Midwifery Diary Guideline

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Summary of document:
The Community Midwife diary is used, in addition to digital records, to support standardised documentation providing evidence of advice given over the telephone, calls undertaken, time worked and mileage travelled.

Scope:
This guideline is for the use of all community midwives and Maternity healthcare support workers who are involved in the care of women and babies at home and in the community setting.

The guidance below uses the term 'woman' (pronouns she or her) to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include people who do not identify themselves as women, but who are pregnant or have recently given birth. Obstetric and Midwifery services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex that they were assigned at birth

To be read in conjunction with:
976 Abbreviations within the Maternity Setting Guideline.-opens in a new tab
rcm_guidance-report_elec_record_keeping-1512.pdf -opens in new tab

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Keywords
Midwife Diary, Community, BadgerNet

Glossary of terms
NMC - Nursing Midwifery Council
AN/ ANC - Antenatal Clinic
SBAR - Situation, Background, Assessment and Recommendation

Contents

Scope

This guideline is for the use of All community midwives and health care support workers who are involved in the care of women and babies at home and in the community setting.

Aim

The aim of the guideline is to:

- To provide standardised guidance on the completion of documentation for all midwives and health care support workers, outlining their responsibilities in relation to the documentation of care provided.

Objectives

The aim will be achieved by the following objective:

All midwives and healthcare support workers complete documentation in the midwifery care diary as required thereby providing evidence of advice, calls undertaken, time worked and mileage travelled.

Introduction

Record keeping is an essential part of midwifery practice and maternity care. It is a vital element of safe, high quality and effective care. It provides clarity and aids good communication for the whole multidisciplinary team, supporting them to work together to deliver coordinated person-centred care. All midwives should already be familiar with the NMC guidance on record keeping within the code. (NMC, The Code, 2019) and Hywel Dda Health board guidance is developed with the NMC code at its centre.

The principles of good record keeping apply to all documentation carried out by a midwife including use of paper records, Maternity Information Systems and Electronic Patient Record systems (BadgerNet). The full electronic recording of all aspects of maternity care is new and supports the unique multifunction of maternity records.

The use of digital records in the community may present certain challenges e.g unable to access the internet and therefore the community midwife's paper diary should be used in addition to the Digital systems as tools of professional practice for keeping records.

By appropriate documentation the community midwives create a comprehensive and effective record keeping that supports, and provides evidence of, their professional practice and enhances the quality of care provided to women.

Principles for use of Community Midwives paper and digital records.

- The NMC Code (2019) highlights that abbreviations /jargon should not be used, and entries should be written in full where possible. However, due to the continuous use of abbreviations by health care professionals an approved list should be agreed. A list of approved abbreviations can be found within 976 Abbreviations within the Maternity Setting Guideline. -opens in a new tab.
- Take all steps to make sure that Community documentation and records, both paper and electronic, remain secure and confidential.
- All staff should keep clear, accurate and concise records relevant to care provided.

- The use of Situation, Background, Assessment and Recommendation (SBAR) have been shown to improve patient safety and outcomes and should be utilised, including when using diary. It enhances communication skills when making referrals or consultations via telephone, ensuring clarity, efficiency, and professionalism.
- Midwives should use appropriate documentation, including mobile digital technology e.g laptops, to document with the woman in her place of care e.g. at the bedside, in her home, to maintain contemporaneous documentation and involve women in their care planning.
- Document at the time or as soon as possible following care/ consultation.
- Where community midwife has planned AN clinic, visits /consultation appointments, the woman records can be uploaded prior to appointment if possible. When woman's record has been uploaded to lap top irrespective of whether IT access is available. contemporaneous documentation can be undertaken at the time of consultation. The record must then be saved and will be uploaded when IT access is available.
- In cases when woman's records are not pre-uploaded before a consultation and therefore not available, the community midwife will use the community paper diary to document but must upload, as appropriate, to the digital system retrospectively
- If unable to document contemporaneously midwives should ensure retrospective entries to BadgerNet, or any other paper documentation, are adjusted to the assessment date and time to ensure chronological order is achieved, but clearly state what the reason for retrospect is, i.e. Clinical emergency type or digital records or diary not accessible, or available, at time of call

Written documentation/ entries in the community Midwife Diary

- The Midwifery care diary provides evidence of advice given over the phone, calls undertaken, times worked and mileage travelled. These should be:
- Written in black ink that can be photocopied.
- Be legible, factual, consistent and accurate.
- Include the start of the working day, lunch break and end of day.
- Visited must be numbered in order of visit and a brief reference to the nature of the visit i.e. "routine", "urgent" with the reason for the visit i.e. "labour", "routine postnatal visit".
- Mileage travelled during day should be recorded at the beginning and end of the day.
- All study days, annual leave and sick leave etc. to be recorded.
- When on call, all phone calls ,that cannot be contemporaneously be documented via BadgerNet, should be recorded to include the name and number, with a very brief reason for call e.g. labour/ SROM/APH. The advice giving and ongoing recommendations should be recorded using SBAR .
- All cancelled or rescheduled calls should be documents, including those passed onto other midwives.
- All time in lieu should be entered and any hours taken back should also be recorded

When situation requires use the diary to document patient contact the relevant clinical information must then be uploaded to the woman's electronic diary(BadgerNet) retrospectively as soon as possible. This ensures that each woman cared for in the maternity has a record of pregnancy care that can be access by other maternity sites if needed, allowing clinicians from different BadgerNet sites across Wales, to access one record, ensuring clinical safety.

Organisational Arrangements

- The Health Board will provide the diaries annually
- The diaries remain the property of the Health Board and should be produced on request
- All diaries are to be forwarded to the Operational Lead Midwife for Community at the end of each calendar year.

Current Storage of old diaries

Old/ non-current Community Midwife dairies are stored appropriately by the Health Board.

Monitoring

- Community Midwives Diaries will be audited by the Operational Lead Midwife on an individual basis as required.

Auditable Standards

- Time: Start/Finish
- Antenatal Clinic attended and numbers seen
- Outgoing calls
- Incoming calls
- On call activity
- Use of SBAR for calls

References.

- NMC. Nursing and midwifery Council. The Code Read The Code online - The Nursing and Midwifery Council -opens in a new tab
- Royal College of Midwives. Guidance report. Electronic Record Keeping Guidance and Audit tool rcm_guidance-report_elec_record_keeping-1512.pdf -opens in new tab
- NICE. NG201 Antenatal Care Overview | Antenatal care | Guidance | NICE -opens in new tab
- NICE. NG194 Postnatal care. Overview | Postnatal care | Guidance | NICE -opens in a new tab
- NICE. NG 235 Intrapartum care Overview | Intrapartum care | Guidance | NICE -opens in a new tab
- NICE. NG121 Intrapartum care for women with existing medical conditions or obstetric complications and their babies Overview | Intrapartum care for women with existing medical conditions or obstetric complications and their babies | Guidance | NICE -opens in a new tab