New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

A Keteparaha/Toolkit

Supporting and enhancing effective midwifery record keeping in Aotearoa.

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Table of Contents

Introduction to the keteparaha 4

1. Background 4

1.1 Reasonable record keeping 6

1.2 Components of a maternity health care record 6

1.3 Regulatory, professional and cultural expectations 7

1.4 The pathway to using Te Reo Māori in health care records 7

2. Legal frameworks for record keeping 8

2.1 Legal considerations for record keeping 8

2.2 Sharing notes with the wahine 9

2.3 Storage of health care records (paper) 9

2.4 Time period to keep health care records 9

2.5 Lost health care records 10

2.6 Midwife stopping practice 10

3. Working with digital technology 10

3.1 Working with digital health care records 10

3.2 Protection of digital health care records 11

3.3 Management of phone calls or texts 11

3.4 Management of photographs 12

4. Confidentiality 12

4.1 Maintaining confidentiality 12

4.2 Sharing information with other agencies 12

4.3 Documenting sensitive information 12

5. Decision making and informed consent 12

5.1 Decision making for the midwife 13

5.2 Recording decision making 13

5.3 Recording informed consent from the woman 14

5.4 Recording decisions when the wahine declines recommendations for care 15

6. Guiding principles for documentation 16

6.1 Professional style of writing 16

6.2 Referral 16

6.3 Transfer of care 16

7. Clinical considerations for documentation 17

7.1 Assessments, investigations, and results 17

7.2 Interpretation of the 'sticker' 17

7.3 Pēpe wellbeing 17

7.4 Retrospective documentation 17

8. Professional considerations for record keeping 18

8.1 Locum work and health care records....18
8.2 Change of care provider....18
8.3 Working with student midwives....18
8.4 Professional development....18
9. Bibliography....19
10. Appendix....21
Guiding principles for documentation....21
Midwifery Self-Audit Tool....22

List of figures

Figure 1: Primary purpose of the maternity record.... 5
Figure 2. Legalisation Frameworks to be considered in keeping health care records 8
Figure 3. Considerations when introducing electronic record keeping 11
Figure 4. The decision-making process 13
Figure 5. When wahine declines recommendations for care 15

List of tables

Table 1: Components of maternity record 6
Table 2. Professional and regulatory frameworks to support record keeping....7
Table 3. Aspects of decision-making 14

The picture on the front page has been used in the *Dotting the I's and crossing the T's* workshops. It represents finding the balance in documentation.

The College would like to acknowledge the support and guidance from Nicole Pihema, President, Crete Cherrington, Kuia and Carla Humphrey, Legal Advisor College of Midwives in the development of this keteparaha.

Introduction to the keteparaha

This keteparaha/toolkit considers the purpose of a maternity heath care record and incorporates the professional and legislative aspects of creating and maintaining such a record. It has strategies and tips to support midwives in practice whilst meeting the obligations of the needs of the wahine/woman, her pēpe/baby and her wider whanau/family relating to health care records. It also offers a framework for midwives to consider enhancing record keeping whilst tackling the sometimes daunting challenges in the 21st century.

In 2005 the New Zealand College of Midwives (the College) designed a workshop titled *Dotting the I's and Crossing the T's: Midwives and record keeping*. This proved to be a popular workshop and over the years has evolved as midwives seek greater clarification on maintaining health care records. It has become evident through these workshops that the recording of midwifery care has become more complex. Therefore, the College has created this keteparaha in order to share these processes more broadly with the whole profession. The content is based on the voices and questions of midwives who have attended the workshops over the years. This is not intended to be definitive but rather a living document that reflects practice. This means it will be reviewed regularly and updated when indicated.

This keteparaha reveals processes which enable midwives to reconsider the impact of the vast array of documentation tools. It also discusses how the midwife can balance the ratio of care provided compared with the amount of documentation expected to support evidence practice. The development of this keteparaha is a strategic action towards supporting midwives to record the holistic nature of midwifery care. It acknowledges the unique model of midwifery care in Aotearoa New Zealand and its application to maintain health care records.

This keteparaha embraces Te Tiriti o Waitangi (Treaty of Waitangi) and recognises and respects the articles of Te Tiriti (https://teara.govt.nz/en/treaty-of-waitangi). In relation to maintaining a health care record the keteparaha acknowledges both written and spoken language. Te Reo Māori is an official language of Aotearoa New Zealand along with New Zealand Sign Language (Māori Language Act 1987 and the New Zealand Sign Language Act 2006). The midwifery profession recognises that English is the common language used in current health care services, however, acknowledges the inclusion of Te Reo Māori in maternity health care records to support equity. As such, a small number of well-known te reo has been used throughout. These include wahine (woman), wāhine (women), pēpe (baby) and whānau (family).

1. Background

Most of the 'expected' aspects that constitute midwifery health care records have morphed from nursing and medicine, and from international sources. The College suggest that whilst reading this keteparaha midwives practising in Aotearoa New Zealand explore and consider what the profession's understanding of 'reasonable practice' entails. The College believe that it is unrealistic to record every single aspect of care. However, it remains important that midwives use their professional judgment about what is relevant and what is considered as reasonable by their peers.

The maternity health care records are amongst the most sensitive of personal records and great care should be taken to ensure the safe holding of such records. Apart from their sensitive nature, there is also the very practical consideration that they are of considerable clinical value in relation to the ongoing care of the wahine and her pēpe. Figure 1 shows the primary purpose of the maternity record.

Figure 1: Primary purpose of the maternity health care record

Together these contribute to the overall quality of care. The College believe that maintaining an accurate clinical health care record is a fundamental part of midwifery practice in Aotearoa New Zealand and that this enhances the provision of wāhine and whanau-centred care.

Months or years elapse between maternity experiences for wāhine. As such, health care providers may change. Therefore, the health care records serve as a record of events to enable communication of the care provided previously for both the wahine and the midwife.

The College acknowledge that aspects of record keeping appear to be in a constant state of flux with new tools being designed and implemented regularly. The main purposes of such tools of record keeping are to enhance care. However, in today's world of midwifery care the College believe some tools do not offer the reassurance they set out to provide. For example, a 'tick box' only focus may inhibit the interpretation of assessments which underpin midwifery care. The College believe this has the potential to reduce a holistic approach to care and record keeping. *This keteparaha seeks to ensure safe documentation is achieved while also enhancing care.*

Anecdotal evidence from practice suggests that midwives are concerned that the balance between care and maintaining documentation is shifting, with the focus on documentation rather than the care provided. For example, audits of record keeping do not consider the wahine's experience and has become more task orientated. This apparent focus on a risk based approach rather than a holistic record of care has the potential for women to become invisible in their care record. The College is concerned that this will take midwives away from care provided to wāhine and create a further risk-based approach to care. *This keteparaha seeks to redress the balance*.

In the development of this keteparaha the College recognise the impact of technology as a variety of electronic forms of maternity care records are introduced. While it is recognised that electronic health care records are the way of the future, the design and implementation of such tools need to consider the professional responsibilities for record keeping. *This keteparaha offers guidance as midwives navigate the use of electronic records.*

1.1 Reasonable record keeping

There is little evidence to support the 'suggested' information expected to be written in notes. Rather, it is based on interpretation and expectations. These can vary from peer to peer, from professional group to group, and from organisation to organisation. Much of the current suggested components of record keeping are based on experience and are almost always viewed retrospectively, particularly in legal cases. It is vital in today's world of midwifery practice that both context and the 'practice of the day' that the care was provided, be considered.

The College believe that record keeping should be based on the principle of what is reasonable and that the requirements for reasonable record keeping should be defined by the professional group that the health care provider belongs to. The concept of reasonable health care underpins the Code of Health and Disability Services Consumers' Rights.

Reasonable is described as showing reason or sound judgement, something that is sensible and fair.
A reasonable decision is described as rational and thought out.

Therefore, the College believe the standard of reasonable record keeping is that which a reasonable midwife would undertake in similar circumstances.

1.2 Components of a maternity health care record

For the purpose of this keteparaha it is important to clarify what constitutes a maternity health care record in today's world of maternity care. Midwives have always maintained records of births they have attended. Historical records enable a fascinating glimpse of practice and continue to provide the wahine with a story of her pregnancy and validate her memory. They also provide midwives with the opportunity to reflect on their practice.

A health care record is a record of an identified individual's health and the health care they received. It may be in a single file, multiple files, hard copy (paper based) or electronic (digital, video etc.) format, and held by an organisation, service provider or the consumer themselves (MOH 2002). The maternity health care record can comprise of but is not limited to, midwifery clinical notes, assessment tools, records of tests and investigations and care plans. Table 1 shows the components that may be included in a maternity health care record.

Table 1: Components of maternity health care record

A maternity health care record includes components such as:	
assessments and clinical findings	care decisions and rationale
discussions of care and information shared with the wahine	administrative aspects such as a record of date and time
discussions & consultations with the wahine and health professionals including care plans	any referrals plus name and designation of health professionals consulted and/or referred to
evidence of informed choice and consent	any medication or treatment prescribed
(Adapted from Midwifery Council documentation and record keeping, 2018)	

1.3 Regulatory, professional and cultural expectations

Reference to record keeping is inherently linked between both the Standards of Practice and the Competencies. However, currently there are no 'exact components' expected of the profession.

Midwives are accountable for their practice and this includes record keeping. Accountability underpins professional midwifery practice. The rationale for decision making must be considered in the context of legislation, professional guidelines, and evidence-based practice whilst always including the wahine. Good record keeping and record management therefore underpins professional practice. The Competencies and Scope of Practice and midwifery Standards guide and support midwifery practice in relation to maternity record keeping. Turanga Kaupapa are guidelines on the cultural values of Māori and provide cultural guidelines for midwifery practice to ensure that cultural requirements are met for Māori during pregnancy and childbirth. Table 2 shows how record keeping is embedded in regulatory, professional and cultural frameworks.

Table 2. Regulatory, professional and cultural frameworks to support record keeping.

Midwifery Council Te Tatau o te Whare Kahu The Midwifery Council as the regulatory body for midwives upholds expected competencies and details the skills, knowledge and attitudes of a midwife to work within the Midwifery Scope of Practice (MCNZ, 2010).	Competency Two states: "the midwife provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided" (Competencies for Entry to the Register of Midwives)
New Zealand College of Midwives The College, as the professional organisation sets the standards of the profession for everyday practice expectations. Its standards refer to midwives maintaining purposeful and updated health care records which keep the woman at the centre of care (New Zealand College of Midwives, 2015).	Standard Four states: "The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons" (Standards of Practice)
NGĀ MAIA Turanga Kaupapa are integrated in the Standards for Practice and Competencies for entry to the register.	The principles provide cultural guidance for midwives to ensure cultural needs are met for Māori throughout pregnancy and childbirth. These principles should also guide record keeping and reflect culturally appropriate care.

1.4 The pathway to using Te Reo Māori in health care records

Midwives are encouraged to use or consider how they can incorporate Te Reo Māori within their documentation. Use of te reo seeks to recognise and support a Māori world view of birthing, particularly where te reo is the chosen language of the wahine and her whānau. Everyday use fosters te reo as the language of Aotearoa New Zealand. Language is important to explain, to express how one is feeling, and to describe how we understand and experience the world we live in. We are all on our own journey with te reo; for some this might be an everyday language, while for others it may be a conscious effort. Regardless, the use of te reo is undertaken in collaboration with wahine and whānau, respecting their worldview.

Considerations to support using te reo Māori within the maternity health care record may include:

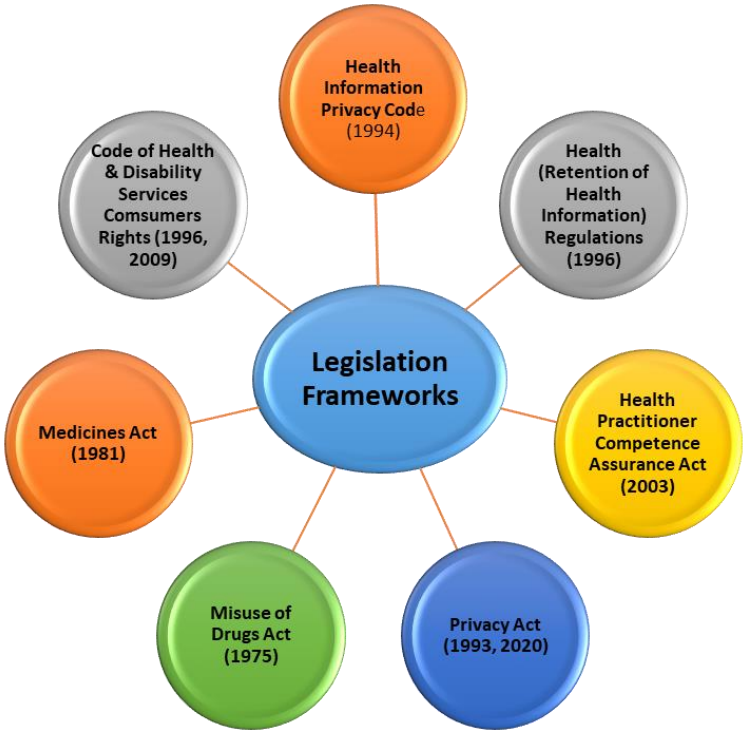
- It is reasonable for midwives to use te reo when caring for wāhine. We acknowledge that midwives and wāhine will have different levels of understanding of te reo.

- The College acknowledge the health care record is a form of communication. However, where other health providers or the wahine do not understand te reo, this needs to be considered by the midwife to ensure seamless communication. This contributes to quality and equitable care.
- When the health care record uses comprehensive te reo then inclusion of an English translation in the record needs be considered. This is to ensure that all providers of care and wahine are aware of all discussions, decisions and care provided. This strategy supports effective continuity of care between midwives and other providers and therefore supports wāhine-centred care.

2. Legal frameworks for record keeping

There are many different Acts of Parliament and Secondary Legislation that support record keeping. Figure 2 shows the relevant Acts and laws that need to be considered in keeping health care records.

Figure 2. Legislation frameworks to be considered in keeping health care records



2.1 Legal considerations for record keeping

A health care record is a not regarded as a 'legal' document. There are legal requirements relating to such things as storage and confidentiality. However, it could be argued that a health record only becomes truly 'legal' when a lawyer becomes involved. The rise in medico-legal cases within health care suggests that health records are scrutinised under many different lenses (e.g. ACC, HDC). Further, anecdotally it has been suggested that a 'gold standard' of record keeping must be obtained by midwives. The College consider this is an aspirational expectation. The College believe that midwives should meet a standard of record keeping that is reasonable and recognises that record keeping that is not reasonable could lead to a wahine and her pēpe care being adversely affected.

The Privacy Act (2020) includes a number of privacy protections for individuals and organisations which need to be considered with record keeping. These include mandatory notification of certain privacy breaches; for example, other people have accessed the health care record without permission. The other relevant principle is that information can only be collected if it is needed. This means that information is documented that is relevant to care of the wahine. If you have any concerns please call the legal advisor for guidance.

The Health Information Privacy Code 2020 has 13 rules regarding the health information of identifiable individuals. The code recognises that people expect their health information:

- to be kept **confidential**, because it was probably collected in a situation of confidence and trust
- to be treated as **sensitive**, because it may include details about body, lifestyle, emotions and behaviour
- may have **ongoing use** if a piece of medical information becomes clinically relevant even a long time after it was initially collected
- will be **used for the purposes** for which it was originally collected, and they will be told about those purposes.

2.2 Sharing notes with the wahine

The wahine is entitled to have a copy of her health care record because that information concerns her. Wāhine may hold their own notes through their pregnancy journey. This is negotiated between the wahine and the midwife at the start of her care and revisited during her care. This may be a copy of all of her record or some of them. It is recommended that wāhine have access to their notes at all times if requested. The original record should be retained by the midwife.

People may wonder who owns their health information. However, ownership isn't necessarily the best way to think about health information. It is more accurate to say that people have **rights** over health information about themselves. Individuals have the right to access information about themselves and to seek correction of that information if they think it is inaccurate or misleading (Health Information Privacy Code 1994).

The wahine may request a copy of her and/or her pēpe's health care record relating to care provided by the relevant District Health Board (DHB).

2.3 Storage of health care records (paper)

The Health Information Privacy Code is 'technology neutral' and regards health information the same, regardless of its format. The midwife should do everything reasonably possible to ensure that there are reasonable safeguards in place to prevent loss, misuse, or disclosure of health information. This applies to health care records while in use for each episode of care and upon completion of care for all areas of midwifery practise.

Health care records should not be stored in areas which can be easily accessed by 'non-care' providers. For example, workspaces open to public view in hospital settings. Community-based midwives need to consider storage of records while in their cars. Ideally all records should be kept out of sight, perhaps in the boot of the car in a secure box.

Upon completion of care, records stored by community-based midwives should be protected by high quality security e.g. a locked cupboard. Health care records in long term storage need to be accessible to the midwife within a short timeframe should she require access. Health agencies such as DHB are required to keep health information safe from loss, unauthorised access, use, modification or disclosure.

2.4 Time period to keep health care records

Legislation requires that health agencies (the midwife):

- must keep health care records for 10 years from the last time the midwife provided care (Retention of Health Information). This information includes the woman and her baby's notes as well as the midwife's **diaries and phone logs** where records of calls and advice given by phone should be kept. The last date of care should be documented in the health record.
- should **not** keep medical information for any longer than they have a lawful purpose for using that information (Health Information Privacy Code). This means that records should be confidentially disposed of at 10 years unless you have a reason to retain them. You **may** keep the record after ten years if it is desirable for providing health and disability services to the client.
- longer periods may apply for records held by District Health Boards (DHB)

This time period still applies if the midwife has transferred the files to a new healthcare provider or if they have given a copy of the complete file to the client (or, if the client has died, to the client's executor). Midwives need to be aware of this and ensure that mechanisms are in place for such events.

All records must be destroyed in a way that preserves the privacy of the individual. You can use a document destruction company to securely destroy the records. Shredding or burning records is also acceptable.

It is not necessary to offer the health care record back to the client at ten years.

2.5 Lost health care records

Occasionally health care records are misplaced, lost, or accidently destroyed by either the wahine or the midwife. This can occur with both paper and electronic records and midwives need to consider strategies to minimise this occurring. Immediate action by the midwife is paramount as confidentiality is the key concern for wāhine and their babies.

When a copy of the health care record is provided to the wahine it is reasonable to record this in the body of the record. Should the wahine lose her copy of the record, midwives are encouraged to record this in the body of the health care record.

In the event of any records being lost midwives are advised to contact the legal advisor at the College who can provide guidance, as each situation is unique. There are legal protocols, including the Health Information Privacy Code (Rule 6) to follow in this situation to mitigate any risk.

2.6 Midwife stopping practice

When entering community practice the midwife should consider who will take responsibility for the health care records when they cease practice. It is recommended that the midwife includes who will take responsibility for their health records and include this information in their will. When a midwife ceases practice, they may:

- store their own records
- negotiate for the records to be held by the midwifery practice. This may be appropriate when practice has been shared.
- return the record to the wahine if this is practical

All records need to be stored securely.

In the event of the midwife dying, their instructions for management of health care records should be followed as laid out in their will or agreed within the midwifery practice.

In the event of the midwife dying without a will, a family representative/administrator should negotiate with the midwife's practice/partner for the management of the records.

3. Working with digital technology

Digital technology refers to electronic tools, systems, devices, and resources that generate, store or process data. Well known examples include smartphones, mobile apps, computers, and social media. Technology is everywhere and is continually evolving. The College acknowledge that technology can streamline the midwife's documentation process. If there are digital barriers to the wahine receiving a copy of her health care record, midwives may offer an alternative such as a paper print out.

3.1 Working with digital health care records

The principles of digital health care records remain the same as hard copy records. Many midwives use information technology to document the planning, assessment, and delivery of care. The principles underlying documentation, access, storage, retrieval, and transmission of information are the same for digital health care records as for a paper-based system. Each electronic login provides a time signature for the information that is entered into the health care record. This also provides an audit trail for every entry. Figure 3 shows the considerations when introducing electronic forms of record keeping.

Figure 3. Considerations when introducing and using digital/electronic record keeping

Strategies to support the use of electronic documentation include:

- Use narrative entries to demonstrate your decision making and interpretation of data, for example to interpret the data entered into tick boxes
- Use autofill/snippets cautiously ensuring they are relevant and personalised to the wahine
- Keep your care wahine-centred, rather than device-centred
- Enable the wahine to share with you before you start recording information
- Consider how you can improve your use of the device and system, for example typing skills

3.2 Protection of digital health care records

There are specific considerations when considering security of health information stored electronically. Digital security includes both secure storage (including anti-virus and firewall, back-up and password protection) and secure transmission (secure internet connection, secure email address, use of encryption). Midwives are encouraged to check their IT provider meets this expectation.

Midwives are reminded that their electronic login is a digital signature. When logins are shared the owner is vulnerable to claims of a breach of confidentiality and confusion about the identity of who made the entry. It is reasonable that each midwife has their own digital login. This includes those providing back up services.

3.3 Management of phone calls or texts

Caring for the wahine and her pēpe includes responding to any test results and managing contact between scheduled appointments. Whenever we use phone calls and texts to inform decision making this information should be included in the health care record.

When giving advice by telephone make a record of the time, date and what advice was given. If the health care record of the wahine is available, the entry can be made directly into this. If this is not available, the midwife may record information in her diary or on a clinical note that includes identifying details for the wahine. This will then be incorporated into the main body of the notes for the wahine when they are available. Record a summary of any text communication, including your response as soon as possible after

the contact. Midwives are reminded to be cautious about providing clinical advice via text (Midwifery Council, Be Safe, 02, 2016).

3.4 Management of photographs

There may be times when it is reasonable to take photos that inform the care you are giving. These may be of the wahine and/or her pēpe, or to record a clinical situation. The taking and storage of any photos must be with the consent of the wahine. The wahine may also send you photos of a situation that she wants your advice about. This may be used to inform decision making and should be referred to in the health care record. These photos should be stored with the consent of the wahine, in her or her pēpe health care record and any copies held on other devices such as phones, electronic devices are deleted. Caution is advised when using photographs to make clinical decisions.

4. Confidentiality

Midwives should be familiar with the principles of confidentiality. Confidentiality concerning the health care record is an expression of the trust inherent in the relationship between the wahine and the midwife. Health care records are often only viewed by the wahine and the providers involved in her care. If there are no extenuating circumstances, then they should not be viewed by anyone else.

4.1 Maintaining confidentiality

Only the wahine can share her health care record with her whanau. Midwives should not share information directly with whanau, even if asked, unless this has been explicitly agreed to by the wahine.

There are government agencies that are able to access the health care record under statute. These include but are not limited to the police and coroner. Should this occur please contact your professional body for legal advice. It is advisable to keep a record of the written request for the information and this request would be expected to identify their legal right to request this information.

4.2 Sharing information with other agencies

Sharing information with other agencies is covered in numerous Acts and Regulations. It is advised that midwives contact the College for legal advice.

4.3 Documenting sensitive information

In the course of midwifery care, the wāhine may share personal and sensitive information that needs to be recorded while also respecting her confidentiality, privacy and maintaining her safety. This may include situations such as disclosures relating to family violence, a history of sexual abuse, previous hidden pregnancy or perhaps drug and alcohol abuse. Recording this information may be challenging to midwives.

Practice Tip

Ensure the wahine knows you have recorded this information in another place and not in the body of the main notes and that it is secure, for example, a separate page held securely.

That this information may be shared with practice partners and other health professionals involved in her care as agreed with the wahine.

5. Decision making and informed consent

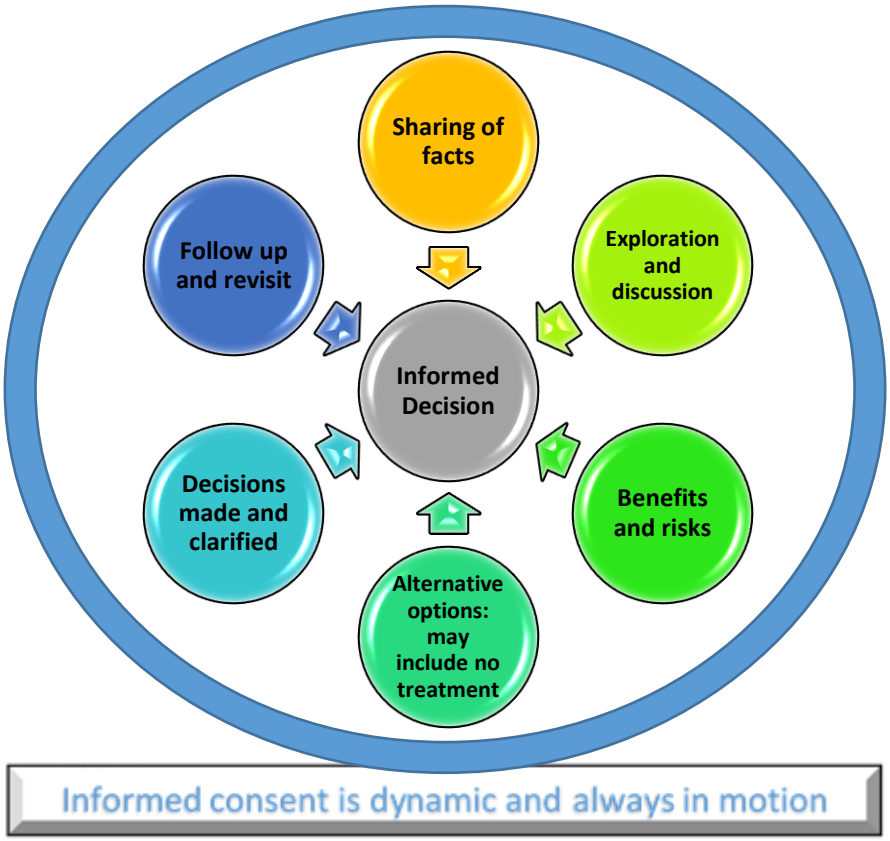
The College believe that midwifery care takes place in partnership with wāhine. It is the midwife's professional responsibility to uphold informed decision making for each wahine. Therefore, recording these processes are an integral part of record keeping. Wāhine have the right to make decisions about care that will affect them or their pēpe. Informed decision making is a process that results in the wahine either giving informed consent or declining care that is offered or recommended.

5.1 Decision making for the midwife

Decision making can be complex process. It includes the exchange and understanding of information that is relevant and emphasises the autonomy of the wahine. It requires the midwife to make professional judgements based on the information they have gathered, using their clinical reasoning and problem solving. Decision making essentially starts before any decision is made and continues after that decision is reached. Therefore, it is ongoing. Critical thinking is central to professional practice.

Any decisions cannot be made without the wahine. The decision-making process enables the midwife to draw on her knowledge and experience to share information with the wahine so they can identify an appropriate plan of care. Figure 4 explores the decision-making process and how it is inextricably linked with making informed choices. This draws on the College's Informed Consent and Decision Making consensus statement (2016).

Figure 4. The decision-making process



5.2 Recording decision making

A midwife's reasonable decision is rational and thought out and includes the wahine. When considering this process, it is important to think through how you will record all decisions and actions, including what the wahine consents to. The College believe that a record of all decisions made, assessments and outcomes are important aspects of maintaining a health care record. Table 3 shows the aspects midwives could consider when writing their clinical notes.

Table 3. Aspects of decision-making to be considered in record keeping

	Aspects of Decision making (not necessarily in this order)
D	Decision & rationale for midwifery care provided
E	Evidence of information shared & discussed
C	Care plan – Created - Reviewed – Updated
I	Investigations: why and results: shared with wāhine
S	Situation: context of care being provided e.g. rural/hospital/home
I	Informed consent – given or declined
O	Outcomes: including all assessments, investigations & referrals
N	Next steps: are there any aspects of care that you believe also need to be added in order for seamless care to be provided to wahine/pēpe

Practice tip

Documentation should include a brief outline of the information shared and when this occurred.

All decisions should be clearly documented.

5.3 Recording informed consent from the woman

Health care records should be used to document discussions and interactions with the wahine in planning her care. Consent to midwifery care should never be assumed. A summary of the discussion should be recorded as it is acknowledged that not every aspect of the discussion can be captured. Resources used may also be listed. Key points to include could be the risks, side effects, benefits and any other options for the wahine to consider, as well as any concerns she may have raised. It is reasonable that written consent is not expected for most midwifery care. However, where a suggested procedure carries risk, then an explanation of this should be documented in the notes of the wahine. Wāhine have the right to receive care, refuse care, or withdraw from care and to do so without coercion (Code of Rights) (Standard five). Written consent must be obtained where either party requests it (Informed Consent and Decision Making consensus statement, College of Midwives, 2016).

Resources such as leaflets or media may be used to share information with the wahine. It is reasonable that the midwife is aware of the range and content of the resources used most often for wāhine to assist in their decision making for example, Ministry of Health resources, DHB resources, resources from consumer organisations such as Women's Health Action and Maternity Services Consumer Council.

Interpreters may be required to support midwifery care, information sharing, informed consent and decision making. Midwives are encouraged to record the name and where appropriate the organisation, of the interpreter.

Practice Tip

Consider collating resources such as flyers and information sources that you share with wāhine into a resource folder/kete. Midwives are encouraged to include any resources that support health literacy of wāhine. This can be updated annually in collaboration with your practice partners/colleagues. Each year's resources can be dated and stored with your health care records to demonstrate the information you shared for that year.

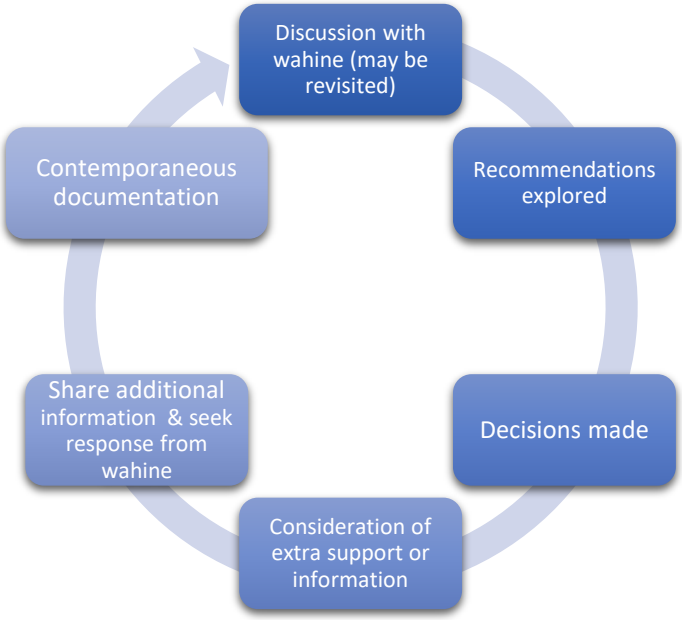
Wāhine need to be informed that their health care record may be accessed by other health providers involved in her care. Additionally, her information will be used for claiming purposes and to contribute to the national data set record of care.

5.4 Recording decisions when the wahine declines recommendations for care

The College states that "the midwife upholds each wahine right to free and informed choice and consent throughout the childbirth experience" (College of Midwives, 2015, p. 19). The Code of Rights advises that "every consumer has the right to refuse services and to withdraw consent to services".

The College acknowledge that when the wahine declines recommendations for care it may challenge the midwife-wahine relationship. If a wahine declines a recommendation for care it is important the midwife "clearly states when her professional judgment is in conflict with the decision or plans of the woman" (College of Midwives, 2015, p. 19). The midwife's documentation should reflect the process undertaken, discussions, recommendations given and any decisions made, including the response from the wahine.

Figure 5. When wahine declines recommendations for care



As part of the process the midwife may discuss the situation with their colleague or offer the wahine the option to discuss with another health practitioner. This should be discussed with the wahine first and recorded in the health care record. Additionally, the midwife may be expected to use tools such as the processes described in the referral guidelines (Ministry of Health, 2012).

If the midwife **continues to provide care**, earlier decisions may need to be revisited with the wahine as time progresses. A summary of these discussions, including information that was shared, the decisions made and the wahine response should be included in the health care record.

If the midwife decides to **discontinue care**, they should discuss the reasons with the wahine and include options for alternate care. A summary of this discussion should be included in the health care record.

6. Guiding principles for documentation

The guiding principles for documentation reflect the values and standards articulated in this keteparaha are described in a summary table in the appendix (Guiding principles for documentation).

6.1 Professional style of writing

Each midwife will develop their own professional style of documenting the care they have given, while also considering their legal and professional responsibilities. This reflects the context in which care is provided and the unique relationship between the midwife and the wahine.

Writing that is spread out is usually easier to follow rather than paragraphs laid out as a single large block of text. It is recommended that midwives space out their writing to allow for easier review of key points. For example, midwives may choose to indent specific points of care.

Practice Tip

It is not necessary to strike through the blank space left in each line of writing. However, if there is excessive space, for example several lines with no writing, a diagonal line should be put across the block of lines.

If you choose to strike through lines, it is not incorrect either.

Documentation can be spaced out, with indentation and bullet points to highlight aspects of care.

Other people will read the health care record, and this includes the wahine. This means midwives need to consider the language used and information that is recorded to ensure it is factual and reflects the care provided. In most cases the wahine is present when the midwife documents the midwifery care provided, and this enables sharing of what is written so the wahine knows what has been recorded.

Abbreviations in health care records may be used with caution. Where used their meaning should be clear or readily available to all users of the documentation, including wāhine. Agreed abbreviation lists may be available within practices or DHB. The midwife is encouraged to document any misjudgement of practice and to initiate restorative actions (Standard seven).

6.2 Referral

All referrals to other health providers or for any investigations, should be documented in the wahine or pēpe health care record. Midwives are responsible for appropriately documenting their decisions, including the date, reason for the referral and a summary of the information shared with the wahine in the health care record. Midwives should have a plan to follow up if there is an unreasonable delay in the wahine or pēpe being seen following the referral (Standard six).

6.3 Transfer of care

Transfer of care can occur between midwives who work in the community and/or hospital settings, and between midwives and medical staff. When a midwife hands over clinical responsibility for care to a colleague/health provider it is important that it is clearly identified in the health care record who is responsible for care. This documentation should include the time, who has taken over care, and that the wahine is aware of this and what this means. This should occur at every transfer of care.

Transfer of care also occurs at the end of the completion of the midwifery partnership when primary care is transferred back to the GP and referrals are made to a Well Child Tamariki Ora provider (Standard nine).

7. Clinical considerations for documentation

7.1 Assessments, investigations, and results

Midwives are expected to record any assessments that are undertaken, including the rationale for ordering any tests or investigations. It is expected that midwives have a system in place to record the result and follow up on any tests and investigations, including providing the wahine with her or her pēpe results in a way that the wahine can understand. Caution is advised about using text message to convey complex or abnormal test results. The plan of care as a living document will be updated in discussion with the wahine (Standard three).

Where possible, the original assessments and investigations, such as laboratory and ultrasound scan results, and completed cardiotocograph (CTG) tracings should be retained as part of the health care record. These may be retained within the wahine DHB health care record.

Practice Tip

It can be beneficial to step back and take a pause to undertake a holistic assessment of the wahine and/or pēpe. This can be particularly valuable when the woman's care is complex or new complexities have arisen.

7.2 Interpretation of the 'sticker'

A variety of pre-populated stickers/stamps are available to support midwifery practice. Used alone these provide a record of assessment findings only. The addition of a narrative summary makes available the midwife's interpretation, decision making and plan for ongoing care.

7.3 Pēpe wellbeing

Each pēpe should have their own set of health care records commenced at birth. Completed tick box tools provide an overview and summary of the assessment. A narrative in the record supports the interpretation of this assessment data which can be shared with the wahine/whanau.

The Well Child Tamariki Ora health book is held by the whanau as a record of the health and immunisation record for the pēpe. Midwives are reminded to document their care in the midwifery pēpe health care record, with a summary provided for the whanau in the Well Child Tamariki Ora book.

7.4 Retrospective documentation

In most circumstances midwifery notes are completed at, or as close as possible to, the care episode. However, the College acknowledge that this is not always achievable. When the midwife is unable to document at the end of an episode of care, perhaps due to an emergency arising, documentation is done in retrospect. Retrospective documentation should be clearly identifiable within the health care record, with clearly noted time and date.

The College understand retrospective documentation to be that which is done outside the normal parameters of when it would be reasonable for the midwife to record her care.

Practice Tip

Midwives are encouraged to document their care with the wahine, so she is aware of what is being written. For example, take the record of the wahine into the room/home and document before leaving the room. This supports the wahine understanding of her care.

8. Professional considerations for record keeping

8.1 Locum work and health care records

The locum midwife requires access to all maternity health care records for the wāhine and pēpe she is responsible for during the period of her locum activity. This includes her own login for any electronic records. While the health care record remains with the LMC midwife/practice, the locum midwife must be able to access a copy of the original record or retain a copy of the record of the care given during her locum period, for the retention period (10 years). A record of the care provided by the locum midwife could be required for Midwifery Standards Review (MSR) purposes, audit, or complaint process. It may be reasonable for the locum midwife to hold a copy of the original record of her care.

It is important that the wahine receiving locum care is aware that her notes are shared between the care providers.

Practice Tip

As a locum midwife, consider keeping a log of the wāhine you have cared for recording their NHI, date of care provided and whether the care is the antenatal, labour and birth or postnatal period. This can support you when you prepare for your MSR. As the locum you could consider maintaining a running summary of the care you have given. This can be used to write a formal handover when care is returning to the LMC midwife.

8.2 Change of care provider

The presence of the health care record provides relevant historical information in the right place and at the right time to support quality care. All wāhine have the option of carrying a copy of their record, either electronically or in hard copy. However, when the wahine changes care provider it is a requirement that the midwife provides a summary of the care she has given including results of any tests and investigations, to the next provider. This may be by either printing the electronic information or by sharing access if this is possible. This supports the sharing of information between different health providers and provides seamless care.

If health care records are to be posted this should be via registered post to ensure their security.

8.3 Working with student midwives

Student midwives are supported to document care in the wahine health care record (Standard ten). However, each entry must be reviewed by the supervising midwife and countersigned, as the student cannot provide care on their own. The wahine should be made aware that this is expected practice.

8.4 Professional development

Midwives are encouraged to review their documentation regularly as part of their professional development. This is incorporated into the Midwifery Standards Review and Midwifery First Year of Practice processes (Standards eight and ten).

Practice Tip

Please see the appendix for a midwifery self-audit tool as an example of how midwives can reflect on their professional documentation skills. Used at regular intervals, this tool supports critical thinking and reflection on the midwife's own standard of documentation to self-identify where improvements can be made.

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10. Appendix

Guiding principles for documentation

Principle	Guidance
Entries must be legible	The maternity health care record is a communication tool and all providers and wahine need to be able to understand what is written. This includes correct spelling as errors may lead to misunderstanding
Entries should be signed	While every entry should be signed upon completion, we recognise that in the context of primary birthing there may be only one or two care providers. In this situation it may be reasonable to sign after a block of documentation including at least once per page.
Health care records are identifiable	The record should include the wahine and/or pēpe name and NHI. If paper based, consider numbering the pages.
Limit abbreviations	Abbreviations can create confusion for other health providers and the wahine. Writing the full word the first time can limit this.
Recommend 24-hour clock: • **record labour and birth care** • **when multiple care providers are involved**	For routine antenatal and postnatal care in the community it is reasonable that midwives use 'am and pm'. Events should be recorded chronologically and where a retrospective entry is required, this is clearly identified.
Manage incorrect entries	Put a line through incorrect documentation so that the original can still be read. Sign and note the entry was made in error.
Document care objectively.	Be specific and factual. Be cautious with subjective language and interpretation. Where appropriate document key words, feelings or concerns as used by the wahine.
Document assessments and care plans	Document your assessment, care, care plans and updates of care plans.
Document decisions and midwifery actions (Standard two)	Include the reasons for what was done, the decisions made, the outcome and any ongoing plan of care
The wahine is fully informed (Code 6)	The wahine has a right to be fully informed about her care, and this includes the right to decline care. A summary of the discussion and decision should be documented in her health care record.
Midwives document their own care	The midwife has a professional responsibility to record their care provided to wāhine. However, there are times when you may document for another colleague. These may include but are not limited to birth, an emergency situation and birth.
Information may be recorded in a variety of ways	Diagrams, for example showing abdominal palpation, can be used. Assessment tools (e.g. MEWS charts, CTG, partogram) support practice. Consider a narrative entry to ensure a holistic approach and demonstrate the midwife's critical thinking in interpreting the data.
Record as much as you can during an emergency	If able, use a single time device to support consistent time recording of events. If rough notes are recorded these must be included and retained in the record of the wahine. These are used to inform retrospective records and should be completed as soon as possible after the episode of care.
Tick boxes can be used to record midwifery care	These should not be used in isolation of a summary narrative which interprets the data that has been recorded. This includes tools such as partogram, pre-populated sticker/stamp or maternal and newborn early warning systems.

Midwifery Self-Audit Tool

Are you self-auditing paper or electronic notes or a combination (please circle)					
Questions to ask yourself?		**How did you do?**			
Date of self-audit:		YES	NO	N/A	Reflections
1.	The date is recorded				
2.	The time is recorded - 24hr clock - 12hr clock				
3.	Writing is legible if paper based notes				
4.	Appropriate use of te reo Māori - Include translation where appropriate				
5.	The record makes sense: - They are written in chronological order - They provide a sense of recall of what occurred				
6.	It is clear which entries are mine - each entry OR each page signed (depending on context)				
7.	Minimal use of abbreviations or jargon - Which ones?				
8.	The notes mostly written as close to the point of care as possible (contemporaneous) - Retrospective entries are identified including why they are retrospective				
9.	My decisions are clearly highlighted - My decisions include a rationale - The follow up is recorded - Care plans are updated				
10.	The wahine perspective is included: - discussions and informed consent processes for the wahine are described				

Self-reflection

How do you feel you did overall?	
If you used electronic records did they ensure that care was in a chronological order or was it mostly tick-boxes?	
Do you believe that your notes reflect reasonable practice?	
Do you believe that your notes meet professional standards?	
What possible points have you identified to improve?	

Notes at the workshop

Notes at the workshop