Standard:	Record Keeping Standard for Midwives
Reference #:	S_EC121112
Approved by:	EXECUTIVE
Date published:	January 11, 2013
Date Revised:	n/a
Attachments:	none

College of Midwives of Ontario
Ordre des Sages-Femmes de l'Ontario

CMO POLICY SUITE
Record Keeping Standard for Midwives

Purpose

The key purpose of record keeping is to manage information relevant to the client's care for the benefit of the client. Overall, any interaction that relates to the care of a client must be documented. Good record keeping helps to improve client outcomes by facilitating shared care among midwives and other health care professionals, facilitating continuity of care, and by documenting the management of all aspects of midwifery care.

Proper records also demonstrate professional accountability by documenting assessments, treatment and care decisions, informed choice discussions, and compliance with the standards of practice of midwifery. As records represent the care that was delivered, they may also become relevant in investigations (by the CMO or the Coroner's Office, for example) and may become the basis for evidence of care in regulatory, civil, criminal or administrative matters when care is called into question.

The Standards and Guidelines below are the minimum requirements for midwives practising in Ontario. Midwives must also consider the local community standards and incorporate those expectations in record keeping.

Standard:	Record Keeping Standard for Midwives
Reference #:	S_EC121112
Approved by:	EXECUTIVE
Date published:	January 11, 2013
Date Revised:	n/a
Attachments:	none

Standard on Records Relating to a Member's Practice

Each midwife shall, in relation to her practise, take all reasonable steps necessary to ensure that records are kept in accordance with this standard.

A separate client health record will be kept for each client (i.e., one for the woman and another for her newborn). That health record must have a client code identifier assigned by the midwifery practice.

Midwives must use the Ontario Antenatal Record 1 and Ontario Antenatal Record 2. The Antenatal Records must be filled out completely.

Midwifery records are comprised of prenatal, intrapartum and post-partum records.

Midwifery records must also include the following:

- the name of every midwife involved in the client's care
- the business or practice address
- identification of the client's coordinating midwife[1]
- signature sheet
- any significant findings in the health history and/or physical examination of the client
- management plans
- information about every order made by the midwife for examinations, tests, consultations
- a record of every prescription
- orders for treatments performed by any other person
- information about every examination performed by the member and information about every clinical finding and assessment made by the midwife
- information about every referral of the client by the midwife to another health professional
- every written report received by the midwife with respect to examinations, tests, consultations
- reports of treatments performed by other health care professionals
- information about all discussions – including telephone conversations - with the client relevant to client care and decision-making and all recommendations made by the midwife
- information about every controlled act within the meaning of subsection 27(2) of the *Regulated Health Professions Act*, 1991, performed by the midwife
- a copy of every written consent and refusal
- if checklists are used, each entry must be signed and dated

[1] As defined in the CMO Standard, *Continuity of Care*: One of the group of midwives will be identified as the health professional responsible for coordinating the care and identifying who is responsible if she is not on call.

Every part (e.g. each page or every electronic file) of a client health record must have a reference identifying the client or the client health record.

Every entry in a client health record must be dated and the person who made the entry must be legibly identified.

Every client health record shall be retained for at least 10 years following,

a. the client's last visit; or
b. if the client was less than 18 years old at the time of his or her last visit, the day the client became or would have become 18 years old.
c. until the newborn becomes 28 years old (10 years past age of majority)

Client confidentiality is critical regardless of the format of the record. Therefore, records must be secure.

A member shall provide reasonable access to a client health record and copies from a client health record for which the member has primary responsibility to any of the following persons on request:

1. The client
2. An individual that the client authorizes to receive the client health record.

Despite the above, a member is not required to provide access to or copies from a client health record if the member is of the opinion that disclosure of the health record would be likely to result in,
(a) serious harm to the care of the client; or
(b) serious physical or emotional harm to the client or another person.

A member may, for the purpose of providing health care or assisting in the provision of health care to a client in an emergency, permit a health professional to examine the client health record or give a health professional any information or thing contained in the record without the consent of the client.

A member may provide information or copies from a client health record to a person if,
(a) the information or copies are to be used for health administration or planning or health research or epidemiological studies; or

(b) the use of the information or copies is in the public interest as determined by the Minister; and

(c) anything that could identify the client is removed from the information or copies.

Before resigning as a member or ceasing to practice midwifery in Ontario, a member shall ensure that, for every client health record for which the member has primary responsibility,

(a) the record is transferred to another member or midwifery practice; or

(b) stored electronically or in paper format in a secure but accessible location as per the time period outlined above; or

(c) reasonable efforts are made to contact former clients for transfer of the health record so that they may obtain the records or have them transferred to another health care provider.

When a midwife leaves a practice, if records are kept by that practice where care was provided, there is no need to inform clients. A copy of the record must be available to each midwife involved in the care for the time that the record is in storage, regardless of location.

The following are acts of professional misconduct for the purposes of clause 51(1)(c) of the Health Professions Procedural Code:

(1) Allowing any person to examine a client health record or giving any information, copy or thing from a client health record to any person except as required by law or as required or allowed by this regulation.
(2) Failing to provide access to a client health record or to provide copies from a client health record for which the member has primary responsibility, as required by this regulation.

Guideline on Records

Purpose
In the interest of promoting and maintaining informed choice, the midwife must make the client records available to the woman throughout her care. An informed choice discussion with each client is recommended so that the client is aware of the risk, if this is the arrangement, in carrying personal health information in an insecure manner.

The midwife is obligated to provide, upon request, a copy of the complete midwifery records to the woman within a reasonable amount of time following completion of care.

The midwife should make reasonable efforts to ensure that the language and format of the client health records are accessible and understandable to the woman, including use of standard abbreviations in the record.

Practice Protocols

Practices may want to consider the development of a protocol or policy to ensure a consistent approach for all client records. Practices may want to include the following when developing a protocol or policy:

- the most pertinent clinical information should be included in the record
- relevant items such as informed choice discussion checklists, midwife and student signature sheet, narrative notes etc., should be included
- pertinent privacy and protection laws (e.g. locked storage, back-up files)
- an orientation to record keeping for all new midwives and student midwives should be a part of orientation to the practice
- environmental issues (e.g. use of a dehumidifier, fire-proof space and/or cabinets to protect records)
- a process to offer all clients a copy at final discharge

The College recommends that practices have an agreement that when a midwife leaves a practice, she retain or have access to a copy of all relevant client records for the time that the record is in storage.

Checklists

Checklists are an effective tool for use in a client record; they support communication in a shared care model of midwifery care. To ensure continuity of information provided by midwives, it is important to have practice protocols that reflect the items addressed by a checklist. The checklist will document the discussion of a topic and the woman's decision based on that discussion must be included in the chart, date of discussion and identification of midwife/student involved in the discussion.

Retention, Retrieval and Destruction

The College's requirements for records retention do not stipulate the format of the records; electronic or paper is acceptable. It is the responsibility of the midwife to ensure the safety and security of the system that is chosen to store files and to ensure the system employed for records storage meets the requirements of the College and privacy legislation.

If a member or practice group chooses to change to electronic storage of client records, the member(s) should ensure that College policies are followed with respect to:

- the content of the record,
- secure and safe storage of the record,
- reasonable client access, and
- legibility of the record.

In cases where the hospital requires retention of the client record before birth, ensure that there is a copy made prior to delivering to hospital.

Another important factor for practices to consider is that originals are considered the best evidence in the case of a complaint or a lawsuit; practices may want to consider retaining original client records for any case where an incident report has been filed or a complaint has been, or is likely to be laid. Additionally, if the image quality compromises the legibility of the client record, then an original paper copy of the record should be kept.

Once the obligation to retain client records has ceased, the records may be destroyed. Records must be disposed of in a secure manner such that the reconstruction of the record is not reasonably foreseeable in the circumstances, regardless of paper or digital records.

21 St. Clair Avenue East, Suite 303
Toronto, Ontario M4T 1L9
Tel 416 640 2252 **Fax** 416 640 2257 **Email** admin@cmo.on.ca