Management of Maternity Health Records

V1.3

11th April 2017
1. **Aim/Purpose of this Guideline**

1.1. This document has been produced to ensure that maternity health records, (which includes hand held maternity records) are managed in accordance with the Royal Cornwall Hospitals NHS Trust, Policy for managing health records and to identify the specific issues associated with maternity records and the process for managing these issues.

1.2. This document should therefore be read in conjunction with RCH Policy for managing health records 2012 and the Records Management Strategy 2011.

2. **The Guidance**

**Introduction**

Health records form part of the Trust’s corporate memory, providing evidence of actions and decisions and representing a vital asset to support our daily functions and operations. They protect the interests of the Royal Cornwall Hospital NHS Trust and the rights of patients, staff and members of the public who have dealings with the Trust. They support consistency, continuity and efficiency and productivity and help us deliver our services in consistent and equitable ways.

Sound records management ensures compliance with meeting the requirements of the Data Protection Act 1998 (DPA) and Access to Health Records Act 1990 (AHR).

Health Records Management is the process by which this Trust manages all aspects of clinical/health records, whether internally or externally generated and in any format or media type, from their creation, all the way through their lifecycle to their eventual disposal.¹

This version supersedes any previous versions of this document.

**Scope**

This policy applies to all members of staff who handle and use the patient health record.

**Definitions / Glossary**

In this policy, health records are defined as anything that contains information in any media that has been created or gathered as a result of any aspect of the work of NHS employees, which supports patient care and includes agency, casual staff or consultants.

**Ownership and Responsibilities**

**Role of the Managers**

Maternity line managers are responsible for ensuring that records controlled within
their department are managed in a way which meets the standards of the Trust’s records management policies.

**Role of the maternity risk management forum:**
To review any incidents relating to health records management and agree and monitor any action plan.
To receive an annual report on the compliance monitoring of record keeping standards, clinical note keeping and storage arrangements.

**Role of Individual Staff**
This applies to all Trust staff, whether clinical or administrative, who create, receive and use records. In particular all staff must ensure that they keep appropriate records of their work in the Trust and manage those records in keeping with this policy and the Trust policy

**Standards and Practice**

**Creation of maternity records and process for ensuring a contemporaneous complete record of care:** At the community booking appointment the midwife will complete the ante natal section in the RCH hand held maternity record of pregnancy and birth. The hand held notes will be given to the woman to keep safely and bring with her to every pregnancy related appointment. The woman will be informed that the records remain the property of RCH NHS Trust and must be returned following the completion of her care. The purpose of the hand held records is to ensure continuity of care for the woman throughout her pregnancy, child birth and post natal period. Following the booking appointment the midwife will enter the information received from the woman onto the ‘stork’ maternity IT system:

- One copy of ‘stork’ is printed out
- Record on the copy whether the woman requires either a 1st trimester screening appointment, dating appointment and/or referral to consultant obstetrician.
- The ‘stork’ printout is then sent, via internal mail, to maternity reception.
- The ‘stork’ printouts are then reviewed in the fetal medicine department and the appropriate appointments generated for the woman.
- The ‘stork’ printout is then sent to maternity records where the Clerk will either request the woman’s health records or if the woman is new to the area, generate a new set of health records.
- An obstetric divider will be placed in the health records
- The notes will be filed in the maternity records department until requested for either an out patients appointment or an inpatient episode.

**Tracking and retrieval:** All staff must ensure that health records are tracked using the Tracer Module of the Patient Administration System each time they are moved, failure to do so may result in missing records. All staff are mandated to attend PAS Training. Administrative staff will specifically undertake the Tracer Module training and will be issued with a certificate of competence before a password is issued. Health records are the responsibility of the individual that they are tracered to.

**Antenatal:** All antenatal outpatient/day assessment unit (DAU) care is recorded in the woman’s hand held notes. Any inpatient antenatal care is documented in the woman’s hand held notes. If the woman receives an antenatal CTG tracing
in hospital, the trace should be placed in a secure stor envelope, holed punched and filed in the main health records, this should not go home in the hand held notes. If a distance fetal monitoring is performed in the community setting, CTG printout should be sent by internal mail to DAU for filing in hospital health records. If the lead professional changes during the ante natal period, this should be recorded on the ‘stork’ IT system.

Labour and delivery records: The woman will be asked to telephone delivery suite when she is in labour or presenting with an obstetric related problem. If the woman is asked to attend the maternity unit a staff member will identify the location of her health records via the IT tracer system and arrange for the health records to be delivered to the clinical area in preparation for the woman’s admission. The health records must be tracered to the clinical area the woman will be attending. If the lead professional changes during the intrapartum period, this should be recorded on the ‘stork’ IT system.

Completion of intrapartum care:

- If the woman is transferred to the post natal ward for on going post natal care, the health records and hand held notes will accompany the woman to the ward; the appropriate tracer must be created.
- If the woman is transferred home for care by the community midwifery team, the antenatal and intrapartum section of the hand held notes must be removed and filed in the obstetric section of the medical records, this must include all cardiotocograph tracings (CTG’s), partograms, anaesthetic records, operative records, maternity early warning scoring system (MEOWS), high dependency (HDU) charts/intensive therapy (ITU) charts and prescription charts. These documents must not go home with the woman. The front page containing the contact numbers and the post natal section should be filed in the hand held notes and given to the women to ensure continuity of care in the community.
- If the lead professional changes during the post natal period, this should be recorded on the ‘stork’ IT system.

Neonatal notes:

- Immediately following birth neonatal health records will be commenced, the records will be contained in buff folder if the baby is being admitted to the neonatal unit and a yellow neonatal folder for a well baby. Once the baby has been allocated a CR/NHS number labels are printed and one is secured to the outside of the health record.
- Contained within the neonatal health record will be an infant record summary sheet and the ‘stork’ computer printout of the neonatal birth record.
- When the baby is transferred to the community setting the neonatal notes will be sent to the health records library for filing, a tracer must be complete
Return and amalgamation of all maternity records.

- When the woman has been transferred home, all of the records relating to the woman’s pregnancy and birth must be amalgamated, chronologically, into the obstetric section of her health records. Parent’s information that does not contain personal details does not need to be filed.
- The records relating to this pregnancy will be filed in front of any records relating to previous pregnancies.
- The health records will be tracered and filed in the post natal filing room. Tracer ‘PNFR’
- The hand held records will remain in the woman’s home until the last arranged visit by the community midwife; the records will then be removed by the community midwife.
- The hand held records will be stored in a locked cabinet at the midwives work base.
- Each week the post natal records of women who have been discharged from midwifery care will be returned to ‘the Post natal filing room, Princess Alexandra Wing (PAW), RCH’. A record is kept by the community team of the date the records were returned and a list is enclosed with the records giving the name and hospital number of the notes that are included. These records should only be returned via internal post.
- When the hand held records are received, they will be amalgamated, chronologically with the health records, again removing any patient information that contains no personal information and the card section dividers.
- The health records will then be tracered and returned to health records library for filing.

Temporary folders: There must only be one health record registered raised for each woman, duplication of records puts patients and the organisation at risk. Where it is unavoidable and temporary folders have to be raised the key identifiable information must be available so that merging of the records as soon as is possible can take place safely and the tracering system updated to reflect the amalgamation. Temporary folders must be identified as such on the tracer module. Only the Health Records Service Manager can authorise a second duplicate health record to be raised once a complete and thorough search has been made and documented, for the original health record

Women who transfer out of county: The hand held records will be given to the woman to keep safely and bring with her to every pregnancy related appointment. The woman will be informed that the records remain the property of RCH NHS Trust and must be returned following the completion of her care. The purpose of the hand held record is to ensure continuity of care for the woman throughout her pregnancy, child birth and post natal period. If the woman is moving out of the county, her named midwife should provide the woman with a photocopy of her hand held records to ensure continuity of care. The original hand held records should be returned to ‘the post natal filing room, Princess Alexandra Wing (PAW), RCH’ for amalgamation with her main health records. If a woman is transferred out of county for care in another hospital, the transferring midwife must photocopy all documentation necessary to ensure continuity of care; the hand held records will then be amalgamated with her main health records and filed in the maternity records, in case her care is transferred back to RCH at a later date. A tracer should be raised to this effect.
Lost notes: The front of the hand held records inform the women that:
- These notes remain the property of Royal Cornwall Hospitals NHS Trust and must be returned to you midwife after your care is complete.
- Please bring these notes with you to every appointment
- Please look after these notes as they are the only record of your pregnancy and care
- If these notes are found please return them to Princess Alexandra wing, RCHT, Truro TR1 3LJ.

If the woman loses her hand held notes a new set should be started and it should be clearly documented that this is a duplicate and that the first set of notes were lost.

Filing and storage within maternity records: All Obstetric records must be hole punched and filed behind the obstetric divider in the health records in the following order:
- Record of pregnancy and birth (ante natal section)
- Labour assessment and partogram
- Intrapartum records
- Pro formas and operation notes
- Anaesthetic records including epidural records
- MEOWS charts and HDU charts
- All CTG traces should be in a secure-stor enveloped, hole punched and filed in the notes
- Fetal blood sampling results should be written, chronologically in the notes and printed reports filed in the secure-stor envelope.
- All cord gas results should be hand written, chronologically in the intrapartum notes and on the immediate care after birth page, printed reports filed in the secure-stor envelope
- All ultrasound results are stored on the ‘viewpoint electronic database’. In addition a paper copy is added to the maternal hand held notes at the time of the procedure. Following completion of the pregnancy the contents of the hand held notes are amalgamated in the main medical notes.
- 1st and 2nd trimester Downs screening results are entered and stored on the ‘viewpoint electronic database’. There is no paper copy.
- Haematology results are stored on the blood bank electronic system. The community midwife will access the system and hand write the results into the woman’s hand held notes. There is no paper copy
- Ante natal Infection screening results are stored on the pathology system. The community midwife will access the pathology system and hand writes the results into the woman’s hand held notes, there is no paper copy.
- Ante natal sickle cell/thalasaemia screening are stored on the pathology system, there is no paper copy.
- All documentation, reports and results relating to previous pregnancies are stored in the main medical records behind the obstetric divider in chronological order. The CTG tracings will be stored in an envelope, which will be hole punched and secured in the hospital notes. Screening and blood results will be secured using a mount sheet.
Standards for record keeping and clinical note keeping: The following provides the standard expected at RCH in relation to recording in the health record:

- Identification Data - Patient name, CR number and NHS number to be included on both sides of every page of the record
- Date and time – this may be crucial when trying to reconstruct events and treatment given maybe several years later
- Legible – all entries must be legible and where at all possible written in black ink, this provides greater clarity when the records are being reproduced
- Signed – the entry must be attributable to an individual therefore printed name, along with designation as well as a signature must be part of either the first entry or completed in the signature log of the hand held notes, by each staff member, into the patient’s records. The Trust keeps a log of the signatures of all clinical staff and professional groups in all specialties that make entries in health records, at point of employment. This is reviewed annually and kept up to date under governance by Health Informatics. In addition every entry made must be signed by the person making the entry.
- Complete – all episodes and interventions made in regard to a patient must be recorded
- Abbreviations – must be kept to a minimum and the full meaning must appear the first time the abbreviation is used
- Alterations – entries in to the clinical/health record must never be erased, overwritten or inked out. Errors should be scored out with a single line, initialled, dated and timed.
- Additions – anything added to an entry at a later date must be separately dated, timed and signed.
- Personal comments – Employees of the Trust must not use offensive observations about the patient’s character, appearance or habits. Patients/next of kin are allowed to access their records under the Data Protection Act 1998 and Access to Health Records Act 1990
- Dictated notes – should be checked and signed by the professional who dictated them. It is not the responsibility of the person typing the notes.
- Request forms – these must contain enough information to be able to identify the patient, their presenting complaint and the test needed. Ensure the form is correctly dated and signed
- Reports – every report should be seen and acknowledged by a clinician.
- Abnormal results should be recorded in the patient’s clinical/health record along with the appropriate action taken
- Information given to patients – this should be recorded in the patient’s clinical/health record.

Audit of record keeping and clinical records: A high standard of documentation and clinical record keeping should be maintained at all times throughout the maternity service. A woman’s healthcare record should inform any clinician who has to provide care for a woman of all the key features which might influence the treatment proposed. The records should also provide a contemporaneous and complete record of the woman’s treatment and related features. The effective management of health records is a key indicator of good governance. Record keeping is an integral part of a woman’s care; it is not
separate from the process and should not be seen as such. Mistakes can harm women and babies and cause a serious risk for the Trust.

**Dissemination and Implementation**
This document will be submitted for inclusion in the Trust document library. Every clinical staff member in maternity will receive an email with the document enclosed and be included in the monthly risk management newsletter.

**Maternity notes filing process for intrapartum and post natal care**

**On admission in labour**
- Following the initial review main health records to be kept in appropriate pigeon hole.
- All documentation to be kept in green hand held notes
- The Secur-store envelope containing CTG/FBS/Cord gas results to remain in the main health records

**Following delivery**
- All documentation to remain in the green hand held notes whilst the woman an inpatient, to ensure continuity of obstetric, anaesthetic and midwifery care
- This will include all midwifery, obstetric and anaesthetic documentation, stork delivery printouts (2\textsuperscript{nd} copy of neonatal printout into yellow neonatal notes as before)
- If the woman requires an extended stay on delivery suite e.g. HDU, keep all documentation in the intrapartum section and do not include this documentation in the hand held notes on discharge

**On discharge from hospital it is vital that**
- All documentation should be removed from green hand held apart from green post/neonatal care section and information for parents which goes home with the woman.
- All removed documentation and the post natal discharge printout must be placed securely in main health records and left for ward clerk
- Post natal follow up form for woman or baby to be attached securely to front of the main health records.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Tool</th>
<th>Record keeping audit tool</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>How many pages do not have the woman’s CR number</td>
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<tr>
<td></td>
<td></td>
<td>How many pages do not have the woman’s NHS number</td>
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<tr>
<td></td>
<td></td>
<td>How many pages do not have the woman’s surname</td>
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<tr>
<td></td>
<td></td>
<td>How many pages do not have the woman’s first name</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many individual entries are there</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many entries are not dated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many entries are not signed</td>
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<tr>
<td></td>
<td></td>
<td>How many first entries do not have printed name/rubber stamp</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many first entries do not have designation printed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many entries are not in dark ink</td>
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<tr>
<td></td>
<td></td>
<td>How many entries contain some thing illegible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many alterations are there</td>
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<tr>
<td></td>
<td></td>
<td>How many entries are scored through with a single line?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many alterations are timed/dated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How many alterations are signed?</td>
</tr>
<tr>
<td>Storage arrangements audit tool</td>
<td></td>
<td>Are all CTG traces should be in a secure-stor enveloped, hole punched and filed in the notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is the partogram hole punched and filed Chronologically in the notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are all anaesthetic records including epidural records hole punched and filed chronologically in the notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are Fetal blood sampling results should be written, chronologically in the notes and printed reports filed in the secure-stor envelope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are all cord gas results hand written, chronologically in the intrapartum notes and reports filed in the secure-stor envelope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is there any loose documentation in any part of the health records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is there a paper copy of the first trimester and anomaly scan filed in the hand held notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are the ante natal screening test hand written in the ‘ante natal tests’, page 8</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td>1% or 10 sets, whichever the greater, of all health records of women who have delivered will be audited over a 12 month period.</td>
</tr>
</tbody>
</table>
### Reporting arrangements

A formal report, from the supervisors of midwives forum, will be received annually at the maternity risk management and clinical audit forum, as per the audit plan. If deficiencies have been identified by the supervisor of midwives forum an action plan will form part of the report.

| Acting on recommendations and Lead(s) | • Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum, agree the action plan and time frame for the completion of the actions  
• The contact supervisor of midwives will be the action plan lead  
The supervisor of midwives forum will monitor the action plan and provide an exception report for the maternity risk management and clinical audit forum until all actions are complete. |
| Change in practice and lessons to be shared | • Required changes to practice will be identified and actioned within a time frame agreed on the action plan  
• The contact supervisor of midwives will take each change forward where appropriate.  
The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan |

### 4. Equality and Diversity

#### 4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

#### 4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Management of maternity health records</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>11th April 2017</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>11 April 2017</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>11th April 2020</td>
</tr>
</tbody>
</table>
| **Directorate / Department responsible (author/owner):** | Clare Sizer  
Maternity Risk Management Midwife  
Obs and gynae directorate |
| **Contact details:** | 01872 255019 |

**Brief summary of contents**

This document has been produced to ensure that maternity health records, (which includes hand held maternity records) are managed in accordance with the Royal Cornwall Hospitals NHS Trust, Policy for managing health records and to identify the specific issues associated with maternity records and the process for managing these issues.

**Suggested Keywords:**

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>RCHT</th>
<th>PCH</th>
<th>CFT</th>
<th>KCCG</th>
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</thead>
<tbody>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>11th April 2017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>The management of maternity health records</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Approval route (names of committees)/consultation:** | Maternity guidelines meeting  
Obs and gynae directorate meeting |
| **Divisional Manager confirming approval processes:** | Head of Midwifery |
| **Name and Post Title of additional signatories:** | Not Required |
| **Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings** | {Original Copy Signed} |
| **Signature of Executive Director giving approval** | {Original Copy Signed} |
Management of Maternity Health Records

Publication Location (refer to Policy on Policies – Approvals and Ratification): Internet & Intranet  ✓ Intranet Only

Document Library Folder/Sub Folder Midwifery and obstetrics

Links to key external standards CNST 1.7, NHSLA standards

Related Documents:
• RCHT Policy for managing health records 2012
• RCHT Records Management Strategy 2011.
• Clinical guideline for booking, antenatal care and information giving. RCHT 2012

Training Need Identified?

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>January 2010</td>
<td>1.0</td>
<td>Initial document</td>
<td>Jan Clarkson Maternity risk manager</td>
</tr>
<tr>
<td>October 2010</td>
<td>1.1</td>
<td>No changes to content, updating of audit tool</td>
<td>Jan Clarkson Maternity risk manager</td>
</tr>
<tr>
<td>October 2012</td>
<td>1.2</td>
<td>No changes to content, updating of related documents and updating of compliance monitoring</td>
<td>Jan Clarkson Maternity risk manager</td>
</tr>
<tr>
<td>11th April 2017</td>
<td>1.3</td>
<td>Reviewed and no changed made until E3 electronic documentation system in place</td>
<td>Clare Sizer Risk Management Midwife</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) | (Provide brief description): Management of maternity health records |
|----------------------------------------------------------------------------------------------------------------|

<table>
<thead>
<tr>
<th>Directorate and service area: Obs and gynae directorate</th>
<th>Is this a new or existing Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Existing</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment: Clare Sizer</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>01872 255019</td>
</tr>
</tbody>
</table>

1. Policy Aim*
Who is the strategy / policy / proposal / service function aimed at?

| This document has been produced to ensure that maternity health records, (which includes hand held maternity records) are managed in accordance with the Royal Cornwall Hospitals NHS Trust, Policy for managing health records and to identify the specific issues associated with maternity records and the process for managing these issues. |

2. Policy Objectives*
To ensure a good standard of clinical record keeping and documentation and the safe storage of health records

3. Policy – intended Outcomes*
To ensure that health records support a good standard of patient care and are available to identify care given

4. *How will you measure the outcome?
Compliance monitoring tool

5. Who is intended to benefit from the policy?
All pregnant women and the Trust

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

   b) If yes, have these *groups been consulted?

    C). Please list any groups who have been consulted about this procedure.

7. The Impact
Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td>All pregnant women</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities / groups</td>
<td>X</td>
<td>All pregnant women</td>
<td></td>
</tr>
</tbody>
</table>

Management of Maternity Health Records
| Disability -  Learning disability, physical disability, sensory impairment and mental health problems | X | All pregnant women |
| Religion / other beliefs | X | All pregnant women |
| Marriage and civil partnership | X | All pregnant women |
| Pregnancy and maternity | X | All pregnant women |
| Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian | X | All pregnant women |

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No |

9. If you are not recommending a Full Impact assessment please explain why.

Signature of policy developer / lead manager / director Clare Sizer

Date of completion and submission 11th April 2017

Names and signatures of members carrying out the Screening Assessment

1. Clare Sizer
2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed SJ Pedler

Date 11th April 2017
Appendix 3

Filing order

Main health records
- Secure store envelop with all CTGs, FBS and cord gas results

During in patient episode filing order in green hand held notes
- MEOWS chart filed at the front
- Neonatal meconium/PROM observation charts
- Drug chart with VTE assessment
- ID sticky labels
- Pink section: Antenatal Care
- Blue section: Antenatal Filing
- Yellow Section: Intrapartum Care
  - Birth preferences
  - Modified waterlow score/manual handling risk assessment
  - Initial labour assessment and intrapartum notes and partogram
  - Any intrapartum proforma (suturing, operative delivery etc)
  - Any post natal care documentation on delivery suite e.g. HDU care
  - Consent form
  - Epidural forms in tray on delivery suite
  - Anaesthetic and theatre forms (pt operative profile, pre op check list and recovery, WHO check list)
  - Catheter and Cannula care plans
  - Labour and delivery stork printout
  - Neonatal record stork printout

- Green section: Post/Neonatal Care
  - Blood spot labels
  - Summary of labour and immediate post natal and neonatal care
  - Post natal assessments/post natal notes
  - Breast feeding information and support documentation
  - Neonatal assessments/neonatal notes
  - Postnatal information checklists

- Cream section: Information for Parents

On discharge from hospital it is vital that
- All documentation should be removed from green hand held apart from green post/neonatal care section and information for parents (which goes home with the woman).
- All removed documentation and the post natal discharge printout must be placed securely in main health records and left for ward clerk
- Post natal follow up form for woman or baby to be attached securely to front of the main health records.