Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Guideline on Record Keeping, HSE Home Birth Service

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1. Guideline Statement

The Health Service Executive (HSE) National Home Birth Service is committed to ensuring a high-quality service based on best practice in record keeping and documentation. Record keeping is an integral part of midwifery practice and is a reflection of the standard of an individual midwife's professional practice (Nursing and Midwifery Board of Ireland (NMBI) 2015). CEMACH and MBRRACE highlight communication issues as a main overarching theme for midwifery practice. This guideline outlines the principles of good record keeping in line with the Recording Clinical Practice (NMBI 2015) document.

2. Purpose

2.1 To provide a framework for best practice in record keeping for all Self-Employed Community Midwives (SECMs) providing home birth services for women and babies on behalf of the HSE.
2.2 To uphold the standards of safe practice.
2.3 To promote better communication and sharing of information between members of the multi-disciplinary healthcare team.
2.4 To ensure that continuity of care for women and their babies is always maintained.
2.5 To ensure that Self-Employed Community Midwives establish and maintain accurate, clear and current records within a legal, ethical and professional framework.
2.6 To assist with addressing complaints or legal processes.
2.7 To act as a basis for audit and evaluation.

3. Scope

This guideline applies to all Self-Employed Community Midwives providing home birth services on behalf of the HSE.

4. Legislation, Codes of Practice, Standards and Guidance

4.1 Health Acts, 1947 to 2015 and regulations made thereunder
4.2 Nurses and Midwives Act, 2011
4.3 The Scope of Nursing and Midwifery Practice Framework (NMBI 2015)
4.4 The Code of Professional and Ethical Conduct for Registered Nurses and Registered Midwives (NMBI 2014)
4.5 Practice Standards for Midwives (NMBI 2015)
4.6 Recording Clinical Practice (NMBI 2015)
4.7 Guidance for Nurses and Midwives on Medication Management (ABA 2007)
4.8 NICE Clinical Guideline 190 – Intrapartum Care: Care of Healthy Women and their Babies during Childbirth (NICE 2014)
4.9 Evidence Based Guidelines for Midwifery Care in Labour (RCM 2008)
4.10 The Irish Maternity Early Warning System (IMEWS) NCEC (DOH 2014)
4.11 Communication (Clinical Handover) in Maternity Services NCEC (DOH 2014)
4.12 Sepsis Management NCEC (DOH 2014)

4.13 HSE Policy and Procedure for Notification of Home Births to the National Ambulance Service (National Ambulance Service HSE 2015)
4.14 Standards and Recommended Practices for Healthcare Records Management (HSE 2011)
4.15 National Consent Policy (HSE 2013)
4.16 Safety Incident Management Policy (HSE 2014)
4.17 Confidential Enquiry into Maternal and Child Health (2007), Saving Mothers' Lives, CEMACH, London
4.18 Confidential Enquiry into Maternal Death (2015) MBRRACE, London
4.19 DOHC (2008) The Report of the Commission for Patient Safety and Quality Awareness, Building a Culture of Patient Safety, Stationery Office, Dublin
4.20 Health Service Executive (2008) Inquiry into Circumstances pertaining to Death of Tanya McCabe and her son Zach at our Lady of Lourdes Hospital Drogheda, HSE, Dublin.
4.21 Health Service Executive Code of Practice for Healthcare Records Management. Abbreviations. (2010) Version 2. HSE
4.22 National Maternity Strategy 2016-2026 (DOH 2016)

This list is not exhaustive and reference should be made at all times to the guideline for reference sources or the database of legislation, codes of practice, standards and guidance (Clinical Governance Group for the HSE Home Birth Service 2016).

5. Definition & Background

5.1 **Healthcare Record**: All information collected, processed and held in both manual and electronic formats about the woman and/or her baby under the care of a midwife. A healthcare record includes, for example, personal information, clinical information, images, investigation reports, samples, correspondence and communications relating to the woman and her baby and their care (NMBI 2015).

6. Roles and Responsibilities

6.1. The Director of Primary Care shall ensure:

6.3.1 The provision of appropriate systems and structures to support the SECM to provide midwifery care for women and their families availing of the HSE Home Birth Service.

6.2. The Chief Officer shall:

6.2.1 Ensure the implementation of systems and structures for the SECM to provide midwifery care for women and their families availing of the HSE Home Birth Service.
6.2.2 Request that the SECM and DMO report any adverse incidents to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.

6.3. The Designated Midwifery Officer (DMO) shall:

6.3.1 Ensure that the appropriate systems and structures are in place to implement this guideline.
6.3.2 Ensure that the SECM receives this guideline and records same.
6.3.3 Ensure that healthcare records are monitored and audited according to this guideline and feedback given to SECM.

6.3.4 Ensure that completed incident forms are received from the SECM and forwarded to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.

6.4. The Self-Employed Community Midwife (SECM) shall:

6.4.1. Ensure competence in maintaining healthcare records in accordance with NMBI and HSE guidelines.

6.4.2. Ensure that they have all the documentation required to maintain healthcare records.

6.4.3. Report any adverse incidents via the DMO to the National Incident Management System (NIMS) as per HSE Safety Incident Management Policy 2014.

6.4.4. It is the responsibility of the SECM to be aware of and sign that they have read, understood and comply with this practice guideline.

7. Procedure

7.1 All written notes in charts and care plans should be individualised, accurate, clear, up to date, and factual.

7.1.1 Written notes should be free from any jargon, derogatory remarks, inappropriate phrases, irrelevant speculation, offensive subjective statements or witticisms.

7.1.2 Notes should be written in terms that the women can understand, in so far as is possible.

7.1.3 Written notes should be written frequently enough to give a picture of the woman's/baby's progress or condition and care, and to ensure that up-to-date information is available to health professionals.

7.2 All written notes are clear and legible.

7.2.1 It is the Self-Employed Community Midwives' responsibility to ensure that their writing in a record is clear and legible.

7.2.2 Handwriting that is difficult to read should be in print form. A black pen or biro should be used when documenting care to ensure that the record is permanent and facilitates photocopying if required.

7.3 All entries should be signed.

7.3.1 Self-Employed Community Midwives should sign entries using their name as entered in the NMBI Register of Nurses and Midwives, and the occupation of writer should be indicated, i.e. SECM.

7.3.2 The use of initials is not acceptable except on charts where there is a designated place to write a full signature and initials and thereafter initials are used, e.g. drug administration record.

7.4 All entries are clearly dated and timed using the 24-hour clock.

7.5 The time of requesting an ambulance or calling assistance in an emergency should always be recorded.

7.6 Entries in the records should be in chronological order.

7.6.1 Entries in a woman's or baby's chart should normally appear in the chronological order that events/care given occurred, and any variances from this need to be explained.

7.7 Documentation is carried out as soon as possible after providing midwifery care.

7.7.1 It should always be clear from the notes what time an event occurred and what time the record was written.

7.7.2 Late entries are acceptable provided they are clearly documented as such, e.g. 'Retrospective note relating to.....' date, time and sign.

7.7.3 Do not squeeze a late entry into existing notes or write in the margins.

7.7.4 A line should be drawn from the end of last sentence to signature.

7.8 Approved abbreviations should only be used.

7.8.1 Abbreviations should be kept to a minimum in a woman's/baby's notes. Only those approved for use by the HSE (2010) should be used in documenting care.

7.9 Accepted grading systems should only be used.

7.9.1 Urinalysis results (+++) are an example of an official grading system.

7.9.2 Upward and downward arrows to denote changes in heart rate or other vital signs should not be used.

7.10 Entries made in error should be bracketed and have a single line through them so that the original entry is still legible. Error should be written above it, and signed and dated by the SECM.

7.10.1 No attempt should be made to alter or erase an entry made in error. Erasure fluid (e.g. Tipp-Ex) should never be used.

7.11 An SECM making a referral or consulting with another member of the healthcare team should clearly identify, by name, the person in the chart.

7.11.1 'Seen by doctor' or 'doctor informed' is not acceptable.

7.11.2 Information or advice given over the telephone should be recorded by the SECM who took the call, and the person giving the advice should be clearly identified.

7.12 All decisions to take no immediate action but review later should be clearly documented.

7.12.1 Continuous assessment/monitoring and evaluation of a woman's condition is a legitimate midwifery intervention and it requires documentation within the record, particularly in changing circumstances.

7.13 Whilst it is not necessary that written consent be obtained for most midwifery care, some procedures do carry significant risks. An explanation of such procedures should be documented in the woman's notes and agreement of the woman to the procedure should be documented.

7.14 Any information, instruction or advice given, including discharge plan, advice or follow-up should be documented.

7.14.1 Patient education is a legitimate midwifery intervention and should be recorded as such.

7.15 Three handwritten forms of identification, e.g. name, date of birth and address, should be on every page of the record.

7.16 Specific vaginal examination (VE) stickers/labels are available in the Home Birth Service and should be used at all times to ensure standardised and accurate completion of all details required.

7.17 SECMs should not document care on behalf of someone else.

7.17.1 If this becomes necessary, e.g. if an SECM contacts the DMO after submitting midwifery notes to the designated midwifery officer and reports that she/he has forgotten to document care, then this should be clear from the record OR if a second SECM is allocated to scribe events in an emergency situation.

7.17.2 The SECM is still responsible for signing for drugs/fluids administered by her/him in the care of a woman in an emergency.

7.18 All written information relating to a woman/baby should be kept in a designated area with a view to forming a complete single file or chart. The confidentiality of the woman's/baby's notes should be safeguarded.

7.18.1 Confidentiality concerning the woman's records is an expression of the trust inherent in midwifery practice.

7.18.2 Ethical and legal considerations inform professional decision making related to the record management and the sharing of information.

7.18.3 The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (2014) states that '*Your role in safeguarding confidentiality extends to all forms of record management including appropriate use of information technology and social media.'*

7.19 Detailed documentation in relation to incidents/near misses should be made – refer to NIMS/Safety Incident Management Policy.

8. Monitoring and Audit

8.1 Monitoring of compliance with this guideline shall be undertaken by the DMO.

8.2 Audit of compliance with this guideline shall be undertaken by HSE professionals.

9. Training

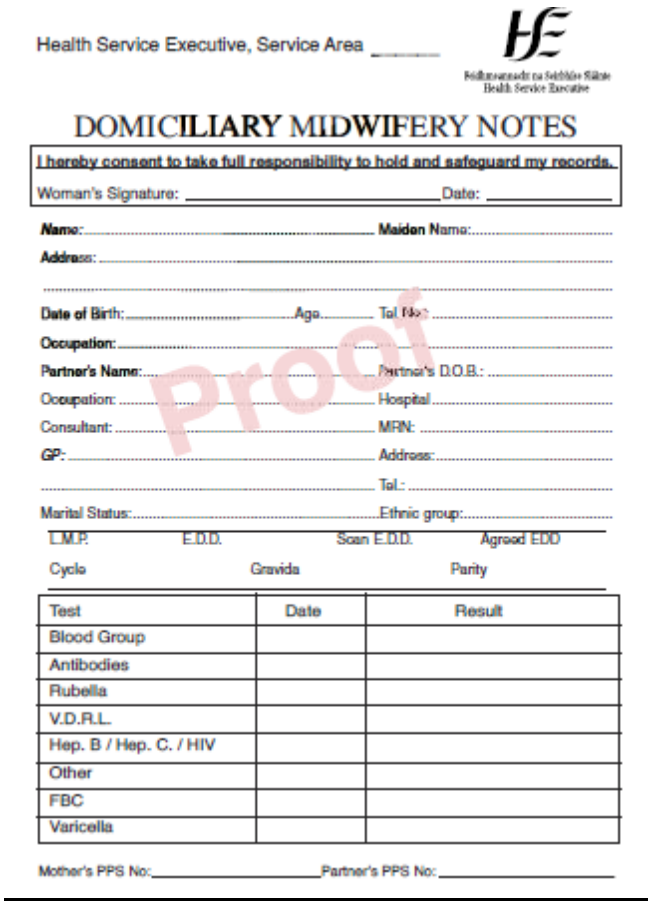
The SECM shall ensure that she/he has sourced appropriate education and training to support the implementation of this guideline.

10. Implementation Plan

The Clinical Governance Group for the HSE Home Birth Service developed this document, which has been approved for implementation by the National Implementation Steering Group for the HSE Home Birth Service. This document will be piloted for a year from the approval date. It will be disseminated by the Designated Midwifery Officers to relevant healthcare personnel and to all SECM who provide home birth services on behalf of the HSE.

11. Appendix I

HSE Home Birth Service Domiciliary Midwifery Record Template: Available on the HSE Home Birth Service Webpage



Health Service Executive, Service Area _____

Seirbhísí Sláinte na Feidhme Sláinte
Health Service Executive

DOMICILIARY MIDWIFERY NOTES

I hereby consent to take full responsibility to hold and safeguard my records.

Woman's Signature: _____ Date: _____

Name: ..... **Maiden Name:** .....

Address: .....

.....

Date of Birth: ..... Age..... Tel No: .....

Occupation: .....

Partner's Name: ..... Partner's D.O.B.: .....

Occupation: ..... Hospital .....

Consultant: ..... MRN: .....

GP: ..... Address: .....

..... Tel.: .....

Marital Status: ..... Ethnic group: .....

L.M.P. E.D.D. Scan E.D.D. Agreed EDD

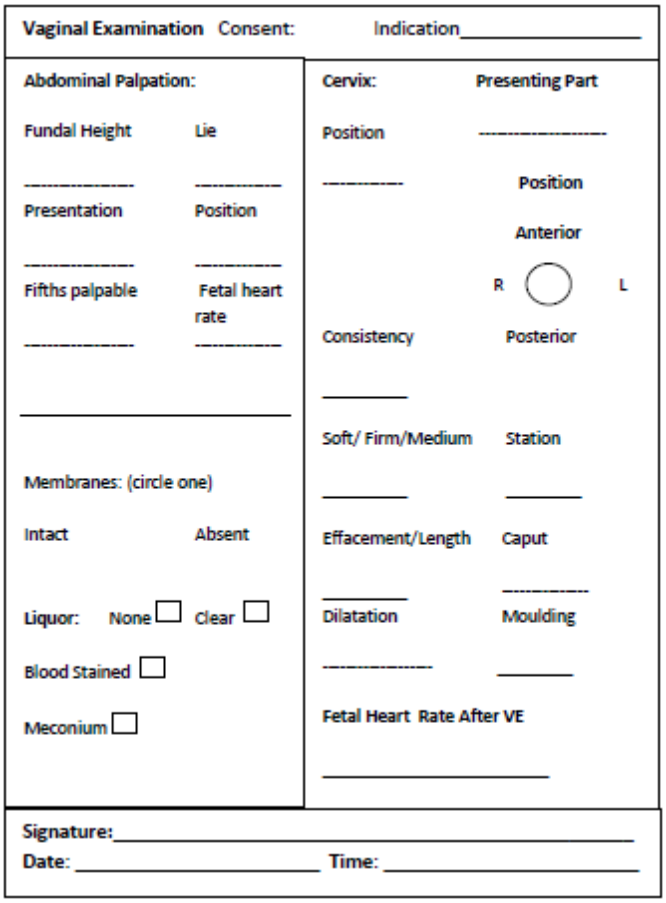
Cycle Gravida Parity

Test	Date	Result
Blood Group		
Antibodies		
Rubella		
V.D.R.L.		
Hep. B / Hep. C. / HIV		
Other		
FBC		
Varicella		

Mother's PPS No:_____ Partner's PPS No: _____

12. Appendix II

Vaginal Examination Record Template



13. Signature Page

I have read, understand and agree to adhere to the attached document:

_____

Print Name	Signature	Area of Work	Date