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**

2.1 **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 General Data Protection Act 2018 (GDPA) 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.

2.2 **Scope**

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

2.3 **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.
2.4 Ownership and Responsibilities

2.4.1 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.

2.4.2 Role of the maternity patient safety 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.

2.4.3 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

2.5 Standards and Practice
2.5.1 All references to E3 are new 2018 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 and on E3 patient electronic record The hand held notes will be given to the woman to keep safely and bring with her to every pregnancy related appointment. The Maternity Unit is moving forward towards paperless electronic patient records this is enabling the reduction of hand held paper records. All staff involved in Maternity Care have training and are using the electronic system. 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 and the Electronic patient record is to ensure continuity of care for the woman throughout her pregnancy, child birth and post natal period.

2.5.2 One copy of E3, Current Pregnancy Questionnaire is printed out. Where E3 is mentioned these will all be new 2018
- Record on the copy whether the woman requires either a 1st trimester screening appointment, dating appointment and/or referral to consultant obstetrician.
- The E3, Current Pregnancy Questionnaire printout is then sent, via internal mail, to maternity reception.
- The E3, Current Pregnancy Questionnaire printouts are then reviewed in the fetal medicine department and the appropriate appointments generated for the woman.
- The E3, Current Pregnancy Questionnaire 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 outpatients appointment or an inpatient episode.

2.5.3 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 traced to.

2.5.4 Triage: all telephone contact will be recorded on E3.

2.5.5 Antenatal: All antenatal outpatient/day assessment unit (DAU) care is recorded on E3 under “Contacts” and 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 store 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 filed in the handheld notes and transferred to the hospital notes at the earliest opportunity. If the lead professional changes during the antenatal period, this should be recorded on the E3 electronic record. All antenatal admissions need to be recorded in the handheld notes and recorded on E3 as ‘admission’.

2.5.6 Labour and delivery records: 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 traced to the clinical area the woman will be attending. If the lead professional changes during the intrapartum period, this should be recorded on the E3 electronic record.

2.5.7 Completion of intrapartum care:
- If the woman is transferred to the postnatal ward for on-going postnatal 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 “Transfer to Community” questionnaire, in Post-Natal Care on E3 must be completed for both mother and baby prior to discharge. (new 2018) 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), Fluid balance chart, 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 postnatal period, this should be recorded on the E3 electronic record.
2.5.8 Neonatal notes:

- Immediately following birth neonatal health records will be commenced, the records will be contained in buff folder. Once the baby has been allocated a CR/NHS number via E3 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 summery sheet and the E3 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 postnatal records of women who have been discharged from midwifery care will be returned to ‘the Postnatal 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.

2.5.9 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 tracing 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.

2.5.10 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.

2.5.11 Lost notes:
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.

2.5.12 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 Fluid balance charts
- All CTG traces should be in a secure-store 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-store 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-store envelope
- All ultrasound results are stored on E3 and 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 E3 ‘viewpoint electronic database’. There is no paper copy.
- Haematology results are stored on MAXIMS. The community midwife will access the system and add them to E3 (new 2018) hand write the results into the woman’s hand held notes (new 2018). There is no paper copy.
- Ante natal Infection screening results are stored on the MAXIMS. The community midwife will access the MAXIMS system and add them to the E3 electronic patient record and (new 2018) 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 MAXIMS, 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.

2.5.13 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 General Data Protection Act 2018 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.
2.5.14 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.

2.6 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 patient safety newsletter.

2.7 Maternity notes filing process for intrapartum and postnatal care

2.7.1 On admission in labour
- Following the initial review main health records to be kept in appropriate pigeon hole.
- All documentation to be completed on E3 and where appropriate (new 2018) kept in green hand held notes
- The Secure-store envelope containing CTG/FBS/Cord gas results to remain in the main health records

2.7.2 Following delivery
- All documentation to be completed on E3 where appropriate and (new 2018) 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, E3 (new 2018) delivery printouts (2nd copy of neonatal printout into buff neonatal
- 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

2.7.3 On discharge from hospital it is vital that
- All documentation should be removed from hand held notes apart from green post/neonatal care section and information for parents which goes home with the woman. Post-natal Transfer to Community on E3 should be completed for both Mother and Baby. (new 2018)
- All removed documentation and the post natal transfer to community (new 2018) 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></th>
</tr>
</thead>
</table>
| • The audit will take into account record keeping by obstetric, anaesthetic and paediatric doctors, midwives, nurses, students and maternity support workers.  
• The audit will measure compliance with filing and storage arrangements  
• The results will be inputted onto an excel spread sheet  
• The audit will be registered with the Trust’s audit department  |

<table>
<thead>
<tr>
<th>Lead</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Audit midwife</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tool</th>
<th>Record keeping audit tool</th>
</tr>
</thead>
</table>
| • How many pages do not have the woman’s CR number  
• How many pages do not have the woman’s NHS number  
• How many pages do not have the woman’s surname  
• How many pages do not have the woman’s first name  
• How many individual entries are there  
• How many entries are not dated  
• How many entries are not signed  
• How many first entries do not have printed name/rubber stamp  
• How many first entries do not have designation printed  
• How many entries are not in dark ink  
• How many entries contain illegible documentation  
• How many alterations are there  
• How many entries are scored through with a single line?  
• How many alterations are timed/dated  
• How many alterations are signed?  |

<table>
<thead>
<tr>
<th>Storage arrangements audit tool</th>
<th></th>
</tr>
</thead>
</table>
| • Are all CTG traces should be in a secure-stor enveloped, hole punched and filed in the notes  
• Is the partogram hole punched and filed Chronologically in the notes  
• Are all anaesthetic records including epidural records hole punched and filed chronologically in the notes  
• Are Fetal blood sampling results should be written, chronologically in the notes and printed reports filed in the secure-stor envelope  
• Are all cord gas results hand written, chronologically in the intrapartum notes and reports filed in the secure-stor envelope  
• Is there any loose documentation in any part of the health records  
• Is there a paper copy of the first trimester and anomaly scan filed in the hand held notes  |

| Frequency | 1% or 10 sets, whichever the greater, of all health records of women who have delivered will be audited over a 12 month period.  |

| Reporting arrangements | A formal report, from the Audit Midwife (new 2018) will be received annually at the maternity patient safety 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 | Any deficiencies identified on the annual report will be discussed at the maternity patient safety and clinical audit  |
### and Lead(s)

| and Lead(s) | forum, agree the action plan and time frame for the completion of the actions  
|-------------|-----------------------------------------------------------------|
|             | • Audit Midwives to lead the action plan. (new 2018)  
|             | • The Audit Midwives (new 2018) will monitor the action plan and provide an exception report for the maternity patient safety and clinical audit forum until all actions are complete. |

### Change in practice and lessons to be shared

| 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  
|                                            | • Audit Midwife will take each change forward where appropriate.  
|                                            | The results of the audits will be distributed to all staff through the patient safety 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 Clinical Guideline V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>10\textsuperscript{th} August 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>10\textsuperscript{th} October 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>10\textsuperscript{th} October 2021</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Clare Sizer  
Maternity Patient Safety 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: | Maternity Health Records Notes Patient |
| Target Audience |  
RCHT  
CPFT  
KCCG  
checkmark |
| Executive Director responsible for Policy: | Medical Director |
| Date revised: | 10\textsuperscript{th} August 2018 |
| This document replaces (exact title of previous version): | Management of Maternity Health Records Clinical Guideline V1.3 |
| Approval route (names of committees)/consultation: | Maternity guidelines meeting  
Obs and gynae directorate meeting  
Divisional Board  
Policy Review Group |
| Divisional Manager confirming approval processes | Tunde Adewopo |
| Name and Post Title of additional signatories | Not Required |
| Name and Signature of Divisional/Directorate Governance | {Original Copy Signed} |
Lead confirming approval by specialty and divisional management meetings

Name: Caroline Amukusana

Signature of Executive Director giving approval

{Original Copy Signed}

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
- Clinical guideline for booking, antenatal care and information giving, RCHT 2012

Training Need Identified?

On-going training for e3 with IT Midwife

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<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 Patient Safety Midwife</td>
</tr>
<tr>
<td>10th August 2018</td>
<td>2.0</td>
<td>See new 2018 in body of text relating to introduction and changes in documenting on E3</td>
<td>Kim Hewlett, IT 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 for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). 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

This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.

<table>
<thead>
<tr>
<th>Name of</th>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of Maternity Health Records Clinical Guideline V2.0</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim Hewlett</td>
<td>01872 25 2720</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***
   - **Who is the strategy / policy / proposal / service function aimed at?**
   - To ensure a good standard of clinical record keeping and documentation and the safe storage of health records

3. **Policy – intended Outcomes***
   - **Who is the strategy / policy / proposal / service function aimed at?**
   - 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. **Who did you consult with?**
   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other
   - X

   **Please record specific names of groups**
   - Maternity Guidelines Meeting
   - Directorate Meeting
   - Divisional Board
   - Policy Review Group

What was the outcome of the consultation?
   - Guideline agreed
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></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></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td></td>
<td>All pregnant women</td>
</tr>
</tbody>
</table>

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 this relates to service redesign or development

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

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

No areas indicated
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

This EIA will not be uploaded to the Trust website without the signature of the
Human Rights, Equality & Inclusion Lead.

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

Signed Sarah-Jane Pedler
Date 10th August 2018
Appendix 2.

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.