RECORD KEEPING STANDARD

Preamble

The midwifery record serves as a factual account of the client's care and is a key form of communication between midwives and between midwives and other healthcare providers. The midwifery record provides evidence to support the quality of the care and clinical decision-making, facilitates continuity of care and reflects the client's values and preferences. To support this the midwifery record must identify what care was provided and why, who provided the care, when the care was provided and recommended follow-up. In telling the story of a client's care, the midwifery record must be chronological, legible, and accurate. Clients have the right to records that are complete and understandable. Those records must remain private and secure.

Purpose

The purpose of this standard is to set out the College's requirements for documentation in, and management of, records related to the practice of midwifery.[1]

Definitions

Midwifery record – a paper or electronic record specific to the care of a midwifery client. Practice owners are custodians[2] of the midwifery record.

Hospital record – a paper or electronic record that includes documentation specific to client care occurring in the hospital. Hospitals are custodians of the hospital record. Requirements for hospital records are the jurisdiction of the hospital[3]

Client – an individual who is receiving midwifery care (i.e., pregnant, intrapartum, postpartum, or newborn).

[1] All institutions and locations where midwives practice will have their own requirements regarding record keeping midwives must follow

[2] The custodian of the midwifery record is the partnership that operates a midwifery practice group or a sole practitioner (Guide on Personal Health Information Protection Act, October 2020)

[3] See section 19 of the Public Hospitals Act for the requirements for record keeping in hospital records

Standard

Standards for the Midwifery Record

1. The midwifery record must include the client's relevant identifiers such as name, date of birth, OHIP number and their contact information (i.e., telephone number and address).
2. Every page of the midwifery record must have a client identifier.
3. The midwifery record must identify the midwife designated as responsible for the overall management of the client's care.
4. The midwifery record must reference care provided to the client outside of the midwifery practice group and update care plans as appropriate.

Standards for Documentation

A midwife is responsible for documenting all care they provide to a client according to the following:

5. Documentation must be chronological and completed at the time, or as soon as possible after an event. When a contemporaneous record of the care cannot be made, a late entry must be documented as soon as possible including the date and approximate time the care was provided and the date and time of, and rationale for, the late entry note.
6. Any corrections that must be made to an incomplete or inaccurate record must be clearly identified as incorrect and kept in the record. Corrections must be dated and signed.
7. Every entry must be legible and written in English or French, and only use terms and abbreviations that are understandable to all health care providers who may provide care.
8. Every entry must be identifiable, containing a signature or initial, or an audit trail that identifies the author and their professional designation.
9. When checklists and fields are part of the record, all relevant checkboxes and fields must be completed.
10. Any care provided under supervision (e.g., by a student) must be identified as such.[4]

[4] The midwifery record and the midwifery practice group's documentation policy should describe how care provided under supervision is identified in the client record.

11. When documentation has been assigned to a recorder during an emergency, the midwife must review the accuracy of the record and sign off on it as soon as possible after the event.

12. Documentation of the clinical encounter must be accurate and objective and include:
    a. the reason for the clinical encounter and information that conveys the client's health status and any concerns
    b. every assessment, clinical finding, treatment, discussion, or other provision of care provided by the midwife to the client
    c. the rationale for providing any procedures or treatments
    d. the client's response and outcomes to the interventions or care provided
    e. the client's care management plans and updates to the management plan
    f. all communication with the client that is relevant to their care whether in-person, virtual or through electronic communication such as email or text
    g. important communication with other care providers, family members, and substitute decision-makers
    h. every recommendation or order made by the midwife for examinations, tests, and consultations, and all associated reports received by the midwife or attempts made to acquire such reports
    i. every controlled act that the midwife has delegated to another care provider or that the midwife has performed under delegation
    j. all relevant information contained in a prescription by the midwife or a copy of the prescription
    k. every informed choice discussion, including risk, benefits, alternatives, any recommendations made and the client's consent or refusal
    l. every transfer of, and discharge from care as well as the reason for the transfer or discharge

Access and Retention of the Midwifery Record

Midwives must be aware of who is the custodian of the midwifery record and the rules and accountabilities with respect to the use, management, and storage[5] of the midwifery record.

Midwives must be aware of how to access past client records after they have left the midwifery practice group in the event the records must be accessed for a review of the care.

[5] Please refer to the Personal Health Information Protection Act, 2004 (s. 14). Available Online.

Every client midwifery record shall be retained by the custodian for the following time periods[6] :

a) For a client who is 18 years or older, the record must be retained for 10 years from the date of the last entry

b) For a client who is younger than 18 years, the record must be retained for 10 years after the day on which the client reached, or would have reached, 18 years of age.

Storage, transfer, and disposal of midwifery records must be in a manner that complies with the provisions of the *Personal Health Information Protection Act*, 2004.[7]

References (legislative and other)

Regulated Health Professions Act, 1991
Personal Health Information Protection Act, 2004.
Guide on Compliance with Personal Health Information Protection Act, October 2020
Strategies for Improving Documentation – Lessons from Medical-Legal Claims, HIROC

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[6] Custodians should note that the limitations period for some legal proceedings might be 15 years after an event and should consider retaining records for longer than the 10 year minimum requirement.

[7] Please refer to the College's Guide on Compliance with Personal Health Information Protection Act for obligations under privacy law (2020). Available Online.