College of Midwives of Alberta

Policy Name	Midwifery Client Records and Record Keeping Policy		Number	P7
Date Approved by Council	August 30, 2013	Revised by Council	May 12, 2014	
Date Accepted by HDB*	June 30, 2014			

Purpose of Policy

Provide Registered Midwives with requirements for the management and maintenance of client health records, whether paper copy or electronic systems.

Function of Health Care Records

Complete and accurate health records facilitate:

- Communication with the woman,
- Communication with other health care providers,
- Demonstration of clinical assessment, clinical judgement, guidance, interventions demonstrated in the provision of care,
- Process of continuous quality improvement,
- Management of medico-legal risk.

Policy Statement

Registered Midwives are accountable for developing, maintaining and keeping records meeting all professional ethics and legal requirements of the Province of Alberta.

Accountability

1. Managing and maintaining complete health care records is an integral part of the work of a health care provider.

2. Collection and Use of client information and completion of records will be as necessary to the professional practice of the Registered Midwife in compliance with **CanLII Midwifery Regulation**[1] and the Province of Alberta **Health Information Act** (HIA)[2]

3. Use of electronic records will comply with HIA, **Alberta Electronic Health Record Regulation**[3]. Registered Midwives will be responsible for all electronic documentation under their personal user identification and password. All electronic health records will be securely backed up. There will be protocol for documentation recovery in place to ensure any lost entries are recoverable.

4. Documentation by a Registered Midwife will reflect the Informed Choice discussions, including information and guidance provided, client's decisions, with specific details when the client's decision varies from the recommended care.

5. When the registered midwife practices within a health care facility, health care records shall be completed and provided in accordance with the facility and regional policies and medico-legal recommendations of that health care facility.

Confidentiality of Client Information

1. The confidentiality of health, personal and third party information shall be protected in compliance with all federal and provincial regulations, including but not restricted to the **HIA**[2], HIA **Alberta Electronic Health Record Regulation**[3] and **Freedom of Information and Protection of Privacy** (FIOPP) Act[4].

2. Information from the health record will be released to a third party only with the written consent of the woman or as required by law. All consents and releases will be documented in the health care record.

3. If the confidentiality of a client's record is breached, the client shall be informed within 24 hours of the incident and remediation steps to retrieve all documents will be taken. Notification to the Registrar of the College of Midwives of Alberta is required.

Client's Right to Individual Health Record

- Midwives will comply with the **HIA** Part 2, in providing access to a client's individual health record.
- Midwives will comply with the **HIA** Part 2, in clients request for amendment or correction to their personal health record.
- Further, Midwives may consider client holding a copy of or having password protected access to own health record.

Professional Standards of Documentation

1. All clinically related contacts (in person, by telephone or e-communication) with the woman will be recorded in the health record.

2. All entries will utilize a standard date format of four digit numeric year, alphabetical month and two digit numeric day (yyyy/mon/dd). The timed entries will utilize the 24 hours clock format.

3. Midwives will utilize the standardized Alberta Health forms or Electronic Health Recording, when available, developed for midwifery/obstetrical care.

4. Recording on health care records will be:
   - Legible, in English,
   - In permanent ink on paper or using only own Password/Personal Access Code uniquely identifying all caregivers' entries in electronic record,
   - Accurate and objective,
   - Contemporaneous and Chronological - Any entry out of chronological order, or beyond 24 hours, shall be labelled "late entry" with the date, time of the actual recording and reason for delayed documentation indicated.

5. Abbreviations, symbols, acronyms are only to be used when defined or described in Standards of Practice approved by the College of Midwives of Alberta or in a legend on an approved record or when written out in full with the abbreviation in brackets at the first entry on each entry by the Registered Midwife on the record.

6. Correct errors on paper chart by crossing out the error with a single stroke and state "error", or "wrong chart" and include your initials. Correct errors on electronic chart by adding correction statement with date and time of correction without deleting the error.

7. There will be replacement paper Alberta Health forms available and used in the event electronic charting is temporarily unavailable.

Contents of Records

The content of the midwife's records will include, but not limited to the:

- client record
- prenatal record
- labour and delivery record
- third stage and immediate postpartum record
- birth summary
- neonatal resuscitation/transport record for infant
- ongoing record of maternal and newborn care provision
- record of the 6 week postnatal visit

All information indicated below is to be considered the minimum standard of information to be collected and recorded.

Client record:

- client and midwife identification,
- booking date,
- menstrual history,
- gynaecological history,
- medical surgical history
- current medications,
- allergies and medication sensitivities,
- family history,
- physical assessment,
- psychosocial assessment (include level of education, socio-economic status, involvement with child welfare agencies, domestic abuse history, and assessment of risk behaviours such as substance abuse and smoking, spiritual and cultural practices affecting behaviour),
- nutrition information.

Prenatal Record:

- pertinent factors from history, physical and psychosocial assessment,
- results of laboratory and diagnostic imaging tests,
- clinical observations and assessments of maternal-fetal well-being,
- education, guidance, advice and information provided,
- intended place of birth and birth plan,
- consultations and transfers of care,
- prescriptions provided with name, dose, route, frequency and duration,
- narrative record of care provided, guidance/advice given, informed choice decisions, interventions, consultations and transfers of care.

Labour and Delivery Record:

The frequency of the observations will be determined using clinical judgement, clinical practice guidelines and medico-legal knowledge and advice. The documentation must include:

- pertinent factors from the history, physical and psychosocial assessment,
- laboratory results,
- birth plan,
- chronology of intrapartum events assessment and care/interventions provided,
- clinical observations and assessments of maternal-fetal well-being, in the latent and active stages of labour,
- medications with dose and route or therapy given,

- narrative record of care provided, guidance/advice given, informed choice decisions, interventions, consultations and transfers of care.

Third Stage and Immediate Postpartum Stage:

Documentation using the appropriate standardized Alberta Health forms will include:

- date and time of birth,
- date and time of completion of third stage,
- assessment and care provided to the newborn at birth (includes 1 and 5 minutes Apgar scores),
- assessment and care provided to the woman during third stage,
- interventions or medications given to mother or infant,
- assessment, care and teaching provided during the immediate postpartum period,
- the detailed newborn examination on the standardized provincial form,
- any consultations and transfer of care for either mother or infant,
- infant feeding, including guidance and teaching provided,
- departure or discharge summary.

Neonatal Resuscitation/Transport Record for Infant:

- summary of events, assessment and interventions provided in the management of a neonatal resuscitation,
- documentation of the consultations undertaken and transfer of care.

Ongoing Record of Maternal and Newborn Care:

- date and time of birth,
- birth weight,
- number of days since birth,
- newborn screening dates,
- neonatal laboratory results,
- maternal laboratory results,
- medications/immunizations given to mother in postpartum period,
- medications/immunizations given to newborn in neonatal period,
- assessment and care provided to mother and infant in the postpartum period,
- education, information and guidance provided, informed choice discussions, consultations and transfers of care.

Six Week Postnatal Visit:

- final assessment of physical and psychosocial well-being of mother and infant,
- documentation of maternal clinical care provided,
- contraceptive education, information and guidance provided, informed choice discussion,
- consultations, referrals for ongoing care for mother and infant, transfer of care.

Storage of Health Records

1. All records will be maintained in a confidential, secure manner at all times. Electronic records shall be password secured, permanent and unalterable. All records will be maintained in accordance with legislation and Alberta Health Services policy.

2. In the event that a midwife carries health records with her to home visits, the records should remain in her possession at all times. If this is not possible, the records shall be secured in a place where they will not be easily viewed by the passing public (ie: in the locked trunk of a vehicle).

3. Permanent records will be stored in secure storage for a minimum of 21 years. Fetal monitor strips will be retained for 30 years. All records involved in an Incident Report or Investigation

will be retained for 30 years. All electronic records will be securely backed up and stored in a separate place from the original. (Records Retention Schedule 1133-01, Alberta Health Services, Approved November 26 2010. Revised December 2011)

4. If the midwife is an employee of a health region, the health region's record management protocol will assume precedence. The health record belongs to that health region, even when the midwife moves or ceases to practice midwifery within that region. If the woman wishes a copy of her record, the policies of the health region will govern this practice.

5. If midwife leaves a group practise, the original remains with the group practise. A copy of the record may be provided to the midwife.

6. If the midwife is in independent practice and moves or ceases to practice midwifery, the midwife will retain a copy of the health record and the original record may, be transferred into the care of another registered midwife or given to the woman. The midwife will inform the College of Midwives of all records transferred to another midwife

7. Paper records containing any client information being destroyed, once retention schedule has been met, must be cross-cut shredded. Electronic records will be destroyed in accordance with legislation and Alberta Health Services policy.

8. Appointment records for each clinical contact with the name of the client receiving service and the name of the midwife will be maintained for at least 2 years.

CROSS REFERENCES

1. **CanLII Midwifery Regulation, Alta Reg 328/1994**, current version as posted on Jan 15, 2013 (Downloaded from http://www.college-midwives-ab.ca/wp-content/uploads/2012/07/Reg.-328-1994-E1589714.pdf)

2. Alberta **Health Information Act** Revised Statutes of Alberta 2000 Chapter H-5, Current as of May 27, 2013, (downloaded from www.qp.alberta.ca/documents/Acts/H05.pdf)

3. **Health Information Act, Alberta Electronic Health Record Regulation**, Alberta Regulation 118/2010 (downloaded from www.qp.alberta.ca/1266.cfm?page=2010_118.cfm&leg_type=Regs&isbncln=9780779750436

4. **Freedom of Information and Protection of Privacy Act** (FOIPP) Revised Statutes of Alberta 2000,Chapter F-25, Current as of June 1, 2013 (downloaded from www.qp.alberta.ca/1266.cfm?page=f25.cfm&leg_type=Acts&isbncln=9780779773466)

5. **Records Management, Retention Schedule** Document #1133-01, Alberta Health Services, December 2011 (www.albertahealthservices.ca/210.asp)

Approved by Council: May 12, 2014

Diane Rach RM, President
College of Midwives of Alberta

*Accepted by the Health Disciplines Board as the standard to be submitted to Alberta Health to meet the requirements of the Alberta Electronic Health Record Regulation.

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