No.31 Maternity Hand Held Notes, Hospital Records and Record keeping

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.

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. The documentation of clinical care must record, as a minimum, the standards required in local and national guidelines, e.g. documented antenatal assessment, labour ward management plan, CTG recordings, operation details (if appropriate), anaesthetic deliveries (if appropriate) discharge arrangements in completed health records. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.
All notes / lab reports, etc. should be stored securely in the designated place within the handheld records or hospital folder. At the conclusion of the pregnancy and postnatal period the obstetric notes must be returned to the hospital notes and securely attached under obstetric chapter card in the appropriate place.

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. The hospital folders for all women booked to have their baby under the care of Plymouth Hospitals NHS Trust (PHNT) will be subsequently requested following ‘booking’ and traced to and stored in Maternity Reception. Women who do not have an existing PHNT folder will be issued with a new folder and hospital number. Patient Identification labels can be printed and attached to the hospital folder to facilitate easy identification of any loose documents.

3. Antenatal

Women are asked to bring their pregnancy notes to all subsequent antenatal appointments, both in the hospital and community setting, for completion by an appropriate professional e.g.; midwife, obstetrician, GP, physiotherapist, US sonographer, specialist midwife. 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 are advised to take their notes with them if they go on holiday or away for any length of time. If the woman forgets to bring her notes to an appointment, a loose-leaf record should be made of the visit using a continuation sheet or blank A/N appointment record. In hospital, this should be photocopied and one copy stored in the hospital folder and the other copy given to the woman to put with her notes. In the community, the original record should be given to the woman to be put in her notes.

Women who **move to Plymouth** having received maternity care elsewhere will need a set of PHNT 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 etc 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.

If a woman is **transferred from Plymouth** to another area for a clinical reason, the PHNT 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 must be clearly handwritten in the birth notes (yellow section) of the maternity record, with maternal observations (temperature, pulse, respiratory rate and oxygen saturation) recorded on the obstetric observations chart (MEOWs); When caring for the well woman in labour, the respiratory rate must be recorded and documented on the MEOWs chart (taking into consideration the patient's pain and activity). Oxygen saturation levels are not routinely required for the well patient. A full set of observations should be carried out when clinically indicated and in any situation where there is concern for maternal or fetal wellbeing
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 perinatal GROW audit form must be completed to obtain the newborn weight centile. The Birth Register must also be filled in correctly.

5. Postnatal

The Mother & Baby postnatal notes must be commenced following delivery. All care must be recorded in designated sections, with postnatal observations continued to be recorded on the MEOW chart. If mum requires postnatal care in HDU, then continue documentation in the yellow notes. If baby is admitted to NICU for any reason the main hospital notes are used to record care in chronological order. 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 MEOWS chart are taken home, together with a Protos (maternity

information system) generated summary of their intrapartum and in-patient postnatal 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 will be returned to the Community Office, Level 5 Maternity Unit. The community admin clerk will sort and collate notes and marry them up with the medical records folder before tracing and sending them to Medical Records.

8. Additional information

8.1 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.

- Blood gas results for FBS and cord gases must be labelled and secured to the labour notes (and baby record for cord gases).

8.2 Antenatal screening and ultrasound results

- antenatal screening and ultrasound results must be stored in designated areas in Maternity handheld notes.

8.3 Other records:

- Anaesthetic and surgical records must be securely fastened to the obstetric handheld notes.
- Combined obstetric records / handheld notes must be securely fastened in the hospital records (brown folder)
- Previous pregnancy notes must be stored in the main hospital brown folder under the appropriate section heading

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. In exceptional circumstances, abbreviations may be accepted if the full word/s are initially written in full i.e. continuous electronic fetal monitoring (CEFM).

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**	Congenital cystic adenomatoid malformation	CCAM
Abdominal palpation	AP	Cytomegalovirus	CMV
Advanced life support in obstetrics	ALSO	**Date of birth**	**DOB**
Alanine transaminase / alanine aminotransferase	ALT	Day Assessment Unit	DAU
Albumin	Alb	Decreased / reduced	↓
Amniocentesis	Amnio	Deep vein thrombosis	DVT
Amniotic fluid index	AFI	Department	Dept
Antenatal	A/N	Diagnosis	Δ / Dx
Antenatal clinic	ANC	Dichorionic diamniotic	DCDA
Antepartum haemorrhage	APH	Did not attend	DNA
Antibiotics	ABs	Discussed with	D/W
Alpha-feto-protein	AFP	Disseminated intravascular coagulation	DIC
Appropriate for gestational age	AGA	Ductus venosus	DV
Approximately	Approx	**Early pregnancy unit**	**EPU**
Artificial / bottle feeding	AF		
Artificial rupture of membranes	ARM	Elective lower segment caesarean section	El LSCS
Aspartate transaminase	AST	Electrocardiograph	ECG
Asked to see patient	ATSP	Electronic fetal monitoring	EFM
Beats per minute	**bpm**	Emergency lower segment caesarean section	Em LSCS
Before, during and after contraction	BDAC		
Bicarbonate	Bicarb / HCO3	Estimated blood loss	EBL
Bi-parietal diameter	BPD	Estimated date of delivery	EDD
Birth weight	BW	Evacuation of retained products of conception	ERPC
Blood pressure	BP	Examination under anaesthesia	EUA
Body mass index	BMI	Expected date of confinement	EDC
Born before arrival	BBA	Expressed breast milk	EBM
Bowels not open	BNO	External cephalic version	ECV
Bowels open	BO		
Breastfeeding	BF	**Fasting blood glucose**	**FBG**
Breech	Br	Femur length	FL
		Fetal blood sampling	FBS
Caesarean section	C/S	Fetal blood transfusion	FBT
Calcium	Ca	Fetal growth restriction	FGR
Cardiotocograph	CTG	Fetal heart	FH
Catheter specimen of urine	CSU	Fetal heart heard and regular	FHHR
Continuous electronic fetal monitoring	CEFM		
Centimetre	cm	Fetal movements	FM
Central venous pressure	CVP	Fetal movements felt	FMF
Cephalic	Ceph	Fetal scalp electrode	FSE
Cervical intra-epithelial neoplasia	CIN	Fetomaternal medicine	FMM
Cervix	Cx	Forceps delivery	FD
Central Delivery Suite	CDS	Full blood count	FBC
Chorionic villus sampling	CVS	**Gamma glutamyl transferase**	**GGT**
Clostridium difficile	C diff	General anaesthesia	GA
Combined spinal epidural	CSE	General practitioner	GP
Congenital dislocation of the hips	CDH	Genito-urinary medicine	GUM
		Gestational diabetes	GDM
Congenital heart disease	CHD	Glucose tolerance test	GTT
Controlled cord traction	CCT	Gram	g
C-reactive protein	CRP	Gravida	G

Cross match	X-match or XM	Group and save serum	G&S
Culture & sensitivity	C&S	Group B streptococcus	GBS
		Manual Removal of Placenta	MROP
Haemoglobin	Hb	Monochorionic diamniotic	MCDA
Head circumference	HC	Monochorionic monoamniotic	MCMA
High dependency unit	HDU	Multicystic dysplastic kidney	MCDK
High vaginal swab	HVS	Multiples of the median (with reference to AFP results)	MoM
History of	H.O / Hx	**Negative**	**NEG/-ve**
Hour(s)	hr	Neonatal death	NND
Human immune deficiency virus	HIV	Neonatal intensive care unit	NNICU
		Neville Barnes forceps delivery	NBFD
Idiopathic thrombocytopenic purpura	ITP	Nitrous oxide & oxygen(entonox)	N_2O & O_2
Immediately	STAT	No abnormality detected	NAD
		Not in established labour	NIEL
Increased / raised	↑	Neural tube defect	NTD
Induction of labour	IOL	Normal	Ⓝ
		Normal delivery	ND
Insulin dependent diabetes mellitus	IDDM	Not passed meconium	NPMec
Intensive care unit	ICU	Not passed urine	NPU
Intermittent positive pressure ventilation	IPPV	Nuchal translucency	NT
Interventional Radiology	IR	Nursery Nurse	NN
Intramuscular	IM		
Intra-uterine contraceptive device	IUCD	**Observations**	**obs**
Intra-uterine fetal death	IUFD	Obsessive compulsive disorder	OCD
Intra-uterine growth restriction	IUGR	Occipito-anterior	OA
Intravenous	IV	Occipito-posterior	OP
Intravenous infusion	IVI	Occipito-tranverse	OT
Investigations	Ix	On admission	O/A
Invitro fertilization	IVF	On examination	O/E
Intrauterine transfusion	IUT	Oral glucose tolerance test	OGTT
Kiellands forceps delivery	KFD or KRFD	Out patients appointment	OPA
Kilogram	kg	Out patients department	OPD
		Oxygen	O_2
Large for gestational age	LGA		
Last menstrual period	LMP	**Parity**	**P/para**
Left occipito-anterior	LOA	Passed meconium	PMec
Left occipito-lateral	LOL	Passed urine	PU
Left occipito-posterior	LOP	Past medical history	PMH
Left occipito-transverse	LOT	Past obstetric history	POH
Left sacro-anterior	LSA	Pelvic girdle pain	PGP
Left sacro-lateral	LSL	Pelvi-ureteric junction	PUJ
Left sacro-posterior	LSP	Per rectum	pr
Left sacro transverse	LST	Persistant occipito-posterior	POP
Litre	L	Per vaginum	pv
Liver function test	LFT	Platelets	Plt
Lower segment caesarean section	LSCS	Positive	+ve
Low vaginal swab	LVS	Postnatal	PN
Manual removal of placenta	**MROP**	Post partum haemorrhage	PPH
		Post partum sterilisation	PPS
Mean cell haemaglobin	MCH	Potassium	K
Mean cellular volume	MCV	Pre eclampsia	PET
Meconium	mec	Pregnancy induced hypertension	PIH
Methicillin resistant staphylococcus aureus	MRSA	Pre-labour rupture of membranes	PROM
Metre	m	Presenting part	PP
Middle cerebral artery	MCA	Preterm Pre-labour rupture of	PPROM

		membranes	
Mid stream specimen of urine	MSU	Protein/creatinine ratio	PCR
Milligram	mg	Pulsatility index	PI
Minutes	min	Pulmonary embolism	PE
Modified obstetric early warning score	MOEWS		
Random blood sugar	**RBS**	**Staff**	
Respirations	resps	Consultant	Cons
Rhesus factor	RhD	Specialist registrar	SpR
		Specialty Trainee	ST
Right occipito-anterior	ROA	Registrar	Reg
Right occipito-lateral	ROL	Senior house officer	SHO
		Foundation year doctor	FY
Right occipito-posterior	ROP	Doctor	Dr
Right occipito-transverse	ROT	Midwife	MW
Right sacro-anterior	RSA	Community midwife	CMW
Right sacro-lateral	RSL	Student midwife	St / Mw
Right sacro-posterior	RSP	Medical student	M / St
Right sacro-transverse	RST		
Serum bilirubin	SBR	Midwifery Care Assistant	MCA
Sexually transmitted infection	STI	Social worker	SW
Small for gestational age	SGA	Senior Registrar	SR
Sodium	Na	Prescribing instructions	
		Once a day	OD
Seen by	S/B	Twice a day	BD
Serum alphafetoprotein	SAFP	Three times a day	TDS
Short of breath	SOB	Four times a day	QDS
Spontaneous rupture of membranes	SROM	Morning	Mané
Spontaneous vaginal birth	SVB	Night	Nocté
Spontaneous vaginal delivery	SVD	As required	PRN
Stillbirth	SB	Medication to take out/away	TTO/TTA
Subcutaneous	SC		
Sudden Infant Death Syndrome	SIDS		
Symphysis fundal height	SFH		
Symphysis pubis dysfunction	SPD		
Temperature	T/temp		
Termination of pregnancy	TOP		
To come in	TCI		
To keep vein open	TKVO		
Toxoplasmosis, rubella, cytomegalovirus, herpes	TORCH		
Transcutaneous electrical nerve stimulation	TENS		
Transitional care	TC		
Treatment	Rx		
Ultrasound scan	**USS**		
Upper respiratory tract infection	URTI		
Urea and electrolytes	U&E		
Urinary tract infection	UTI		
Vaginal examination	VE		
Venous blood	VB		
Venous thrombo embolism	VTE		
Vitamin K	Vit K		
Von Willebrand's Disease	VWD		
Water	H_2O		
Week on service	WOS		
Well contracted	W/C		
White cell count	WCC		

Auditable standards

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

Antenatal Guideline 44 – 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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