



# **Completion and maintenance of maternity records**

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## Guideline Statement

Good record keeping is a fundamental aspect of healthcare professional practice and is essential for delivering safe and effective care. According to the Nurses and Midwives Code of Professional Standards of Practice (2018), it is important to maintain clear and accurate records. Good medical practice also emphasises the need to document work clearly, accurately, factual and legibly.

High-quality documentation supports individual accountability, enhances inter-professional communication and teamwork, aids in the investigation of complaints and claims—especially in the future—and contributes to audit and research efforts. It is expected that records are completed at the time of contact, interaction, or event, or as soon as possible, and no later than 24 hours afterward. Any entries made retrospectively must be clearly identified as such.

Health records can be maintained in various formats and must be managed in compliance with the General Data Protection Act 2018 (GDPA) and the Access to Health Records Act 1990 (AHR). The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR). Maternity-related health records are required to be kept for 25 years (Department of Health, 2016). Individuals, as well as others with parental responsibility, can request access to health care records.

Trust documentation standards establish the foundation for record-keeping practices, supplemented by specialty-specific standards, and should be used in conjunction with these guidelines. A well-maintained record includes all the necessary information to provide safe care and treatment, and it should be accessible to relevant staff in a timely manner. This may encompass care and risk assessments, care plans, and case notes (CQC 2021). The Trust will ensure that evidence-based guidelines are utilised in the management of health records, including maternity notes.


## Executive Summary

Record keeping is essential and affects everyone in the organization, as stated in the Freedom of Information Act 2000. It is, therefore, a shared responsibility.

The Gosport Independent Panel (2018) highlighted a persistent issue of poor record keeping, which included the failure to document fundamental aspects of care and monitoring. The record keeping practices observed were inadequate and did not meet the professional standards expected at the time.

Any document *whether in hard copy or electronic form* that records any aspect of patient or client care may be required as evidence in a court of law or by the Preliminary Proceedings Committee of the Professional Councils. All NHS health care records are owned by the NHS, not by health care professionals or patients/clients. These health records are public records and are considered to be "owned" by the Secretary of State. Therefore, they must be maintained in compliance with the legal and professional obligations outlined in the Records Management Code of Practice for Health and Social Care, as well as the following legislation and any new guidelines that may emerge regarding records management:

- The Public Records Act 1958
- The Data Protection Act 2018

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- The Freedom of Information Act 2000
  - The NHS Confidentiality Code of Practice

The retention and storage of maternity records are addressed in the NHS Records Management Code of Practice, which provides guidance on how long records should be retained and which records should be kept.

## **Definitions**

### **1.0 Roles and Responsibilities:**

#### **All Staff**

Everyone is responsible for maintaining health records. All staff have a legal and contractual obligation to protect confidential data. While certain individuals within the Trust have specific responsibilities for ensuring good practices related to health records, they are not solely accountable for everyone. Each person must take responsibility for documenting their actions regarding the care of women, birthing people and their babies.

### **2.0 Implementation and dissemination of the document**

This policy will be available on the Trust's intranet site and shared with all employees working in maternity.

### **3.0 Processes and procedures**

A health record is any document that contains information regarding an individual's physical or mental health or condition. This record is created by or on behalf of a health professional in connection with the individual's care. An optimal health record is one that includes all consultations and discussions among members of the healthcare team and the woman or birthing person. It should be regularly updated and tailored to meet the needs of the woman or birthing person, as well as any clinical findings.

The complete physical maternity record consists of:

- Electronic patient records
- Paper records


Various information systems, including electronic patient records, badgernet, and ultrasound scan systems, store electronic formats of different parts of the health records. Entries within these IT systems can be printed and added to the physical record. It is essential that the records are organised chronologically and that the entries are presented in a logical and methodical sequence.

### **4.0 Standards for Record Keeping in Maternity**

#### **4.1 Record Keeping in Maternity**

Inadequate and inaccurate record-keeping has been identified as a recurring issue in confidential inquiries into stillbirths and deaths in infancy (MBRRACE, 2020), contributing to suboptimal care. Effective record-keeping is a fundamental aspect of healthcare practice and is essential for maintaining complete and contemporaneous records of care.

Good record-keeping serves several important functions:

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1. **Continuity of Care:** Keeping patients' medical records up-to-date with essential information is vital for ensuring continuity of care. Accurate documentation of the information exchanged that leads to a decision in a patient's record will inform their future care and help explain and justify your decisions and actions.
  2. **Enhanced Communication:** It promotes better communication and information sharing between members of the multi-professional healthcare team.
  3. **Clinical Decision-Making:** Proper documentation shows how decisions related to patient care were made, supporting effective clinical judgments.
  4. **Improving Standards of Care:** Improved communication and information sharing contribute to higher standards of care.
  5. **Audit and Clinical Reviews:** Well-maintained records facilitate audits and clinical reviews.
  6. **Data Collection:** Accurate records support the delivery of healthcare services through efficient data collection.
  7. **Research Contribution:** Good record-keeping contributes to the research environment.
  8. **Professional Accountability:** Maintaining records meets professional expectations and demonstrates accountability.
  9. **Patient Experience Narrative:** Records serve as a narrative of experiences for the woman or birthing person.
  10. **Addressing Complaints or Legal Matters:** Accurate documentation is essential for addressing complaints or legal processes.

In summary, thorough and precise record-keeping is crucial for delivering high-quality healthcare.

#### **4.2 Principles of Good Record-Keeping for Maternity**

Effective record-keeping is essential for all types of documentation, including computerized records, and it plays a crucial role in healthcare.

This practice encompasses:

- Clinical notes that capture patient history and treatment
- Correspondence with other healthcare professionals that fosters collaboration
- Laboratory reports that provide essential diagnostic insights
- Radiology reports that inform clinical decision-making
- Monitoring equipment printouts (e.g., CTG traces, blood gas results, ECGs) that support real-time patient assessment
- Incident reports and statements that enhance safety and accountability
- Prescription charts that ensure accuracy in medication management

#### **4.3 Record-keeping standards**


- All entries should be clear, **accurate** and **legible**.
- All entries should be in **chronological** order.
- All entries should be made **immediately** after an event or as soon as possible no longer than 24 hours later. All entries made in retrospect must be documented as such.
- Relevant, non-factual entries e.g. conclusions, opinions etc. **may** be recorded. All entries must be **timed, dated and signed**.

- All entries in paper format should be written in **black ink only** (Entry must be 'permanent' and readable if photocopied)
- Where a **signature** is required, this must be a full (i.e. minimum one initial plus surname), legible\* signature, **not** initials.
- The **first time** that anyone writes in a woman's/birthing person's medical record regarding a particular episode of care they should print their name and grade, in capitals, under their signature.
- Any errors should be crossed through with a single line so that the previous entry can still be read. (The previous entry must not be obliterated e.g. with correcting fluid or by scribbling/pasting over.)
- All **corrections** should be timed, dated and initialled (A signature is acceptable instead of initials).
- Each new page should have either the woman's/birthing person's name and hospital number written in the designated place, or an addressograph sticker attached there.
- Clinical records should include **relevant** clinical findings, decisions made and actions agreed, and who is making the decisions and agreeing on the actions, the information given to women/birthing people, any drugs prescribed or other investigation or treatment
- Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, **jargon** or speculation
- Identify any risks or problems that have arisen, and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- Take all steps to make sure that records are kept secure. All documentation, correspondence, prescription charts and investigations should be filed securely in the health record in date order.
- Refer to the "Fetal Monitoring guideline" for recordkeeping in relation to cardiotocographs (CTG) and K2.
- Abbreviations can be used if it is documented in full or if there is a key in the documentation to refer to.
- In the unlikely event that health records need to be altered the practitioner must document their name and job title, and sign and date the original documentation. Any alterations made, and the original record must be clear and auditable.
- Mentors should read entries made by a student midwife to ensure accuracy and clarity. Student records in this Trust must be countersigned by a registrant.
- You should take a proportionate approach to the level of detail recorded. Good practice states that you must include the decisions made and actions agreed upon – and who is making the decisions and agreeing to the actions in the clinical records. This includes decisions to take no action.

*\*If the signature is not legible, the writer's name must be printed underneath it, or stamped there with his/her name stamp*

#### **4.4 Best Practice Summary**

- Right record (encounter)/person
- Right place
- Right time (chronology)

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- Right detail – action and reasoning
  - Right Log-in (are you logged in as yourself)

#### 4.5 Clear and organised documentation


- Staff are responsible for all documentation made under their login, therefore **log in details must not be shared**
- Staff should make it clear within the record when they are writing or inputting data on behalf of a colleague. The record must be checked by the person conducting the care for accuracy and a note to confirm the scribing was accurate. Student midwives should complete their documentation and midwives should ensure they know the correct procedure to countersign all student entries on the system
- Where an error or problem has occurred within or accessing an electronic record, the member of staff accessing that record is responsible for escalating appropriately
- Staff should be aware that digital records allow for multiple staff to be documenting and therefore information will update in real-time.
- Where unable to document contemporaneously staff should ensure they adjust the entry and assessment time of their documentation to ensure that the chronology of the record is maintained, but clearly explain the reason for documenting retrospectively

#### 4.6 Accurate documentation content

- Auto text, Powerforms and Tick boxes should be utilised where appropriate to support data capture and for efficiency, but free text detail should be added as required for narrative e.g. actions and rationale behind decisions and care planning.
- Where a system pulls documentation into the record automatically from previously recorded information, it is the responsibility of the staff member to check that information is correct prior to saving the documentation as the clinician will become responsible for everything recorded within that saved record (RCM Electronic Recordkeeping Guidance and Audit Tool 2021).
- Staff should review and update the appropriate risk assessments ensuring the current risk is clear within the record.
- It is advised to use the BRAIN acronym for documentation of discussion. It stands for the following:
  - B** What are the benefits of this course of action?
  - R** What are the risks?
  - A** Are there any alternatives?
  - I** What are the implications of following this course of action? What does intuition tell you?
  - N** What happens if we do nothing?

The use of an SBAR communication tool is a structured form of communication that enables information to be transferred accurately between individuals. It can be used on admission, when escalating a concern or between staff for a change of shift

- S** Situation (Identify yourself and where you are calling from, identify the patient and describe your concern)
- B** Background (give the reason for admission, any significant history, medication etc.)

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- A** Assessment (vital signs, clinical impressions and concerns)
  - R** Recommendation (be explicit about what you need including a time frame, make suggestions, and clarify expectations)

#### **4.7 Informed Consent**

- When obtaining verbal consent, it is essential to record this in the clinical notes.
- Consent forms can serve as helpful reminders for sharing key information and provide a standard way to document decisions, making regular reviews easier. It is the responsibility of the healthcare professional to provide information about the risks and benefits associated with any form of treatment or care pathway, taking into consideration the individual's obstetric and medical history. Whenever possible, use numerical data to describe risks. Keep in mind that different people may interpret terms such as "risk," "rare," "unusual," and "common" in various ways.
- When recording the discussion (for example, in a person's clinical notes or care plan), document any decisions made, along with details of what the person indicated was important to them in making those decisions. Offer to share this information with the individual.
- The healthcare professional must ensure that the information is presented in a way that is easily understood and should verify that the individual has comprehended it, using communication aids as necessary and considering any factors that may affect communication.
- Following this, the healthcare professional has a duty to respect and support the informed decision. If there are concerns about mental capacity, an assessment should be conducted before discussing decision-making to ensure that appropriate support is provided.

#### **4.8 Documentation and storage of Cardiotocographs (CTG)**

- File all CTG traces in the specific CTG wallet envelope in the woman's/birthing person's notes in date order. The tracings should never be left in any area other than the woman's/birthing person's notes. Traces should be kept for 25 years.


#### **4.9 Documentation and storage of cord and PH results and reports**

- The results of paired blood samples must be recorded in the birth notes, in addition to the printout being stapled to the notes, because the printout will fade over time.

#### **4.10 Safeguarding issues**

Midwives must check the electronic records (Z Drive-SIP Files-Sharing Information in Pregnancy) for any potential safeguarding information related to social or child protection issues when a woman or birthing person is admitted. They should continue to document as necessary in all relevant records. If there is an open case with Children's Services (under section 17 for children in need or section 47 for child protection), a safeguarding alert will be present in WPAS. Additionally, the SIP box located in the maternity handheld records can be utilised to indicate that further information is available, particularly in cases where it would be inappropriate to include certain details in the notes, such as issues related to domestic violence.

### **5.0 Recordkeeping Governance**

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- All staff must receive appropriate training for the electronic records systems, WPAS/WCP. Each staff member is responsible for maintaining and updating this training as required whenever the system is updated or changed.
  - All staff should ensure they are up to date with their Information Governance (IG) training. Additionally, staff should be familiar with business continuity procedures in case of faults, cyber-attacks, or system downtime.
  - Healthcare professionals should be knowledgeable about the Trust's information systems and understand how to use them (refer to the Information Security Policy).
  - Passwords for accessing information systems must not be shared. Furthermore, systems should not be left open after staff have finished using them. All healthcare practitioners should complete their Information Governance training every two years, covering Information Governance, Records, and Cyber Learning.

### **5.1 Falsification of records**

Ensure complete records are maintained accurately and without falsification. If you become aware that someone has not adhered to these requirements, take immediate and appropriate action by reporting it to a Senior Midwife or, for medical staff, the Consultant on Call.

### **6.0 Storage and Retention of Maternity Notes**

Records must be retained in accordance with the Human Rights Act 2000 and the Caldicott Principles, as outlined in the 2020 Department of Health Records Management Code of Practice. This code provides guidance on the duration records should be kept and which records are necessary to retain. Maternity records must be stored securely and confidentially for 25 years after the birth of the last child. As per General Data Protection Regulations (GDPR), personal data should be kept only in a form that allows identification of data subjects for no longer than necessary for the purposes of processing. The rights of individuals under GDPR are largely consistent with those outlined in the Data Protection Act. These rights include:

- The right to be informed
- The right of access
- The right to rectification
- The right to erasure
- The right to restrict processing
- The right to data portability
- The right to object
- The right not to be subject to automated decision-making

### **7.0 Lost Records**

Should any handheld maternity health records be misplaced or lost a Datix needs to be submitted (see incident reporting policy and procedure).

### **8.0 In Utero Transfers**

Before transferring a patient, a duplicate copy of any hand-held maternal records must be kept within the Maternity Unit. The original records should accompany the woman or birthing person to the receiving unit. Additionally, photocopies of important documents, such as medication charts, observation records, blood results, and other antenatal screening results, should be made.



## **9.0 Disclosure**

Information that can identify a person in your care must not be used or disclosed for any purpose other than healthcare without the individual's explicit consent. However, you may release this information if required by law or when there is a significant public interest. Under common law, you are permitted to disclose information if it helps prevent, detect, investigate, or punish serious crimes, or if it can prevent abuse or serious harm to others. Any request for patient information by an investigative authority (such as the police, social services, or tax authorities) must be approved by the Trust's Caldicott Guardian before it can be provided. If you receive such a request for disclosure, please contact the Information Security Facilitator.

## **10.0 Compliance, Monitoring and Audit**

Auditing plays a crucial role in ensuring the quality of care provided. By reviewing records, we can assess standards, identify areas for improvement, and facilitate staff development. The maternity services will conduct an audit of maternity health records using the Record Keeping Audit Tool (see *Appendix 1*).

## **11.0 Data Protection**

Information documented in a woman's or birthing person's records is confidential under the General Data Protection Regulation (GDPR), which replaced the Data Protection Act 1998 on May 25, 2018, and must be safeguarded by staff. Access to these records is restricted to individuals directly involved in the care of the woman or birthing person, unless explicit permission has been granted by the individual.

Under GDPR, women and birthing people have the right to understand why their information is being collected and with whom it will be shared. They also have the right to access their own records.

The principles that apply to manual records also extend to electronic records. All electronic records must be uniquely identifiable to clearly indicate who has updated each record. Staff are responsible for maintaining the security of electronic records. Records must be retained in accordance with the Human Rights Act 2000 and the Caldicott Report of 1997. Maternity records should be stored safely and kept confidential for a minimum of 25 years after the birth of the last child.



## 12.0 References

1. General Data Protection Regulations May 2018 (previously Data Protection Act 1988)
2. Access to Health Records Act 1990
3. Freedom of Information Act 2000
4. Computer Misuse Act 2000
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9. National Data Guardian for health and social care: The Eight Caldicott Principles (2020) The Caldicott Principles - GOV.UK (www.gov.uk) accessed on 9th October 2021
10. NHSX Records Management Code of Practice for Health and Social Care (2021) Records Management Code of Practice 2021 - NHSX accessed on 9th October 2021
11. General Medical Council (2020) Guidance of professional standards and ethics for doctors: Decision making and consent. Manchester: GMC 2020. Available at Decision making and consent - GMC (gmc-uk.org)
12. Gosport War Memorial Hospital: The Report of the Gosport Independent Panel (2018). Available at Gosport Inquiry (independent.gov.uk)
13. Royal College of Midwives (2021) Electronic Record Keeping Guidance and Audit Tool accessed on 21st February 2022
14. NICE guideline 2021: Shared decision making, guidance 197



## Maternity Services

### Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Completion and maintenance of maternity records
Name(s) of Author:	Claire Parkin
Chair of Group or Committee approving submission:	Antenatal Forum
Brief outline giving reasons for document being submitted for ratification	Update guideline
Details of persons included in consultation process:	Antenatal Forum
Name of Pharmacist (mandatory if drugs involved):	
Issue / Version No:	3
Please list any policies/guidelines this document will supercede:	Completion and maintenance of maternity records 2011
Date approved by Group:	14 May 2025
Next Review / Guideline Expiry:	May 2028
Please indicate key words you wish to be linked to document	Maternity record, maternity notes, health record
File Name: Used to locate where file is stores on hard drive	