Maternity Hand Held Notes, Hospital Records and Record keeping

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1. Statement of basic record keeping requirements

All women carry their own maternity notes throughout the antenatal and postnatal period. These notes form the only copy therefore any reports (e.g.; blood results, USS reports) and any other additional documentation **must** be securely attached.

All entries must be legible, written in dark, preferably black, ink (as a minimum must be able to photocopy records) and have the **date and time** together with **signature and printed name** (printed name at least once for every shift) or be recorded on signature bank for each set of records. In addition, all student entries must be countersigned.

Every episode of care must be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals. All management plans must be reviewed and updated when appropriate.
All pages should include patient identifies such as name and hospital numbers, as a minimum requirement, this included any documentation added into the hand held notes.

2. At Booking

Pregnancy notes are commenced at the 'booking' interview by the community midwife from that point the notes should remain with the woman for the duration of her pregnancy.

3. Antenatal

Women are asked to bring their pregnancy notes to all subsequent antenatal appointments, both in the hospital and community setting, All results for antenatal screening and ultrasound reports must be recorded and secured in the notes. The clinician who requested / performed the procedure is responsible for ensuring the results are available in the patient healthcare record. Individualised fundal height charts should be present and fundal height measurements recorded as appropriate in all singleton pregnancies.

Women who move to Plymouth having received maternity care elsewhere will need a set of Perinatal Institute notes. All relevant information must be entered into the notes. Transfer of information may take place from one set of notes to the other where original lab reports are present, with the exception of blood group which has to be repeated.
If original reports are not available then all tests must be repeated. In addition, the UHP Antenatal Screening transfer in results form should be completed and sent to the Antenatal Screening office (See Appendix 2).

If a woman is transferred from Plymouth to another area for a clinical reason, the UHP notes should be photocopied and the originals retained in the hospital folder.

If a woman moves away from Plymouth during her pregnancy, the midwife should inform the Community Admin Clerk who will remove her hospital folder from Maternity Reception and return them to Medical Records. The woman may take a photocopy of her handheld notes with her to facilitate booking in another area. Her original hand held notes should be retained. A computerised note should be made on IPM to recognise that the woman has moved and her new locality. If there are any safeguarding issues then the safeguarding team need to be informed.

4. Intrapartum

All care in labour, including women with fetal loss must be clearly handwritten in the birth notes (yellow section) of the maternity record. When in established labour the partogram is commenced. At the end of labour and delivery, the Protos record of delivery must be

completed accurately and secured in the patient notes. The Birth Register must also be filled in correctly.

5. Postnatal

The Mother & Baby postnatal notes must be commenced following delivery. If mum requires postnatal care in the Enhanced Observation room, then continue documentation in the yellow notes.
Safeguarding documentation must be transferred from the mother's hospital record to the baby's, placed behind the safeguarding chapter card.

On transfer to the community, after delivery, the maternal and infant postnatal care plans and MOEWS chart are taken home, together with a Protos generated summary of their intrapartum care.

Following discharge from hospital, all hospital folders and notes must be sent for coding then forwarded to Medical Records.

6. Documentation of lead professional

The lead professional must be recorded on the front of the pregnancy, birth and postnatal notes. If there is any change at any stage of care this must be re-coded in the designated area on the front of the notes together with the named professional and reason for change. Reception should be notified of any change in order to update iPMs (patient information system).

7. Return of notes and care plans at end of postnatal period

When community midwifery care is completed and care is transferred to the Health Visitor the maternal and infant care plans, including the green antenatal summary and postnatal triage form will be returned to the Community Office, Level 5 Maternity Unit. The Health Visitor discharge form must also be completed by the discharging midwife and left in the patient's house with the red child health record.

8. Additional information

CTG storage:
All CTGs must be filed in the brown CTG envelope, clearly labelled and each CTG documented by date and time and if antenatal or intrapartum.

- This then becomes part of the hand held notes.

9. Abbreviations

The use of abbreviations should be kept to a minimum, where abbreviations are used; these should be restricted to the approved list of abbreviations as listed in appendix 1.

10. Record keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All entries must have the **date and time** together with **signature and printed name.**

Appendix 1: Accepted abbreviations

Abdominal circumference	AC	Expressed breast milk	EBM
Abdominal palpation	AP	External cephalic version	ECV
Amniocentesis	Amnio	Femur length	FL
Amniotic fluid index	AFI	Fetal blood sampling	FBS
Antenatal	A/N	Fetal heart	FH
Antenatal clinic	ANC	Fetal heart heard and regular	FHHR
Antepartum haemorrhage	APH	Fetal movements	FM
Antibiotics	Abx	Fetal movements felt	FMF
Artificial / bottle feeding	AF	Fetal scalp electrode	FSE
Artificial rupture of membranes	ARM	Full blood count	FBC
Asked to see patient	ATSP	Haemoglobin	Hb
Beats per minute	bpm	Head circumference	HC
Bi-parietal diameter	BPD	High vaginal swab	HVS
Birth weight	BW	Human immune deficiency virus	HIV
Blood pressure	BP	Induction of labour	IOL
Body mass index	BMI	Insulin dependent diabetes mellitus	IDDM
Born before arrival	BBA	Intramuscular	IM
Bowels not open	BNO	Left occipito-transverse	LOT
Bowels open	BO	Liver function test	LFT
Breastfeeding	BF	Intravenous	IV
Cardiotocograph	CTG	Intravenous infusion	IVI
Continuous electronic fetal monitoring	CEFM	Lower segment caesarean section	LSCS
Cephalic	Ceph	Low vaginal swab	LVS
Cervix	Cx	Left occipito-posterior	LOP
Central Delivery Suite	CDS	Left occipito-anterior	LOA
Chorionic villus sampling	CVS	Left occipito-lateral	LOL
		Gestational diabetes	GDM
Combined spinal epidural	CSE	Glucose tolerance test	GTT
Congenital heart disease	CHD	Gravida	G
Controlled cord traction	CCT	Group and save serum	G&S
Cross match	X-match or XM	Group B streptococcus	GBS
Cytomegalovirus	CMV	Manual Removal of Placenta	MROP
Date of birth	DOB	Methicillin resistant staphylococcus aureus	MRSA
Day Assessment Unit	DAU	Mid stream specimen of urine	MSU
Deep vein thrombosis	DVT	Modified obstetric early warning score	MOEWS
Dichorionic diamniotic	DCDA	Monochorionic diamniotic	MCDA
Did not attend	DNA	Neville Barnes forceps delivery	NBFD
Discussed with	D/W	No abnormality detected	NAD
Early pregnancy unit	EPU	Not in established labour	NIEL
Elective lower segment caesarean section	El LSCS	Normal delivery	ND
Electronic fetal monitoring	EFM	Not passed urine	NPU
Emergency lower segment caesarean section	Em LSCS	Occipito-anterior	OA
Electrocardiograph	ECG	Occipito-posterior	OP
Estimated blood loss	EBL	Occipito-tranverse	OT
Estimated date of delivery	EDD	On admission	O/A

On examination	O/E	**Prescription:**	
Oxygen	O_2	Once a day	OD
Oral glucose tolerance test	GTT	Twice a day	BD
		Three times a day	TDS
Per vaginum	PV	Four times a day	QDS
Postnatal	PN	Morning	Mané
Post partum haemorrhage	PPH	Night	Nocté
Pre eclampsia	PET	As required	PRN
Pregnancy induced hypertension	PIH	Medication to take out/away	TTO/TTA
Pre-labour rupture of membranes	PROM	Subcutaneous	SC
Preterm Pre-labour rupture of membranes	PPROM		
Protein/creatinine ratio	PCR		
Pulmonary embolism	PE	**STAFF:**	
Right occipito-anterior	ROA	Consultant	Cons
Right occipito-lateral	ROL	Specialist registrar	SpR
Right occipito-posterior	ROP	Specialty Trainee	ST
Right occipito-transverse	ROT	Registrar	Reg
Short of breath	SOB	Senior house officer	SHO
Spontaneous rupture of membranes	SROM	Midwife	MW
Spontaneous vaginal birth	SVB	Community midwife	CMW
Spontaneous vaginal delivery	SVD	Student midwife	St / Mw
Stillbirth	SB	Midwifery Care Assistant	MCA
Symphysis fundal height	SFH	Medical student	M / St
Symphysis pubis dysfunction	SPD		
Termination of pregnancy	TOP		
To come in	TCI		
Transcutaneous electrical nerve stimulation	TENS		
Transitional care ward	TCW		
Urinary tract infection	UTI		
Vaginal examination	VE		
Venous thrombo embolism	VTE		
Monochorionic monoamniotic	MCMA		

Monitoring and Audit

Auditable standards:

Were all records written in black ink, legible, dated and timed with signature and printed name?
Were there any unacceptable abbreviations?
Evidence of documented antenatal assessment, labour ward management plan, CTG recordings, operation details, anaesthetic deliveries (if appropriate) discharge arrangements in completed health records
Appropriate storage arrangements for: CTG, anaesthetic records including epidural, FBS results and cord gases, previous pregnancy records, antenatal screening results and USS reports.

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:

Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Clinical Governance & Risk Management Committee

Frequency of audit:

Annual

Responsible person:

Trust audit dept

Cross references

Clinical Records Keeping Policy – Derriford Hospital

Guideline development within the maternity services

References

NMC 2012. The Code: Professional standards and behaviour for nurses and midwives. NMC London.
NMC 2010 *Midwives rules and standards*. NMC London.

Author	Guideline Committee	
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