Mid Essex Hospital Services NHS
NHS Trust

MATERNITY RECORD KEEPING INCLUDING DOCUMENTATION IN HANDHELD RECORDS	CLINICAL GUIDELINES Register no: 06036 Status: Public

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Related Trust Policies (to be read in conjunction with)	08086 Clinical Record Keeping Policy 05098 Maternity Risk Management Policy 04085 Patients Records on Wards Policy 07011 Confidentiality Policy 09062 Mandatory training policy for Maternity Services

Document History

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1.0	Anne Smith	February 2009
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2.1	Equality and diversity; audit and monitoring sections	January 2010
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3.0	Sarah Moon	October 2012
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3.3	Sarah Moon – clarification to point 7.6	May 2013
3.4	Sarah Moon – clarification to point 7.6	June 2013
3.5	Sara Smith – clarification to point 11.1 and 12.2	July 2013
3.6	Gemma May – clarification to point 11.1, 12.2 and Appendix B	June 2014
4.0	Sarah Moon	10 May 2016

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1.0 Purpose

1.1 This guideline is to enable staff to be aware of the process for initialising, accessing and storing maternity records during the full maternity episode.

1.2 The support staff in achieving high standards in maternity documentation.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Scope of the Guideline

3.1 The 'Guideline for maternity record keeping including documentation in handheld records' is a specialist document (register number 04085) and will be in addition to the current trust policies entitled 'Clinical record keeping standards' (register number 08086) and 'Patients records on wards policy' (register number 04085) and the 'Confidentiality Policy' (register number 07011). This guideline should be read in conjunction with these policies.

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4.0 Background

4.1 The Department of Health Code of Practice for Records Management requires that maternity records will be retained for a minimum period of 25 years. Maternity records must be easily retrievable from whatever format or location they are stored in.

4.2 Maternity records are designed to be multidisciplinary and all professionals who see the woman during her maternity care should be encouraged to use the single set of records. This is to ensure that there is a complete and contemporaneous record of all the care the patient receives and that a full and accurate picture is provided to all care givers.

4.3 It is expected that Allied Health Professionals write directly into the maternity record when seeing a patient as an inpatient. If care then continues on an outpatient basis, regular reports should be filed in the record particularly if there is a change in treatment, or on discharge.

4.4 All staff must comply with the Clinical Record Keeping Policy; register number 08086.

5.0 Initialising Maternity Records

5.1 This process is to be followed when it is known a woman wishes to have her baby at Mid Essex Hospital Services NHS Trust:

5.2 A booking letter confirming the pregnancy will be sent to the Maternity Secretaries' Office from either a patient self-referral, the general practitioner or the community midwife.

5.3 The Administration Clerk will check to see if the woman has had previous care with the Trust and has an established hospital number or lilac folder. This relates to any care and not just previous maternity care.

5.4 If the patient has previous medical/maternity records, those records will be requested and this

hospital number will be used for the current pregnancy. It may be necessary for these records to be regenerated from microfilm or the digitally stored image.

5.5 If the patient has never had any previous care with the Trust, a lilac folder with a hospital number will need to be generated. This applies irrespective of whether the patient intends to have a hospital or home birth.

5.6 The lilac folder will remain in the Antenatal Clinic at Broomfield Hospital or either of the two Midwife-led Units (MLU's) based at St Peter's, Maldon; and WJC, located at St Michael's Community Hospital, Braintree where there is 24 hour access. The lilac folder will retain basic demographic information, alert information and any details which cannot immediately be married up with the handheld records. This includes any documentation from maternity services contact episode when the patient forgets to bring her handheld records with her.

5.7 Arrangements must be made to link up the documentation with the handheld records (from any previous maternity episode) as soon as possible following discharge to ensure all Information pertaining to the current pregnancy is available to the multidisciplinary team.

5.8 When the midwife books the woman for maternity care, she will prepare a set of handheld Antenatal Care Records which will remain with the patient throughout her pregnancy.

5.9 At the first antenatal booking the midwife will complete a risk assessment as to whether the patient has a 'high' or 'low' risk pregnancy and will arrange an appointment with a consultant obstetrician, if required.

5.10 The name of the lead professional will be allocated at this time and will be reviewed and amended at each contact as this may change at different times throughout the pregnancy. It should be made clear in the patient's health care records who the lead professional is as the patient may move between low and high-risk care during her pregnancy, labour and puerperium

6.0 Handheld Records

6.1 Handheld records are produced in three booklets as follows:

- Antenatal Care Record
- Postnatal Care Record – Maternal
- Postnatal Care Record – Baby

6.2 Antenatal Care Record contains the current and past medical/surgical history, health and family support assessment, anaesthetic assessment, antenatal appointments, antenatal clinical assessments and individual care plans and antenatal inpatient records.

6.3 Pregnant patients will hold their own 'Antenatal Care Record' for the duration of their pregnancy.

6.4 The midwife should ensure that the patient's name, hospital number and NHS number are recorded on the front of each complete set of healthcare records

6.5 It is very rare for a patient to lose her handheld records. If this does happen, staff should be alert to any possible wider issues relating to her personal circumstances. A continuation sheet

must be used for recording the relevant information but cannot be entered into the handheld records. Furthermore, this continuation sheet must be kept within the lilac folder. All continuation/ additional sheets must contain the patient's name, hospital number and NHS number recorded on the front sheet only.

6.6 On admission, in labour, these records will become part of the lilac folder and will be retained by the maternity staff. If a patient is admitted in labour and has not brought her handheld records with her, her partner should be asked to either to return home to collect the records or have someone else to bring them in. In the meantime, a continuation sheet should be used and then filed securely as per order of filing schedule in the handheld records when available. (Refer to Appendix A)

6.7 New handheld records should only be generated in exceptional circumstances and only after it has been confirmed that the originals are irretrievable. These will be designated as duplicate records.

6.8 The 'Labour and Delivery Care Record' must not go home with the mother following delivery. Once the mother has gone home, the Labour Care Record will then go to the maternity administration office, Broomfield Hospital to be coded. Once the 'Postnatal Care Record – Maternal' and the 'Postnatal Care Record – Baby' has been returned from the community/ MLU's they will be coded; both 'Labour and Delivery Care Record' and 'Postnatal Care Record' will be reunited and then returned to the Medical Records Library at Broomfield Hospital.

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6.9 The standard for the order of filing must be met for any loose documentation within any of the healthcare records before it is secured in the document wallet within the lilac folder. The purpose of this is to minimise the risk of lost documentation and incomplete records. (Refer to Appendix A)

6.10 The 'Postnatal Care Record – Maternal' and the 'Postnatal Care Record – Baby' will be commenced immediately after delivery and will go home with the mother and baby for the duration of her postnatal care (if the patient is in area; refer to point 6.13). The community midwife will retain these records once the mother and baby are discharged to the care of the Health Visitor.

6.11 The Community Midwife will then return these postnatal records to the Broomfield Maternity administration office, known as the Maternity Library within 2 weeks at which time they will be coded.

6.12 After coding the 'Labour and Delivery Care Record' and 'Postnatal Care Records' are secured in the lilac folder and returned to the Medical Records Library at Broomfield Hospital.

6.13 Neonatal notes are retained by the Neonatal Unit prior to discharge home. These notes are then sent for coding and then forwarded to the Phoenix Satellite Library, at Broomfield Hospital.

6.14 For those patients who live out of area the Labour Care Record and Postnatal Care Record should be retained on discharge home to the community midwife. A copy of the patient's labour summary should be placed in the discharge letter informing the

community midwife.

7.0 Style and Content

7.1 **Style** - date, time and sign each new entry and record your name, signature and designation on page 2 of each care record in black ink. All entries should be neat, legible and use objective, precise language and avoid subjective 'casual' remarks and abbreviations that might not be understood.

7.2 The responsible midwife or professional reviewing a CTG trace should ensure that they date, sign and print their surname on each occasion.

7.3 Discharge and clinical letters for outpatients' attendance (i.e. ones that will be sent from the hospital to other health care staff) should be timely, neat and accurate.

7.2 **Content** - remember to record all information regarding current and future care; record relevant conversations with the family or friends of the patient; record the details of the information give to patients at the time of discharge. The health professional should ensure that where verbal consent is required for procedures that this documented in the patient's healthcare records. (Refer to the guideline for 'Clinical record keeping standards'; register number 08086) (Refer to Appendix B)

7.3 **Data Quality** - the patient's hospital number is always the patient's primary identifier and must be recorded on the front page of each care record booklet. In addition, the patient's name i.e. first name followed by the surname, and the patient's NHS number which is a unique identified should also be recorded in same manner. For any additional pages required refer to point 6.4.

7.4 **Retrospective entries** - records should always be written contemporaneously or as soon as possible after the events described. One of the greatest problems in midwifery is the fact that a midwife may be under pressure during a delivery and could also be care providing for more than one patient when in the hospital setting. This makes it impossible for her to record events at the same time as the delivery takes place; in this situation the health professional is required, prior to her documentation of events to identify this entry as 'written in retrospect'.

7.5 There is no fixed time limit on retrospective writing but best practice as the Nursing Midwifery Council (NMC) advises is to record as soon as possible after the event has occurred, ensuring that the date and time of retrospective entries are recorded.

7.6 The records should be completed accurately and without falsification, taking immediate and appropriate action if you become aware that someone has not kept to theses requirements.

7.7 As a midwife, if you delegate record keeping to pre-registration students of nursing or midwifery, you must ensure that they are adequately supervised and that they are competent to perform the task. You must clearly countersign any such entry and remember that you are professionally accountable for the consequences of such an entry.

7.8 **Errors** - draw a single line through incorrect entries; initial the error; add today's date; make

a note in the margin that the entry was made in error and note what the correct entry should be; never erase or use white-out liquid.

7.9 **Other Printed Records** - printed test results are part of the patient record and should be filed at the back of the antenatal care record booklet

7.10 **Consent Forms** - record any information you have given to the patient before they have made the decision to sign any consent form; this helps ensure that you have gained informed consent; consent forms are signed by the patient after the treatment has been discussed with the doctor; If there is clinical photography planned during surgery, include this on the consent form prior to signing.

8.0 Confidentiality and Sourcing Notes

8.1 Do not remove case notes from the hospital or send original records to other hospitals. The Medical Records Tracking System on PAS must be used to track the location of the notes e.g. when case notes are taken from one area of the hospital to another.as per the Trust's Casenote Tracking Policy

8.2 Refer to the Trust's Confidentiality Policy (register number 07011) for detailed information about the need for confidentiality and compliance with the data protection and Caldicott Principles.

8.3. All staff to be familiar with the Information Governance Handbook.

9.0 Structure of Medical Records

9.1 It is the responsibility of all staff using maternity records to understand the structure and filing system.
(Refer to Appendix A)

9.2 All items in this case note folder must be filed in accordance with these guidelines. There should be no loose papers, every user must leave the folder with the contents secured by the binding system. Filing will be routinely audited.

9.3 Records of previous pregnancies, for in area women will be filed in a plastic wallet and located behind the current pregnancy episode.

10.0 Alert Stickers

10.1 An **alert sticker** is the **only** sticker that may be placed on the front cover of a set of maternity records. It should highlight anything that would need to be known by the next clinical member of staff to be involved with the care of the patient. If an alert sticker is used then it is the responsibility of the person making the decision, to input the reason for the 'alert' on the inside front cover of the records. This must happen even with the older buff folders that do not have a specific printed box.

10.2 An alert sticker can be used to denote the following though this list is not exhaustive:

- Drug allergies

- Anaesthetic allergies/problems
- Any adverse reaction
- The presence of a **do not resuscitate order** (order to be filed in correspondence)
- Hearing or visual impairments
- Language issues
- Fetal loss (tear drop sticker)
- Another member of the family with the same name/initials
- A same gender twin
- Any medical records elements that are known to be permanently missing (only medical records staff will record these)

11.0 Staffing and Training

11.1 All midwifery and obstetric staff must attend yearly mandatory training which includes record keeping update.
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

11.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

12.0 Supervisor of Midwives

12.1 The supervision of midwives is a statutory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives who are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

12.2 Record keeping audits will be undertaken by staff as part of annual supervisory reviews. As a minimum 2 record keeping audit tools should be completed on an annual basis and discussed as part of the annual supervisory review.
(Refer to Appendix B)

13.0 Audit and Monitoring

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13.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

13.2 As a minimum the following specific requirements will be monitored:

- Basic record-keeping standards against which the health records must be audited for all healthcare professionals
- Basic clinical note keeping standards against which the health records must be audited for all healthcare professionals
- Storage arrangements for:
    i. cardiotocographs
    ii. anaesthetic records, including epidural records
    iii. fetal blood sampling results/reports
    iv. cord pH results/reports
    v. securing results/reports relating to previous pregnancies
    vi. antenatal screening and ultrasound results

- Arrangements for documenting the name of the lead professional (to include the process for recording any changes to the lead professional)
- Process for ensuring a contemporaneous complete record of care
- Frequency of audit of health records
- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

13.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 13.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken

13.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

13.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

13.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

13.7 Key findings and learning points will be disseminated to relevant staff.

14.0 Guideline Management

14.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

14.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

14.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

14.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

15.0 Communication

15.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarize themselves with and practice accordingly.

15.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

15.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

15.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

16.0 References

Nursing and Midwifery Council (2015) The Code – Professional standards of practice and behaviour for nurses and midwives. NMC: March.

Clinical Negligence Scheme for Trusts (2009) Maternity Clinical Risk Assessment Standards CNST.

DoH Code of Practice for Record keeping including Schedule D – the Retention and Destruction Schedule

Appendix A

Mid Essex Hospital Services NHS Trust

Women's and Children's Directorate
Filing for Maternity Records

The list below details the order of filing for current Maternity Care Records and lilac folders:

Antenatal Care Record		Situated at the front of the lilac notes	
Antenatal screening		Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Patient information leaflet proforma	(As appropriate)	Behind Antenatal Care Record / or within the care records	Filed chronologically and secured in the behind the Antenatal Care Record
Neonatal alert form	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Proforma for Management of Multiple Pregnancy and Birth	(As appropriate)	Behind Antenatal Care Record	Secured behind the Antenatal Care Record
Raised BMI Care record pathway	(As appropriate)	Behind Antenatal Care Record	Secured behind the Antenatal Care Record
Risk Assessment for Equipment Needed for Patient with Raised BMI Proforma	(As appropriate)	Behind Antenatal Care Record	Secured behind the Antenatal Care Record
Ultrasound reports		Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
CTG	Small envelope with CTG number, patient name, hospital number and date. Insert small brown envelope into A4 CTG storage envelope	Record the name, hospital number, EDD, sequence of order, reason for CTG, outcome and signature on the front of the A4 CTG storage envelope	Secured the A4 CTG storage envelope on the behind the Antenatal Care Record
Handover of care proforma (Antenatal)	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
Maternal transfer proforma	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record
In utero transfer proforma	(As appropriate)	Behind Antenatal Care Record	Filed chronologically and secured in the behind the Antenatal Care Record

Labour CDC computer print out		In front of the Labour Care Record	Filed chronologically and secured in front of the Labour Care Record
Labour and Delivery Care Record		Situated behind the Antenatal episode	
Drug chart		Behind Labour Care Record	Secured behind the Labour Care Record
MEOWS chart		Behind Labour Care Record	Secured behind the Labour Care Record
HII form	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Epidural Record and observations chart	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Shoulder dystocia proforma	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Postpartum haemorrhage proforma	(As appropriate)	Behind Labour Care Record	Secured behind the Labour Care Record
Fetal Blood Sampling (FBS) results	FBS results should be placed in a small brown envelope	Secure the small brown envelope chronogically in the Labour Care Record	Chronological within the documented Labour Care Record
Cord pH results	Cord pH results results should be placed in a small brown envelope (As appropriate)	Secure the small brown envelope on the Birth Assessment page	Secured behind the Labour Care Record
Urinalysis results		Secure chronogically in the appropriate Care Record	
Operative Delivery and Theatre Care Record	(As appropriate)	Behind the Labour Care Record	Secured behind the Labour Care Record
Anaesthetic records	(As appropriate)	Integral to the Operative Delivery and Theatre Care Record	Secured behind the Labour Care Record
Consent form	(As appropriate)	Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
VTE Assessment form		Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Operative theatre times	(As appropriate)	Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Baby Delivery Record		Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Handover sheet from NNU admission	(As appropriate)	Behind the Operative Delivery and Theatre Care Record	Secured behind the Operative Delivery and Theatre Care Record
Handover of care proforma (postnatal)	(As appropriate)	Behind the Labour Care Record	Secured in the behind the Labour Care Record
Postnatal discharge CDC	1 copy required	In front of the Postnatal Care Record - Maternal	Secured in front of the Postnatal Care Record - Maternal

Postnatal Care Record – Maternal		Behind the Labour Care Record	Secured in the behind the Labour Care Record
Specialist referrals	(As appropriate)	Behind the Postnatal Care Record - Maternal	Secured in the behind the Postnatal Care Record - Maternal
Postnatal Care Record – Baby		Behind the Postnatal Care Record - Maternal	Secured in the behind the Postnatal Care Record - Maternal
Baby drug chart, observation and feeding charts, referral forms, immunisation forms	(As appropriate)	File chronologically: baby drug chart, observation and feeding charts, referral forms, immunisation forms	Secured in the behind the Postnatal Care Record –Baby
Newborn screening forms		Behind the Postnatal Care Record - Baby	Secured in the behind the Postnatal Care Record –Baby
Clear Folder	(Retained in the lilac folder inserted behind pregnancy episode)	Clear folder should be located behind pregnancy episode chronologically	
Mat Ad 1 (Self/ Midwife/GP referral)		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Antenatal booking CDC		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
GP referral letters		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
FAQ		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Telephone message proforma		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Yellow Alert Forms		Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Early pregnancy assessment clinic	(As appropriate)	Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder)
Previous pregnancies	Securing results/reports relating to previous	Insert in to the clear plastic wallet file	Secure in the main health record folder (lilac folder) filed behind the current pregnancy episode

Mid Essex Hospital Services NHS
NHS Trust

Women's and Children's Directorate

Maternity Services

Record Keeping Audit Tool

Audit Date _____

Hospital Number _____

Auditor _____

	Antenatal			
	NB; all the questions follow in relation to the Hand held notes. Please circle your responses.			
1	Has the lead professional been identified	*Yes*	*No*	*N/A*
2	If the lead professional has changed has this been identified	*Yes*	*No*	
3	Is there evidence of information and discussion regarding place of birth options	*Yes*	*No*	
4	Is there documented evidence that social circumstances have been discussed	*Yes*	*No*	
5	Is there documented evidence that Domestic Violence has been discussed	*Yes*	*No*	
6	Has the ethnic origin been documented	*Yes*	*No*	
7	Has the woman's medical history been discussed	*Yes*	*No*	
8	Have risk factors been identified, i.e. medical conditions, anaesthetic factors, previous pregnancy factors, lifestyle factors, if so is there documented evidence that the appropriated referral has been made	*Yes*	*No*	
9	Is there documented evidence that family history has been discussed	*Yes*	*No*	
10	Is there evidence that Allergies have been identified	*Yes*	*No*	
11	If a current mental health problem, or risk has been identified, is there documented evidence that this has been communicated to, Mental health services, GP's, Health Visitors, Interpretations services where appropriate	*Yes*	*No*	*N/A*
12	When mental health issues have been identified, has a plan been made, and potential problems in Postnatal period been acknowledged	*Yes*	*No*	*N/A*
13	Has previous obstetric history been recorded	*Yes*	*No*	*N/A*
14	Is there documented evidence that written information has been given and discussed regarding; 1. Screening tests , inc; Downs, U/Scan, Blood tests, **Including consent obtained** (NHS Screening leaflet) 2. Place of birth options 3. Vitamin K Prophylaxis 4. Fetal Monitoring in labour **If the woman has declined initial screening, is there evidence of another offer of screening**	 *Yes* *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No* *No*	 *N/A*

15	Is there documented evidence **if appropriate** that written information has been given and discussed regarding; 1. Induction of labour 2. General anaesthetic 3. Vaginal birth following Caesarean Section 4. Perineal repair 5. External Cephalic Version 6. Women who decline blood and blood products	 *Yes* *Yes* *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A* *N/A* *N/A*
16	Are all blood results recorded appropriately	*Yes*	*No*	
17	Has the BMI been calculated and documented	*Yes*	*No*	
18	For women with BMI above 30, macrosomic baby>4.5kg, first degree relative with diabetes, family origin with a high prevalence of diabetes (south Asian, Black Caribbean)and Middle Eastern has there been a referral for GTT	*Yes*	*No*	*N/A*
19	For women who have abnormal GTT has care been provided in the joint clinic	*Yes*	*No*	*N/A*
20	For women with BMI >25 Was there a consultant referral	*Yes*	*No*	*N/A*
21	For women with BMI >40 Was there an Anaesthetic referral – with a plan for labour and delivery	*Yes*	*No*	*N/A*
22	For women with BMI >40 during 3rd trimester – has individual assessment been undertake re Manual handling, tissue viability and Del Suite special persons form completed	*Yes*	*No*	*N/A*
23	Was the booking history completed by 12 weeks gestation	*Yes*	*No*	
24	If the referral was received after 12 weeks, was the booking history completed within 2 weeks of referral being received	*Yes*	*No*	*N/A*
25	Is there any documented evidence of an individual plan of pregnancy care	*Yes*	*No*	
26	For women who have had a previous caesarean birth, is there documented evidence of a discussion regarding the following; 1. Mode of delivery 2. Place of delivery 3. Individual plan for delivery 4. Plan for labour should this commence early 5. Plan for monitoring fetal heart in labour	 *Yes* *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A* *N/A*
27	If breech presentation has been identified 36/52, is there evidence of discussion regarding ECV	*Yes*	*No*	*N/A*
28	Has the Infant Feeding Antenatal Check been completed 1. At Booking 2. 28 weeks 3. 34 weeks	 *Yes* *Yes* *Yes*	 *No* *No* *No*	
29	If labour had not commenced by 40 weeks, is there documented evidence that IOL has been discussed	*Yes*	*No*	*N/A*

30	If Labour had not commenced by 40 weeks, has a membrane sweep been offered at 41 weeks for; 1. Primips 2. Multips	 *Yes* *Yes*	 *No* *No*	 *N/A* *N/A*
31	If this is a multiple pregnancy is there documented evidence of discussion regarding the following; 1. The risks and benefits of different modes of delivery 2. Place of birth 3. Timing of birth 4. Individual plan for birth	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*
32	If there is a pre existing medical / familial reason for antenatal Thromboprophylaxis has the appropriate risk assessment been performed and medical prescribed	*Yes*	*No*	*N/A*
33	For women with Type 1 diabetes; 1. Was care given in the joint clinic, (Obstetrician/Midwife/Diabetic Physician, dietician) 2. Is there documented evidence the timetable of antenatal care has been discussed 3. Has he Diabetes Flow sheet been completed and secured I the records 4. Is there documented advise regarding changes in awareness of Hypo / Hyperglycaemia	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*
34	For all antenatal admissions was a clear indication for the admission documented at the beginning of the episode of care	*Yes*	*No*	*N/A*
	Labour Care			
1	Has the woman completed a birth plan	*Yes*	*No*	
2	Is there documented evidence that the birth plan had been discussed	*Yes*	*No*	
3	Have admission observations been completed	*Yes*	*No*	
4	Was the woman admitted for an Elective Caesarean Section? ***If yes please go to question 35***	*Yes*	*No*	
5	Is there documented evidence that Fetal monitoring in labour has been discussed	*Yes*	*No*	
6	Is there evidence of discussion regarding he plan of care for labour	*Yes*	*No*	
7	Has a review of History taken place and the labour assessed as either Low Risk or High Risk	*Yes*	*No*	
8	Has the fetal heart rate been auscultated and recorded at 15min intervals during 1st stage	*Yes*	*No*	
9	Has it been recorded that the fetal heart was auscultated for 1min following a contraction	*Yes*	*No*	
10	If continuous electronic monitoring is used, has the indication been documented	*Yes*	*No*	*N/A*
11	Has the Frequency, Length and Strength of contractions been recorded every 30 mins	*Yes*	*No*	

12	Has the maternal pulse been recorded hourly, unless it is indicated to be more frequent	*Yes*	*No*	
13	Has the maternal Blood pressure been recorded 4 hourly, unless it is indicated to be more frequent	*Yes*	*No*	
14	Has the maternal temperature been recorded 4 hourly, unless it is indicated to be more frequent	*Yes*	*No*	
15	Has a vaginal examination 1. Been offered 4 hourly 2. Consent obtained 3. Abdominal palpation performed prior to each VE	*Yes*	*No*	
16	Has the woman passed urine at least 2-3 hourly	*Yes*	*No*	
17	Was action taken if the woman is unable to pass urine	*Yes*	*No*	*N/A*
18	Has the woman's emotional and psychological needs been considered	*Yes*	*No*	
19	Has the colour of liquor been documented	*Yes*	*No*	
20	Has midwifery led care been offered for all low risk women	*Yes*	*No*	*N/A*
21	Has non invasive methods of analgesia including water been offered	*Yes*	*No*	*N/A*
22	Has the woman been encouraged to adopt alternative positions	*Yes*	*No*	
23	Has every effort been made to ensure the woman was actively mobile in labour	*Yes*	*No*	
24	If epidural analgesia was used was; 1. Informed consent obtained 2. Time of siting reordered 3. Anaesthetist completed appropriate documentation	 *Yes* *Yes* *Yes*	 *No* *No* *No*	 *N/A* *N/A* *N/A*
25	If there was delay in the first stage of labour was the following informed; 1. Deliver Suite Coordinator 2. Obstetric Registrar 3. And a plan of care documented 4. Was the plan appropriate	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*
26	If Oxytocin was used to augment labour was the following completed; 1. Assessment by an Obstetrician and appropriate plan of care documented 2. Informed consent form the woman 3. Continuous electronic monitoring of the fetal heart rate 4. Review by an Obstetrician prior to stopping syntocinon in the case of fetal compromise	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*

27	If there is a pathological recording of the fetal heart rate was; 1. Delivery Suite Coordinator informed 2. Obstetric Registrar informed 3. Fetal blood sampling performed / results documented / secured in the records 4. Appropriate plan of care documented	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*
28	Second stage, was; 1. Fetal Heart auscultated / recorded at 5min intervals / between contractions 2. Hourly vaginal examination performed, (with consent)	 *Yes* *Yes*	 *No* *No*	 *N/A* *N/A*
29	If there was a delay in the Second stage of labour, was the following informed; 1. Delivery Suite Coordinator 2. Obstetric Registrar 3. And a plan of care documented 4. Was the plan appropriate	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*
30	Instrumental Delivery 1. Has the indication for instrumental delivery been recorded 2. The procedure documented appropriately	 *Yes* *Yes*	 *No* *No*	 *N/A* *N/A*
31	Has the indication for performing an episiotomy been recorded	*Yes*	*No*	*N/A*
32	Third Stage 1. Has the management been discussed 2. Was consent obtained prior to administering Syntometrine for active management of 3rd stage 3. Has the method of delivery / examination been recorded	 *Yes* *Yes* *Yes*	 *No* *No* *No*	 *N/A* *N/A* *N/A*
33	Perineal trauma 1. Informed consent obtained for procedure of repair 2. Has a systematic assessment of perineal and vaginal trauma been recorded 3. Effective analgesia given 4. Anal sphincter integrity reviewed 5. Record of repair of perineum, including type of suture 6. Appropriate referral made following 3rd degree tear	 *Yes* *Yes* *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A* *N/A* *N/A*
34	Have all drugs administered in labour been recorded on the partogram	*Yes*	*No*	*N/A*
35	Has the delivery outcome been recorded on the partogram	*Yes*	*No*	*N/A*
36	Has insertion of any Venous Cannula been insertion been recorded using cannulation pack sticker	*Yes*	*No*	*N/A*
37	If a Urinary catheter was required has the insertion date and time been recorded	*Yes*	*No*	*N/A*
38	If a fetal scalp electrode was requires, was the date and time recorded	*Yes*	*No*	*N/A*

39	Is there evidence of consent being obtained and removal date and time for the following; 1. Venous Cannula 2. Urinary catheter 3. Epidural Cannula 4. Fetal scalp electrode	 *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A*
40	Is there documented evidence of informed consent prior to any operative procedure	*Yes*	*No*	*N/A*
41	Has the consent form for any operative procedure been secured in the records	*Yes*	*No*	*N/A*
42	Has the indication for Caesarean section been recorded	*Yes*	*No*	*N/A*
43	Has the category of LSCS been documented	*Yes*	*No*	*N/A*
44	Has the swab count completeness been recorded	*Yes*	*No*	*N/A*
45	Have the anaesthetic record, who checklist, recovery care record been completed and secured in the records	*Yes*	*No*	*N/A*
46	Have the maternal observation following labour been recorded	*Yes*	*No*	*N/A*
47	Has the woman passed at least 200mls of urine following delivery	*Yes*	*No*	*N/A*
48	Is the labour summary page complete	*Yes*	*No*	*N/A*
	Continuous electronic fetal monitoring (EFM)			
1	Is there documented evidence of indication for changing from intermittent auscultation to continuous monitoring	*Yes*	*No*	*N/A*
2	Is there documented evidence in the recording of the **Woman's name**	*Yes*	*No*	
3	Is there documented evidence on the recording of the **Date of commencement**	*Yes*	*No*	
4	Is there documented evidence on the recording of the **Time of commencement**	*Yes*	*No*	
5	Is there documented evidence on the recording that **chronological time is the same as the time printed by the machine**	*Yes*	*No*	
6	Is there documented evidence on the recording of the woman's **Hospital number**	*Yes*	*No*	
7	Is there documented evidence on the recording of the **Indication for commencing the CTG**	*Yes*	*No*	
8	Is there documented evidence on the recording of the **woman's pulse** at commencement and intermittently throughout the recording	*Yes*	*No*	
9	Has the member of staff commencing the recording **Signed it and printed their name**	*Yes*	*No*	
10	Is there documented evidence on the recording of the **fetal heart rate heard using Pinard stethoscope** at commencement of recording	*Yes*	*No*	

11	Is there documented evidence on the recording of any events, such as; 1. Maternal position 2. Fetal movements 3. Dilation 4. Medication given 5. Vaginal examinations 6. Description of liquor	 *Yes* *Yes* *Yes* *Yes* *Yes* *Yes*	 *No* *No* *No* *No* *No* *No*	 *N/A* *N/A* *N/A* *N/A* *N/A* *N/A*
12	When events are annotated, are they recorded at the time of the event (i.e. does it correspond to the labour summary)	*Yes*	*No*	*N/A*
13	Are all the annotations signed and the time noted	*Yes*	*No*	
14	Signature of member of staff reviewing recording	*Yes*	*No*	
15	Is there documented evidence on the recording of the date ad time of review	*Yes*	*No*	
16	Is there documented evidence on the recording of the date and time of discontinuation	*Yes*	*No*	
17	Is there documented evidence on the recording of the reason for discontinuation	*Yes*	*No*	
18	Has the member of staff discontinuing the recording signed and printed their name	*Yes*	*No*	
	Storage of Continuous electronic fetal monitoring (EFM) for each recording			
19	Is the recording secured in the healthcare records inside CTG envelope	*Yes*	*No*	
20	Is the woman's details clearly written (label) on the envelope	*Yes*	*No*	
21	Is each recording numbered according to the number on the envelope	*Yes*	*No*	
22	Is the date of each recording on the envelope	*Yes*	*No*	
23	Is the time and date if each recording on the envelope	*Yes*	*No*	
24	Is there documented evidence of hourly assessment of the CTG using Dr C Bravado pneumonic	*Yes*	*No*	
	Treatment Cards			
25	Is there a treatment card for this episode of care secured in the notes	*Yes*	*No*	
26	Are the women's details recorded on the card	*Yes*	*No*	
27	Is there documented evidence of drug allergies being identified	*Yes*	*No*	
28	Is any medication that had been prescribed, written in a legible manner	*Yes*	*No*	

29	Is each prescription signed	*Yes*	*No*	
30	Is the signature legible	*Yes*	*No*	
31	Is there documented evidence that each medication, has been administered as prescribed	*Yes*	*No*	
32	Is there a VTE Risk Assessment attached to the treatment care	*Yes*	*No*	
33	Have the VTE Risk Assessment been signed	*Yes*	*No*	
	Postnatal Care / Documentation regarding the baby			
1	Is there documented evidence of the initial examination by the midwife	*Yes*	*No*	
2	Is there documented evidence of skin to skin contact	*Yes*	*No*	
3	Is there documented evidence of first feed including type of feed	*Yes*	*No*	
4	Is there documented evidence of the first feed being given whilst the woman was in deliver suite, preferably within 1 hour from birth	*Yes*	*No*	
5	Is there documented evidence of support with positioning and attachment with the first feed	*Yes*	*No*	*NA*
6	Is there documented evidence of the quality of the feed / amount of formula taken	*Yes*	*No*	
7	Is there a baby care pathway included in records	*Yes*	*No*	
8	Has the healthcare professional signed against a coloured pathway	*Yes*	*No*	
9	Are the observations completed on the care pathway appropriately	*Yes*	*No*	
10	Is there documented evidence of the babies temperature being taken following delivery	*Yes*	*No*	
11	Vitamin K, was there documented evidence of the following; 1. Parental consent 2. Being administration 3. Route of administration	 *Yes* *Yes* *Yes*	 *No* *No* *No*	 *N/A* *N/A* *N/A*
12	Is there documented evidence of baby's weight and head Circumference	*Yes*	*No*	
13	Are the postnatal notes stored within the main health records	*Yes*	*No*	
14	Is there documented evidence of discussion regarding the baby's security whilst in hospital	*Yes*	*No*	*N/A*
15	Is there documented evidence of an individualised plan of care plan, the woman and her baby	*Yes*	*No*	
16	Is the infant feeding Postnatal check list completed and secured in the records	*Yes*	*No*	
17	Is there documented evidence of appropriate instruction in sterilisation of feeding equipment / reconstitution of feeds	*Yes*	*No*	*N/A*
18	Is there documented evidence of the woman being offered an opportunity to discuss the birth	*Yes*	*No*	

19	Is there documented evidence of plan of care following transfer home from hospital	*Yes*	*No*	
20	Is there documented evidence of the baby having had a full physical neonatal examination	*Yes*	*No*	
21	For women with multiagency / multidisciplinary needs is there evidence of coordination between all concerned	*Yes*	*No*	
22	Is it documented that the NICE Postnatal guidance including information for parents to be able to assess their baby's well being has been given	*Yes*	*No*	
23	Have contact details been given for support from the relevant healthcare professionals	*Yes*	*No*	
24	Is there documented evidence of the baby's red book being given to the parents to discuss	*Yes*	*No*	
	Support for parents in case of actual or suspected poor outcome for the newborn			
	If no fetal / neonatal loss go to question 30			
25	is there documented evidence of support from appropriate healthcare professionals	*Yes*	*No*	*N/A*
26	Is there documented evidence of the provision of written information	*Yes*	*No*	*N/A*
27	Is there documented evidence of the parents being given information regarding support groups	*Yes*	*No*	*N/A*
28	Is there documented evidence of discussions had between healthcare professional and parents, regarding care and advice	*Yes*	*No*	*N/A*
29	Is there documented evidence of support for parents who have communication or language support needs?	*Yes*	*No*	*N/A*
	General Record Keeping			
30	Is all documentation written legibly in manner that the text cannot be erased	*Yes*	*No*	
31	Is all documentation written in black ink	*Yes*	*No*	
32	Are all entries recorded contemporaneously	*Yes*	*No*	
33	Is all the women's name and unit number recorded on each loose page / inserts	*Yes*	*No*	
34	Are all entries dated and times using the 24 hour clock	*Yes*	*No*	
35	Are all entries signed	*Yes*	*No*	
36	Is the name printed and qualification stated by each health professional making an entry	*Yes*	*No*	
37	Is all information in chronological order	*Yes*	*No*	
38	Have all handovers of care been clearly identifies	*Yes*	*No*	
39	If abbreviations have been used have they previously explained (or agreed by the trust)	*Yes*	*No*	

40	Are all errors crossed once, dated, timed and signed the words 'written in error' entered	*Yes*	*No*	
41	Are all records factual, free from; jargon, meaningless phrases, irrelevant speculation and subjective statements	*Yes*	*No*	
42	Are all documents / loose papers filed in chronological order securely	*Yes*	*No*	
43	If the woman has had an operative procedure is the anaesthetic record secured in the records	*Yes*	*No*	
44	If a fetal blood sample or paired samples were taken are the results secured in the records	*Yes*	*No*	
45	Are the Ultra scan reports secured in the records	*Yes*	*No*	
46	Is there any evidence of records from previous pregnancies being filed with this pregnancy	*Yes*	*No*	
47	Are any scraps of paper, e.g. used for noting times of events, secured in the records, in a visible manner	*Yes*	*No*	
	Postnatal Care / Documentation regarding the mother			
1	Is there documented evidence of delivery summary	*yes*	*no*	
2	Is there documented evidence of thromboprophylaxis risk assessment	*yes*	*no*	
3	Is Home birth check list done if Applicable	*Yes*	*no*	
4	Is postnatal handover complete	*yes*	*no*	
5	Is transfer from hospital to community filled in	*yes*	*no*	
6	Is infant feeding checklist complete	*yes*	*no*	
7	Is each entry timed dated and signed	*yes*	*no*	
8	Is modified early obstetric warning system filled in	*yes*	*no*	
9	Has community discharge letter been completed	*yes*	*no*	
10	Are the notes stored within the main notes	*yes*	*no*	