POLICY ON RECORD CONTENT

The midwife is expected and responsible to keep comprehensive records, documenting the care provided and ensuring prompt and accurate completion of records as per the PSBC forms and guides for completion when providing primary care[1]. These records must contain the following information.

I. CLIENT RECORD
- client and midwife identification
- booking date
- demographics
- menstrual history
- gynaecological history
- obstetrical history
- medical/surgical history
- substance use
- family history
- physical assessment
- psycho-social information

II. PRENATAL CARE RECORD
- pertinent factors from history and physical assessment
- results of laboratory tests and diagnostic imaging
- intended place of birth
- prenatal clinical observations and assessments of - well-being including discussions, advice, consultations and transfers of care
- notes of any prescription given

The midwife will be expected to use clinical judgement in determining how frequently to make any of the following observations. All relevant observations should be recorded. Informed choice discussions, consultations and transfer of care must be documented. ***All verbal communication including in person visits and telephone calls and written communication including letters, emails and texts must be clearly documented at all times.***

III. LABOUR RECORD
- Pertinent factors from history, physical assessment and prenatal care including relevant laboratory results
- chronology of intrapartum events, observations and assessments for well-being
- narrative recordings of care provided, discussions, advice, interventions, consultations and transfers of care

1 Perinatal Services BC- Perinatal Forms and Guides for Completion
http://www.perinatalservicesbc.ca/ForHealthcareProviders/Forms/PerinatalForms/default.htm

IV. THIRD STAGE AND IMMEDIATE POSTPARTUM CARE
- observation, assessment and care provided to the client during third stage and immediate postpartum
- medications
- departure note
- observations and assessments of well being
- date and time

V. IMMEDIATE CARE AND ASSESSMENT OF THE NEWBORN
- observations, assessment and care given to the newborn at birth
- newborn identification
- documentation of detailed newborn examination
- medications
- feeding

VI. POSTNATAL RECORD: NEWBORN
- observations, assessment and care provided in the postpartum period
- date and time of birth
- birth weight
- number of days
- newborn screening dates
- laboratory results
- medications
- narrative

VII. POSTNATAL RECORDS
- observations, assessment and care provided in the postpartum
- date and time of delivery
- number of days
- laboratory results
- medications
- Rh immunoglobulin: date/batch number
- narrative

VIII. SIX-WEEK POSTNATAL VISIT: NEWBORN
- final assessment and completion of care provided
- date and narrative

IX. SIX-WEEK POSTNATAL VISIT
- final assessment of physical and emotional status
- completion of clinical care and contraceptive advice
- date and narrative

X. NEONATAL RESUSCITATION/TRANSPORT SUMMARY
- summary of relevant events and the actions taken in the course of a neonatal resuscitation
- record of management, consultation and transfer of care

XI. BIRTH SUMMARY

- age
- gravida and para
- weeks gestation
- place of birth; planned / actual
- date and time of delivery
- live birth
- still birth
- spontaneous rupture of membranes
- artificial rupture of membranes
- length of rupture of membranes
- 1st stage; latent / active
- 2nd stage
- 3rd stage
- length of labour
- placenta
- membranes
- estimated blood loss
- perineal tears
- episiotomy
- perineal repairs
- consultations
- transfer of care
- medications

XII. BIRTH SUMMARY: NEWBORN RECORD

- date and time of birth
- sex
- weight
- multiple
- single
- Apgar - 1 minute / 5 minute
- suctioning
- oxygen administration
- resuscitation (indicate admission to level 1 or 2 hospital)
- abnormalities
- consultations
- transfer of care
- medications

XIII. GENERAL

Every entry in the clinical record must be signed or initialled by the care provider.