2001). Clinical risk management paper 4: communication and record keeping. *RCM Midwives Journal* 4(3):82-3.
- Deering SH, Tobler K, Cypher R (2010). Improvement in documentation using an electronic checklist for shoulder dystocia deliveries. *Obstetrics and Gynecology* 116(1):63-6.
- Dimond B (2003). Freedom of information. *British Journal of Midwifery* 11(4):233-6.
- Dimond B (2006). Record keeping, statements and report writing. In: Dimond B. *Legal aspects of midwifery*. 3rd ed. Oxford: Books for Midwives:238-57.
- Fraser J (2010). Keeping midwives out of court. *Practising Midwife* 13(3):36-7.
- Hoban V (2003). How to... improve your record keeping. *Nursing Times* 99(42):78-9.
- Hoban V (2005). For the record. *Nursing Times* 101(27):20-2.
- Jones SR, Jenkins R (2004). Use and abuse of information. In: Jones SR, Jenkins R. *The law and the midwife*. 2nd ed. Oxford: Blackwell:131-43.
- Lynch J (2009). *Health records in court*. Abingdon: Radcliffe Publishing.
- Nursing and Midwifery Council (2004). *Midwives rules and standards*. London: NMC. [The *Midwives rules and standards* published in 2004 are currently being reviewed by the NMC to ensure they are still robust and relevant. Amendments were made to this document in 2007 and 2010 – full details available at <http://www.nmc-uk.org>]
- Nursing and Midwifery Council (2007). *The Code: standards of conduct, performance and ethics for nurses and midwives*. London: NMC. [The current document design was introduced in April 2010; however the content has not changed].
- Nursing and Midwifery Council (2008). *The Prep handbook*. London: NMC. [The current document design was introduced in April 2010 with the addition of paragraph numbers for the PREP standards; however the content has not changed].
- Nursing and Midwifery Council (2009). *Record keeping: guidance for nurses and midwives*. London: NMC. [The current document design was introduced in April 2010; however the content has not changed].
- O'Malley M (2009). The ball's in your court. *RCM Midwives* October/November:24-5.
- Solon M (2003). Bum notes. *Health Service Journal* 113(5862):33.
- Solon M (2009). In the dock: threat of litigation. *RCM Midwives* June/July:43.
- Wood C (2003). The importance of good record-keeping for nurses. *Nursing Times* 99(2):26-7.

Suggested further reading

- Bruce S (2010). Portsmouth signs up for digi-pens. *E-Health Insider* 3 March.
- Chandrahara E, Arulkumaran S (2006). Medico-legal problems in obstetrics. *Current Obstetrics and Gynaecology* 16(4):206-10.
- Department of Health (2006). *Records management: NHS code of practice Part 1*. London: DH.
- Department of Health (2009). *Records management: NHS code of practice Part 2*. 2nd ed. London: DH.
- Every M (2001). Surviving complaints and statement writing. *RCM Midwives Journal* 4(6):174.
- Gould D (2009). Re-engaging with accountability. *British Journal of Midwifery* 17(1):6.
- Hardman L, Bates C eds (2005). *Litigation: a risk management guide for midwives*. 2nd ed. London: Royal College of Midwives.
- Mander R (2004). Where does the buck stop? Accountability in midwifery. In: Tilley S, Watson R eds. *Accountability in nursing and midwifery*. Oxford: Blackwell Science:132-42.
- Marko WH (2001). Key issues within safe practice. *Professional Nurse* 16(7):S5.
- McHale JV, Tingle J (2001). *Law and nursing*. Oxford: Butterworth Heinemann.
- Montgomery J (2003). *Health care law*. 2nd ed. Oxford: Oxford University Press.
- Tinsley V (2002). Record keeping for dummies. *British Journal of Midwifery* 10(3):158.