THE ROYAL COLLEGE OF MIDWIVES

GUIDANCE REPORT

ELECTRONIC RECORD KEEPING GUIDANCE AND AUDIT TOOL

DIGITAL RECORD KEEPING GUIDANCE FOR MIDWIVES

GUIDANCE FOR MIDWIVES

Record keeping is an essential part of midwifery practice and maternity care. It is vital to support safe and effective care. All midwives should already be familiar with the NMC guidance on record keeping within the NMC Code.[1]

Midwives must have a clear understanding of their responsibilities for record keeping in line with local guidance and the NMC code of conduct. This includes any entries, omissions, error correction, scribing and transcribing.

The principles of good record keeping apply to all documentation carried out by a midwife including paper records, Maternity Information Systems and Electronic Patient Record systems. The full electronic recording of all aspects of maternity care is relatively new and supports the unique multifunction of maternity records. This multifunction was explored by Kirkin et al[2], and includes:

1. Partnership relationship between the woman and the midwife
2. Continuity of care
3. Communication between health professionals
4. Improving standards of care
5. Audit and clinical reviews
6. Data collection
7. Contribution to the research environment
8. Makes midwifery work visible
9. Reflection on practice and experience for midwives
10. Professional expectation and demonstration of professional accountability
11. A narrative of experience for the woman

Electronic maternity records support all these functions and enhance many through their digital functions such as women's digital care records, automated processes, and data collection. Midwives must adapt their practice to make full use of all the digital functions within electronic maternity records.

The NMC Code doesn't explicitly state how midwives should keep digital recordshowever, it's statement on safe practice can be applied to digital records like paper records to support good practice.

> **"1.2 make sure you deliver the fundamentals of care effectively"**

Record keeping is a fundamental aspect of midwifery care. The maternity record is unique as a multidisciplinary record, carried by the woman during her pregnancy, where she is given a new pregnancy record for each pregnancy. Information in this record will also form the basis for the newborn's record when they are born.

Digital records not only form part of the women's medical records, but also facilitate sharing of information between health professionals and with the pregnant woman. Clear, accurate and accessible maternity records support local safety procedures such as the risk governance process by making important aspects of maternity care easily available for review. Digital maternity records additionally have a secondary purpose enabling the collection of data which is used for national mandatory reporting and local audits. Digital records can therefore be seen as a key element of improving quality and safety in maternity care.

[1] Nursing & Midwifery Council (NMC) (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates. London: Nursing & Midwifery Council.

[2] Kerkin, B. Lennox, S. and Patterson, J. (2017) *Making midwifery work visible: the multiple purposes of documentation*. Women and Birth 31, 232-239.

The NMC outlines principles of good record keeping

10	Keep clear and accurate records relevant to your practice. This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:
10.1	complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
10.2	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
10.3	complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
10.4	attribute any entries you make in any paper or records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
10.5	take all steps to make sure that records are kept securely electronic

Digital records include a summary of key maternity events, e.g. booking and birth, and will eventually replace paper records entirely allowing for digital documentation of all aspects of maternity care.

The NMC highlights the importance of risk in midwifery care:

"8.6 share information to identify and reduce risk"

Assessing and documenting risk in an electronic record is essential to providing safe effective midwifery care. Digital tools within electronic records have been built to support this risk assessment process. They form an essential part of the risk management process to review untoward incidents and identify learning.

Electronic records additionally support the appropriate sharing of a woman's health information with all healthcare providers providing her care. This easy access to all health information allows healthcare providers to quickly risk assess a woman's health needs and ensure they can provide the safest possible care and undertake detailed accurate care planning. Electronic records further support best practice information governance for record keeping ensuring that there is a clear and transparent audit trail of who information has been shared with.

ELECTRONIC RECORD KEEPING BEST PRACTICE SUMMARY

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

To maintain these principles midwives should regularly undertake an audit of their own documentation. Maternity services should have a localised audit tool specific to local practices and procedures as well as the electronic system used within that service.

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

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

Record keeping governance

> Midwives and MSWs must receive appropriate training for the electronic record system used in their organisation. Each midwife or MSW is responsible for ensuring this is maintained and updated as required when the system is updated or changed.

> Midwives 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

> Midwives and MSWs should audit their own records regularly in keeping with local guidance and be aware of data which is collected from the electronic system to ensure they support this collection.

> Midwives should be familiar with local business continuity procedures in case of faults, cyber-attacks, or downtime

Clear and organised documentation

>	Staff are responsible for all documentation made under their login, therefore login details must not be shared
>	It is important that midwives and MSWs make it clear within the record when they are writing or inputting data on behalf of a colleague. The record should be checked by the midwife conducting the care for accuracy and a note added 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 midwife or MSW accessing that record is responsible for escalating appropriately.
>	Where unable to work 'online' midwives may need to update a record in an 'offline' setting. It is the responsibility of the midwife to ensure the record is synced with the 'online' record prior to finishing their shift/period of oncall.
>	Midwives should be aware that digital records allow for multiple staff to be documenting and therefore information will update in real time.
>	Midwives should use appropriate mobile digital technology to document with the woman in her place of care e.g. at the bedside, in her home, to maintain contemporaneous documentation and involve women in their care planning.
>	Where unable to document contemporaneously midwives should ensure that 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

Accurate documentation content

>	Tick box options should be utilised where appropriate to support data 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 midwife to check that information is correct prior to saving the documentation as the clinician will become responsible for everything recorded within that saved record.

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Accurate documentation content (continued)

>	Midwives should follow local guidance to ensure that errors made in records are corrected in a timely fashion maintaining the integrity of the record.
>	Midwives should ensure they are aware of where other members of the multidisciplinary team are documenting if not within their maternity record e.g. hospital wide system.
>	Midwives should review and update the appropriate risk assessments ensuring the current risk is clear within the record.
>	When a staff member is unable to use the electronic record due to emergency or downtime, all paper records should be scanned and uploaded to the electronic record for completeness.
>	Midwives should be aware of documentation in the electronic record which will be automatically available to the woman in her digital care record. Midwives should ensure that sensitive or safeguarding information is documented in the designated place within the electronic record to be made available to the woman when appropriate

PRINCIPLES FOR A GOOD AUDIT TOOL

The maintenance of good record keeping standards can be supported by using a documentation audit tool.[3]

To ensure standards are maintained for good documentation[4]; a midwifery documentation audit tool should be established within every maternity service which allows for midwives to undertake regular self-audits of their documentation and sets out a regular audit by peers or managers.

When practice changes significantly, auditing new practice is advised to ensure that it is well integrated by all midwives, expected outcomes are achieved and no adverse outcomes occur. Regular audit also supports the maintenance of good care through continuous quality improvement[5]. When maternity services implement a new electronic record, it is important to update the documentation audit tool and increase the frequency of audits to ensure standards are maintained. Audit tools may need to be adapted and updated as the system updates or when concerns are raised through the risk governance process. Themes from risk governance should inform the local documentation audit tool used.

[3]Citation: Walker S (2012) Using self-audit to improve nurses' record keeping. Nursing Times; 108: Online issue.

[4]Royal College of Midwives (2016) RCM Standards for midwifery services in the UK. Royal College of Midwives.

[5]Griffiths, P. Ddbbage, S. and Smith, A. (2013) A comprehensive audit of nursing record keeping practice. British Journal of Nursing 16(21).

Documentation audit tools should:

- Allow midwives to self evaluate their record keeping standards
- Be specific to electronic maternity record in your maternity service
- Clearly highlight minimum required documentation expected
- Support data collection expectations for internal and external audits and data sets
- Have explicit areas which identify if documentation is not of an acceptable standard
- Link to actions if documentation not to an acceptable standard

The use of a documentation audit tool should facilitate reflection and learning from practice. Reflection on practice is an essential part of revalidation and is highlighted within the purpose of revalidation, "to encourage a culture of sharing, reflection and improvement"[6]. Therefore midwives may wish to use reflections on documentation audit as part of their NMC revalidation. This process allows midwives to identify areas for learning and improvement in their individual practice.

Maternity services may use documentation audits as part of the annual appraisal process or where there are concerns around an individual's practice. This standardised audit of record keeping allows for impartial review of the quality of midwifery documentation and can facilitate improvement plans.

An example of a midwifery electronic documentation audit tool is included in the appendix and may be adapted for local use within your organisation.

[6]Nursing and Midwifery Council (2019) How to revalidate with the NMC: requirements for renewing your registration. London, Nursing and Midwifery Council.

Appendix A

Scoring tool for documentation audit: Midwifery out-patient ante natal care

Use this tool to review and audit documentation within the designated period above. Use one audit tool per record. Place a tick against each aspect of the documentation within one of the columns below. On the final page add up how many ticks appear within each column. Use this tool to reflect on the overall quality of documentation and make note of any areas for improvement.

Column A	✓	Column B	✓	Column C	✓
Risk assessment completed at Booking & detailed appropriate management plan documented.		Inaccurate Booking risk assessment. Management plan lacking detail or inappropriate.		Risk assessment not completed or lacking significant detail. No management plan documented.	
Appropriate named midwife & team documented at booking.		Inappropriate named midwife & team documented at booking.		No named midwife or team documented.	
Management plan reviewed and updated at every antenatal follow up with appropriate detail.		Management plan reviewed & updated at most antenatal appointments. Management plans contain appropriate detail.		Management plans not updated or lack accuracy and detail.	
Assessment of any safeguarding issues documented at booking with appropriate detail. If any social concerns.		Safeguarding documentation present but lacking sufficient detail.		Assessment of any safeguarding issues not documented at booking.	
EDD by scan updated following nuchal scan appropriate update to management plan made if required.		EDD by scan updated but management plan not updated when required.		Inaccurate EDD documented or not updated from EDD by LMP.	
Infant feeding discussed appropriately between 25-36 weeks.		Some, but not all infant feeding topics discussed between 25-36 weeks.		No infant feeding discussions documented.	
Only approved abbreviations used which are recognisable.		Minimal use of non approved abbreviations.		Multiple use of non-approved abbreviations or meaning unclear.	

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Electronic Record Keeping Guidance and Audit Tool

Column A	✓	Column B	✓	Column C	✓
Carbon Monoxide test offered at booking & 36 weeks. Results documented if accepted.		Carbon monoxide test offered at booking but not at 36 weeks.		No documentation of carbon monoxide testing offered during pregnancy.	
Domestic violence screening questions completed at booking, repeated at 28 & 36 weeks.				No domestic violence screening completed during pregnancy.	
VTE risk assessment completed at booking & actioned appropriately.		VTE risk assessment partially completed or actions unclear.		No VTE risk assessment documented.	
Birth options discussed and any plans or preferences clearly documented.		Limited discussion of place of birth and woman's preferences documented for labour and birth.		No discussion about preferences for place of birth or Labour and birth.	
Evidence of informed consent noted throughout documentation.				No evidence of consent noted throughout the documentation.	
All visits have documented: • BP, SFH urinalysis • Review results of investigations • Information shared, advice given.		Minimal documentation of care given and further plan of care.		Missing documentation of BP, SFH or urinalysis without explanation.	
Overall, the antenatal care documentation demonstrates a consistently detailed review of pregnancy health to date, new risks and clear action plans.		Documentation occasionally unclear or lacking detail.		No evidence of a regular review of pregnancy and health to date. Plan of care unclear or significantly lacking detail or regular updates when indicated.	
Total:		**Total:**		**Total:**	

Mostly Column A (No Column C): Excellent!
Very well done
Keep up the good work
Watch out for minor errors – see below

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Mostly Column B (No Column C): Satisfactory
Some areas for improvement required to your documentation – see below
Overall satisfactory

Any Answers in Column C: Unsatisfactory
Some major areas of concern
Action plan to be made with manager including regular repeat documentation audit

Areas for Improvement

Named of Midwife Reviewed

Name of Reviewing Midwife

Date of Review

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