College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

Chart Review Tool

Chart Review

The chart review can be used for looking at the record keeping and documentation of a chart in accordance with the standard **maintain contemporaneous, accurate, objective, and legible records of the car that was provided during client care**. To understand more about requirements for charting please refer to the College's Professional Standard for Midwives and Record Keeping Standard for Midwives as well as other guiding documents such as HIROC's Strategies for Improving Documentation).

CHART REVIEW	
INDICATORS:	COMMENTS:
Chart includes all documents[1]	
Care provider signatures identified in chart	
Coordinating midwife MRP identified	
All records are complete, organized and legible	
All entries are dated and signed. Late entries are identified	
Informed choice discussions and informed consent documented[2]	
Client identifier included on each page of the chart	
Record of everyone who accessed the chart in included	
Client and newborn charts are complete and can be separated	

[1] For example, antenatal, intrapartum, postpartum and newborn records, lab results, consultations, notes of all contacts with clients between appointments.

[2] Documentation must include proposed test or treatment, expected benefits and potential risks See Health Care Consent Act's *Consent to Treatment* https://www.ontario.ca/laws/statute/96h02#BK13 and include decisions made (and consents if required).

Chart Interview

The chart interview can be used to look at a midwife's **care management, decision-making** and **knowledge-base** as well as **non-technical competencies** such as communication with clients or other health care providers. The interview is a discussion with the midwife where they have the opportunity to explain background information and the rationale for their decisions. The chart interview can be used on its own or can be a follow-up from the chart review allowing the midwife to discuss or reflect on any gaps identified that may be the result of incomplete care or incomplete record keeping.

Part 2: Chart Interview
Can you briefly tell me about this client and include anything that stands out about this client and the baby (e.g. physical, emotional, social)?
Summary:
Describe your management and treatment decisions for this client. What did you decide was appropriate for follow-up? What factors influenced your decision?
Summary:
Describe how you managed any clinical indications that exceeded your knowledge and skills, or the midwifery scope of practice?
Summary:

Were there any unique needs of this client that were challenging to work with and if so, how did you deal with those needs?
Summary:
What were the client's expectations and decisions around prenatal screening and choice of birthplace? Do you feel the client received the information needed to be the primary decisions maker in this aspect of care? Why or why not?
Summary:
Tell me about how you communicated with the client about normal and abnormal test results and discussions about the care plan for the client or newborn.
Summary:
Describe how your final visit went and if there was anything in particular you noted in your discharge letter to the client's family physician or paediatrician.
Summary:

Describe any discussions you had with midwives in your practice or other health care professionals about the client's care. This may include discussing the care plan and expected outcomes, or any concerns with the client's or newborn's health.
Summary:
When working collaboratively with other midwives or health care professionals, or when going off call for a period of time, describe how you provided continuity of care to your client.
Summary:
Were there any situations where you delegated or accepted delegation and if so, how did you manage those situations (e.g. client consent, charting, assuring competence)?
Summary:
Can you tell me what college standards, college guidelines, community standards, other guidelines (e.g. SOGC, AOM) and research evidence you used in the care of this client?
Summary:

Is there anything special about your practice environment (e.g. practice protocols, chart reviews) that contributed to a culture of client safety and quality of client care?
Summary:
When you reflect on this client's care, is there anything you wish you had done differently? Is there anything you think you should have asked the client about or discussed with the client?
Summary: