Midwifery Documentation and Record Keeping Audit Tool

Midwives have an obligation to provide a meaningful, useful, and thorough record of care, which includes all midwifery care provided, advice given, discussions, and the outcomes arising from discussions which are updated on the care plan[1]. This audit tool is designed to ensure midwives are meeting minimum competence standards for registration related to documentation. It is designed to be used alongside other resources for midwifery documentation and record-keeping, such as:

- Midwifery Council of New Zealand, Be Safe. Documentation and Record Keeping https://www.midwiferycouncil.health.nz/sites/default/files/images/Be%20Safe%204%20Documentation%20and%20record%20keeping%20final.pdf
- Relevant New Zealand Legislation
- Ministry of Health Referral Guidelines (p. 2) https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf

In order for midwives to periodically review their documentation practice we encourage self and/or peer review. This has been shown as an effective method for improving clinical practise. Review provides a systematic method to ensure that practice meets professional competencies and legislative requirements, and should include review of over health record management systems.

Regular audit using the tool (at least yearly) will enable:

- A methodical method to identify risks related to documentation practice
- A means to seek feedback and improve professional practice
- Identification of any gaps in your documentation practice
- A proactive method to improve quality

Method:

- Three-step Audit
  - Overall record management audit
  - General record keeping audit
  - Clinical Midwifery documentation audit
- Self-audit or peer audit
- Select minimum of six sets of client documentation related to your midwifery practice context. This could be midwifery care provided to a woman/baby over one shift, or locum antenatal or postnatal consultations, or midwifery care across the scope from booking to discharge
- Include at least one set of baby notes and, if continuity practice, consider a set of notes of outlying care episodes such as early termination of midwifery relationship (i.e. miscarriage or a woman moving out of area) and complex care situations such as poor attender or women with anxiety/complex care issues
- Ensure your selection is random and represents your practice and client population – such as every 10th set
- Complete the tool with a tick **√** (yes) or **X** (no) or **N/A** (not applicable)

[1] Kerkin, B., Lennox, S., & Patterson, J. (2018). Making midwifery work visible: The multiple purposes of documentation. *Women and Birth (31),* 232-239.

Part One:

Overall Midwifery records management system

Midwives have a professional responsibility to take active steps to store and protect confidentiality and privacy of all records.

Use this tool as a general 'across your practice' guide to ensure you have a robust practice management system

Record Management system	Yes	No	N/A	Comment
1. Accessible filing system for hard copy and/or soft copy documentation?				
2. Password protected electronic records?				
3. Hard copy documentation locked, fire-proof and protected from water, dirt, dust, humidity, insects and rodents?				
4. Soft copy documentation up-to-date virus protection, future proofed and encrypted?				
5. Regular maintenance and back-up of computer or other electronic equipment?				
6. System for secure record disposal 10-years following final entry?				
7. Arrangements for expected or unexpected absence from practice? (i.e. holiday, retirement or illness)				
8. Up-to-date schedule of actions taken and future plans for secure record storage and record disposal?				

Part Two:
General Midwifery Documentation requirements

	Set			
General requirements	**1**	**2**	**3**	**Comment**
1. Client name (woman or baby) on each page?				
2. Additional identification information on each page? (DoB, NHI or unique code)				
3. Individual set of notes for each client? i.e. separate woman and baby notes				
4. Date shown on each page?				
5. Time recorded using 24-hour clock with a clear indication of start/finish retrospective documentation?				
6. All entries clear and legible?				
7. Lines through excessive gaps/space?				
8. Minimal use of abbreviations?				
9. Every entry signed?				
10. At least once on each page clear identification of midwife's name and designation?				
11. System to record and secure laboratory results, USS and other reports?				
12. Documentation of midwifery recommendations, consultations, referrals or other communication?				
13. Documentation of outcome of consultation or referral?				
14. System in place for documenting phone calls, texts and other midwifery care provided outside formal consultations?				
15. Documentation of hand over of care and/or completion? i.e. secondary care or well child provider; final referral to GP at care completion.				

Part Two continued …

General requirements	Set 4	5	6	Comment
1. Client name (woman or baby) on each page?				
2. Additional identification information on each page? (DoB, NHI or unique code)				
3. Individual set of notes for each client? i.e. separate woman and baby notes				
4. Date shown on each page?				
5. Time recorded using 24-hour clock with a clear indication of start/finish documentation?				
6. All entries clear and legible?				
7. Lines through excessive gaps/space?				
8. Minimal use of abbreviations?				
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14. System in place for documenting phone calls, texts and other midwifery care provided outside formal consultations?				
15. Documentation of hand over of care and/or completion? i.e. secondary care or well child provider; final referral to GP at care completion.				

Part Three:

Midwifery Clinical Documentation Review

Your documentation should demonstrate and communicate all midwifery care you have recommended and provided in partnership with your client. This includes evidence of information-sharing and woman-centred care, your discussions, recommendations, and the woman's decisions and midwifery actions taken.

An outside reviewer should have a clear understanding of the chronological order of events and see evidence of midwifery care offered and provided, as well as processes of critical thinking and decision making.

	Set			
Midwifery care Documentation	**1**	**2**	**3**	**Comment**
1. Chronological, ongoing assessment, and clinical findings of all midwifery care provided?				
2. Documentation written in a logical and sequential manner?				
3. Factual and accurate observations and assessments? i.e. FH 140 bpm not FHH; i.e. protein: neg, glucose neg not urine dip stick NAD				
4. Evidence of discussions and process of informed consent, including information provided to the woman?				
5. Documentation of discussions, consultation and referral with other health professionals?				
6. Evidence of partnership/woman-centred care? i.e. the woman and her decisions are present				
7. Care plan updated as relevant?				
8. Evidence of rationale for clinical decisions (including woman declining midwifery recommendations)?				
9. Medications and/or treatment prescribed?				
10. Clear documentation of critical or unexpected events and midwifery recommendations and actions?				

Part Three continued…

Your documentation should demonstrate and communicate all midwifery care you have recommended and provided in partnership with your client. This includes evidence of information-sharing and woman-centred care, your discussions, recommendations, and the woman's decisions and midwifery actions taken.

An outside reviewer should have a clear understanding of the chronological order of events and see evidence of midwifery care offered and provided, as well as processes of critical thinking and decision making.

	Set			
Midwifery care Documentation	**4**	**5**	**6**	**Comment**
1. Chronological, ongoing assessment, and clinical findings of all midwifery care provided?				
2. Documentation written in a logical and sequential manner?				
3. Factual and accurate observations and assessments? i.e. FH 140 bpm not FHH; i.e. protein: neg, glucose neg not urine dip stick NAD				
4. Evidence of discussions and process of informed consent, including information provided to the woman?				
5. Documentation of discussions, consultation and referral with other health professionals?				
6. Evidence of partnership/woman-centred care? i.e. the woman and her decisions are present				
7. Care plan updated as relevant?				
8. Evidence of rationale for clinical decisions (including woman declining midwifery recommendations)?				
9. Medications and/or treatment prescribed?				
10. Clear documentation of critical or unexpected events and midwifery recommendations and actions?				