STANDARD ON RECORDS AND RECORD KEEPING

PURPOSE

To provide midwives with guidelines for the management and maintenance of client health records, whether paper or electronic systems.

Required Forms
The midwifery records are comprised of prenatal, intrapartum, and postpartum records. Midwives will utilize the following provincial forms:

- Manitoba Prenatal Record
- Midwifery Discharge Summary Form

Other forms should be completed or maintained as required by the Regional Health Authority, midwifery practice, law, or hospital policy.

Completion of records
Midwives will complete and maintain standardized records, documenting care for each client as required by the practice, employer or hospital policy.

Important elements to consider:

- All documentation must be legible.
- All contact with clients must be documented (including telephone calls and text messages if applicable).
- All entries in the chart must be dated and signed, including professional designation, by the person making the entry (Signature sheets are acceptable. Signature sheets should not be photocopied).
- Entries in the chart will be made as close as possible to the time of occurrence. If a late entry is made, it will be timed and dated.
- Student documentation in the chart will be co-signed by a supervising midwife.
- All lab and diagnostic test results will be reviewed by a midwife responsible for care (reports will be reviewed daily by the coordinating midwife or another designated midwife).
- Every page of a client health record must have a unique client identifier.

Midwifery records must also include the following:

- Information about every order, request, or referral made by the midwife for examinations, tests, consultations, and treatments by other health care professionals
- Every written or verbal report received by the midwife with respect to examinations, tests, consultations, and treatments by other health care professionals
- A record of every prescription given and OTC medications and supplements recommended by the midwife
- Information about every examination performed by the midwife and information about every clinical finding and assessment made by the midwife
- Management plans/plan of care
- Effective documentation of all informed choice discussions that take place with a client, including the decision of the client and any relevant narrative notes

Storage, Confidentiality and accessibility
Midwives are responsible to adhere to their employers' policies regarding storage, confidentiality and accessibility in cases where the midwife's employer is a trustee as per the Personal Health Information Act (PHIA).

In the case of records regarding care provided by a midwife who is not employed by a trustee as per PHIA, the midwife is the trustee.
In such cases, every client health record shall be retained for at least 10 years following,

- The client’s last visit; or
- The day the client became or would have become 18 years old if the client was less than 18 years old at the time of their last visit,.
- Until the newborn becomes 28 years old (10 years past age of majority)

Client confidentiality is critical. Therefore, records must be kept secure.

Clients must be able to receive a complete copy of their midwifery records upon written request as per practice or Regional Health Authority policy. The midwife must make an effort to ensure that records are in a format that is accessible to the client. The midwife will provide a copy of the client’s records to another primary caregiver upon written request.