Midwives Protection Program

RISK NOTE

SUBJECT: Documentation for Midwives

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Midwives must take care to ensure that all documentation in a client chart is complete, accurate, and meets standards of professional excellence. Charting is an integral part of health care. It is a key method of communication between health care team members while client care is occurring, and it is the way in which the care provided to a client is recorded and preserved for future reference should the care provided require review or legal defense. As such, the chart is the primary evidence as to the events which transpired and the care provided.

This risk note is intended to identify some of the issues that arise with charting, and to provide tips and resources for improved excellence in documentation.

General Charting Principles

The chart is the entire content of a medical record.

The chart should include all records pertaining to the client and the care they received, including but not limited to progress notes, flow sheets, visit entries, vital and other measurement data recorded, medical orders, diagnostic test results, lab results, written or electronic communication (including emails and texts), consent and any other records.

The chart tells the story of what you did, and why you did it.

The chart is your opportunity to prove that your care was excellent and met professional standards. Therefore, it should include details on actions taken, as well as rationale for those actions, in order to preserve a clear memory of the events. While the old adage “if it isn’t written, it didn’t happen” has some merit, it is not entirely true. In the absence of documentation, a court may consider a provider’s evidence about their usual practice in similar circumstances. However, without documentation the court may not accept the care provider’s testimony about what occurred. Therefore, the best evidence remains that which the provider documented in the medical record at the time care was provided.

Only the facts should be charted.

The writer should only record facts they have personally seen or measured. Actions taken in response are also facts which should be recorded. The point is that there should be no speculation, guesses, or personal opinions as to what transpired or what may have been causative. It is also inappropriate to comment on the quality or standard of care provided by another health care professional.

In the case of adverse events, incident report forms and quality assurance (QA) review materials do not form part of the client's chart. There should be no mention of incident reports including Patient Safety Learning System (PSLS) reports in the client's chart, nor any materials related to a Section 51-protected QA review[1] including the incident report form, summaries, recommendations, or other QA documents.

Good charting can prevent litigation.

When considering litigation, a lawyer will usually request and review the client's chart to decide if there are sufficient reasons to believe a health care professional has been negligent. With accurate, detailed and concise charting, the lawyer may determine that appropriate care was provided and recommend the client not start a lawsuit. In the face of regulatory complaints or negligence actions, good charting can "facilitate a prompt and successful resolution or, better yet, a dismissal of the action".[2] This may reduce further the risk of potential litigation related to the same issue in future.

Charts form the factual evidence in court proceedings.

The health record is useful in "reconstructing events, establishing times and dates, refreshing memories, and resolving conflicts in testimony".[3] Charts are such an important piece of evidence that the Supreme Court of Canada[4] ruled that hospital records, written contemporaneously by someone having personal knowledge of the matters being recorded and under a duty to make the entry in the record should be considered by courts as *prima facie* proof (accepted as truth unless proven otherwise) of the facts stated therein.

Credible and Defensible Documentation

Accurate and Complete[5]

Documentation should accurately reflect the state of the client, the treatments / interventions provided, and the client's outcomes. In midwifery, this includes fetal status as well as maternal status. Make sure to complete your entries, and sign them. Anyone reading the chart should be able to determine what care was provided, to whom, by whom, when and why.[6]

Be sure that you only chart what you actually did. In the case of checklists, or checkboxes in Electronic Medical Records (EMR), be sure to only check those that you can demonstrate you performed, and what the results were. If you were to check boxes that you did not actually assess or address, it could negatively impact the credibility of the whole chart, as well as the care you provided.

Factual and Objective

Record your assessments and observations factually, objectively, and completely. Record what was done, seen and heard. Avoid vague or ambiguous statements, and the

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[1] For details on Section 51 reviews, please refer to the MPP Risk Note *"Understanding Section 51 of the Evidence Act".*

[2] Healthcare Insurance Reciprocal of Canada (HIROC) (2017). *Strategies for improving documentation: Lessons from medical-legal claims.* At page 5. https://www.hiroc.com/getmedia/9b3d1ed1-b2e1-45fc-ae18-bfc998177d15/Documentation-Guide-2017.pdf.aspx

[3] HIROC (2017), *supra*, at 5.

[4] *Ares v. Venner,* [1970] SCR 608.

[5] HIROC (2017), *supra*, at 5.

[6] *Ibid*.

use of adjectives. For example, when documenting a labour, instead of stating “coping well”, state what the client is actually doing and what you are observing, such as “breathing deeply, on hands and knees, partner assisting, does not appear to be in distress”.

When recording what a client said, use their actual words in quotation marks where possible, especially in times of hostility, upset, or non-compliance. For example, instead of simply writing “declines non stress test appointment” for a post-dates client, record “Called client to inform of non stress test appointment. Client stated, ‘I am not going back to that hospital again’ and that she refuses to have a non stress test. Hospital informed, appointment cancelled.”

When variations of normal arise, clearly document the specific steps taken in response. Remember that your actions are much easier to defend if the thought processes and clinical judgement applied in care decisions were mapped out clearly in a chart.

Contemporaneous

The frequency of documentation should increase as the acuity of the client increases. In acute care, ensure documentation occurs at regular intervals, as large lapses in time can make it difficult to accurately reconstruct events. Never document in advance of providing care. Record each call and page as close to the time they are received as possible. Include the time, reason for call, information received from the client, advice or recommendations provided, and the client’s response.

Chronological

Chart in the order that events occur. Writing out of order can raise doubt as to when the entries were made. When documentation is out of chronological order, those reviewing them will be left to try and determine how that occurred and why. They may question whether the entry was made due to liability concern, or due to forgetfulness. Do not leave blank spaces, or write in margins. If there is blank space on a page after going on to a new page, cross through it to avoid entries being written on it out of order.

Permanent and Legible

Sign each entry in full, with professional designation such as RM, BCCNM member number, etc. Ensure to sign the face sheet of a hospital chart, if your site uses them, with printed name, designation, full signature and initials. Use patient identifiers on each page so the record is linked to the correct client.

Avoid non-standard abbreviations as they may be difficult to recall or understand years later if needed. If handwriting legibility is an issue, use block printing or dictate notes instead. Illegible and scant notes can be detrimental to client care. They have been interpreted as evidence of haste and lack of care, and may therefore impact the credibility of even the most seasoned and expert healthcare professional.

Documenting Informed Choice

To be defensible, all elements of informed consent or informed refusal must be documented. In the case of specific recommendations, be sure to clearly document what recommendations were made and the reasons. Other elements of informed choice provided to the client as well as best practices to use are listed in the **MPP Risk note: Informed Choice for Midwives**. The importance of documentation applies equally to situations where clients accept or refuse recommended care as a part of the informed choice process.

For further information, please review the BCCNM's Policy on Requests for Care Outside Standards.[7]

Documenting Midwifery Discussions and Physician Consultations

For each client, midwives should review the BCCNM's Indications for Discussion, Consultation, and Transfer of Care[8] and record in the chart which indications are relevant, and which discussion, consultations, and transfers occur. Within this documentation, a detailed note including who was involved, when the discussion/consultation occurred, and the resulting care plan or management decisions that were recommended. Ensuring that this charting standard is met for discussions between midwives is as important as charting consultations, in the case that a chart was reviewed by the BCCNM or by a court, as this is the only way to evidence that the midwife is following professional guidelines.

When consulting with physicians, it is important to make your own entries in the chart, instead of relying solely on what the physician recorded. Chart consultations completely including what a physician was specifically told, the time they were told, by what method (phone, in person) and their response, such as stated would come to see client, new orders given or if they provided advice but are not coming to see the client. For office consults, keep copies of all communication sent and received. Ensure all relevant portions of the medical record are available to the consultant and record which documents were sent with the request.

All of these specific indications, as referenced to the BCCNM's Indications for Discussion, Consultation, and Transfer of Care, represent risk factors that should also be documented on the Antenatal record clearly, so that any other provider involved in the clients care is readily aware of the risk factors.

> **TIPS:** Always document in the chart: dates of chart review, RMs present, *Indications for Discussion, Consultation, and Transfer of Care* that are relevant to a client, and any care plans made.
>
> Be sure to note all risk factors clearly on the Antenatal record (for example, in Antenatal Part 2 section 15), so that other providers are aware as well.

[7] BCCNM (2020). *Policy on Requests for Care Outside Standards.* https://www.bccnm.ca/Documents/standards_practice/rm/RM_Policy_on_Requests_for_Care_Outside_Standards.pdf

[8] BCCNM (2020). *Indications for Discussion, Consultation, and Transfer of Care.* https://www.bccnm.ca/Documents/standards_practice/rm/RM_Indications_for_Discussion_Consultation_and_Transfer_of_Care.pdf

Advocacy and Charting

On occasion, a midwife may have concern about the care provided by a nurse or physician, or recommended care plans from consultant physicians. If not in acute situations, request second opinions and thoroughly document the discussion. If acute and occurring in hospital, follow protocols for escalating concerns through a chain of command. Chart the specific actions taken (i.e. who was informed, what they were told, what their response was, and when they were informed).

Recording Detailed Notes for Legal Purposes

In the case of an adverse outcome, midwives may want to preserve their memories of the event by making personal notes about observations and opinions beyond what is recorded in the chart. These notes can be helpful for future potential litigation as they can be written in more detail than would be in the medical record.

In general, these notes are protected under solicitor-client privilege only if they are prepared in the interest of obtaining legal advice – for clarity, mark the notes "for my lawyer only". Therefore, it may be best to contact the MPP prior to making such notes. If unsure in the event of an adverse outcome, contact MPP the same business day, or the day following to seek advice from MPP legal counsel.

Late Entries

Late entries are any notes, comments, or new information recorded in a chart after the event occurred or care was provided. Late entries can also be additions made to existing documentation. While late entries can be made for valid reasons, courts may not find them to be reliable evidence, because the writer was aware of the outcome when the note was made. As such they may be seen as suspicious or a cover-up of facts that the provider would like to diminish or hide.[9]

There are times when a late entry is appropriate.

It is understandable that in acute or emergent situations, midwives are providing client care and unable to make timely chart entries. In these situations, where there are human resources available, appoint one person as recorder. The more contemporaneous the charting, the more reliable it will be considered in future.

If you are making late entries, be sure to document a reason for them.

For example, you may note that the client (initials only) required emergency care, or that you were urgently called away to another client, so you were unable to chart at the time. It is also inappropriate to attempt to reconstruct the events that occurred and record them as if they were recorded at the time they occurred. From a medical legal perspective this can appear that the writer was worrying in hindsight about the care provided in light of an outcome, and could be seen as falsification of the record.[10]

[9] HIROC (2017), *supra*, at 16.

[10] Woods, Catherine, QC, *In Defence of Nurses. Standard of Care and Causation in Medical Malpractice Cases,* article written for the Canadian Institute course entitled Critical Developments in Reducing the Risk of Obstetric Malpractice Lawsuits February 16, 1998 at 26.

In the event that a late entry is needed, the date and time of the entry should be of the note itself, followed by the date and time of the events described in the note.

Make your note as precise as possible, leaving a clear intellectual footprint of when the note was made as well as when the care occurred. Use the words "late entry" and then record reasons for the lateness. Use the word "approximately" if there is uncertainty around timing.

For example:

Late Entry, August 7/18 06:21
Writer called away to attend to another client urgently after delivery. Late entry of third stage as occurred on August 6/18 at approximately 23:30-23:45. Placenta delivered intact at 23:35 with maternal effort and CCT, EBL minimal approx. 150 cc., fundus firm, central, at umbilicus. Maternal VSS. Perineum intact. Pt stable, cuddling with newborn.

> **TIP**: Only use late entries if they are required to complete the documentation of care. When required, make them as soon as possible, avoiding late entries being made several days later.

Making Corrections

While errors in charting occur, it is important to clearly differentiate corrections from alterations.

Changing or altering a written record can be perceived as hiding facts, and can cause a court to question the credibility of the care provider who made the change, as well as undermine the court's view of the entire chart's reliability. Therefore, care providers should never alter any part of the chart or add charting to the original once it has been recorded, unless it is an error that is being corrected, or additional information is needed to make a more fulsome note.[11] If there is blank space in the chart near an entry, cross it out and move on to the next page. Avoid squeezing extra writing in at the end of an entry or in margins as this may appear to have been added after the fact.

In case of error, the incorrect entry should be crossed out with one line, identified as an error, dated and initialled.

Only the person who made the error should make the correction. Never erase or delete the error entirely or in a manner that leaves it unreadable. If the error was made using EMR, it is important to mark the error in quotes, brackets, or another way that identifies the section being corrected, with a corrected entry right beside it. Do not delete the old entry as the EMR software will record the change in its "audit trail".[12] In litigation, this would leave the care provider that made the deletion open to potential criticism that they altered the record to hide facts.

Email, Text, and Phone Communications

Midwives frequently receive client questions and concerns by either email or phone, or more urgent concerns through paging systems. All of these must be included in the chart in one form or another. Ideally attach a printout of the actual record if written in either text

[11] Canadian Medical Protective Association (CMPA) (2011). *Why good documentation matters*. At 2. https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2011/why-good-documentation-matters

[12] Canadian Medical Protective Association (CMPA). *The Electronic records handbook.* https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/com_electronic_records_handbook-e.pdf

or email. Be aware of the permanency of written advice, and ensure to take care when providing advice by email. Consider whether an in person assessment and discussion about the issue would be more appropriate. For telephone communications, record the date and time of inquiry, the relevant history and clinical issues, the question posed or concerns raised by the client, the advice provided, and the client's response to the advice.

> **TIP**: Make entries into the chart as soon as possible after a telephone conversation or page is received.

For further guidance on use of email or text, please review the BCCNM's Guideline for Using Electronic Communication to Transmit Client Information.[13]

Variance Charting

Variance charting (also known as charting by exception) is often used on standardized forms to reduce the amount of writing required, as well as to make charting more consistent between providers. With variance charting, objective assessments are recorded as data. This includes checklists and measurements such as blood pressure, weight, contraction frequency, temperature, etc. Should the measurements be outside of what would be considered normal, the provider writes a longer narrative note describing the assessments in detail. An example of a form that uses variance charting is the provincial partogram used throughout the province to track progress in labour and delivery.[14]

Concerns with variance charting:

1. **The absence of variance notes suggests that only normal observations and assessment were made, or that no care was provided at all.** Not all providers use variance charting the same way, and not all abnormal findings are noted to be variances. In the case of legal proceedings where there was clearly abnormal events, this lack of charting or errors in documentation can form the basis for a court to find that the provider either did not make the correct assessments or failed to chart adequately, which can raise questions for the court in other areas of the adequacy of the provider's care and charting.

2. **Providers can accidentally misuse checklists and checkboxes commonly found in variance forms**.[15] Whether in EMR or on paper, a provider can casually tick off boxes that perhaps were not assessed in a client's particular case. When using checkboxes, be sure to only check the ones you can demonstrate or explain how the assessment was made, or what the conversation consisted of. Be sure to leave others blank if you did not assess them.

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[13] BCCNM (2018). *Guideline for Using Electronic Communication to Transmit Client Information.* https://www.bccnm.ca/Documents/standards_practice/rm/RM_Guideline_for_Elec_Comms_to_Transmit_Client_Info.pdf

[14] Perinatal Services of British Columbia (PSBC) (2010). *A guide for completion of the BC Labour Partogram (BCHCP 1583)* http://www.perinatalservicesbc.ca/health-professionals/professional-resources/pathways-toolkits/labour-toolkit

[15] HIROC (2017), *supra*, at 19.

TIP: When using variance charting, pay close attention to record all normal data, and add detailed narrative notes about abnormal observations and assessments including what the variance was, what action was taken, and what the response to the actions was.

Charting with Templates

Midwives may utilize features in EMR that allow pre-entered text to be cut and pasted into a chart entry. Similar to charting with checkboxes, these features can save valuable time and energy. However, templates that are copied and pasted into charts also provide opportunity for liability. Risks of using templates include having inaccurate or outdated information in the chart, repeating information or making too lengthy notes which are not beneficial,[16] and not personalizing the record to the circumstances of the client or the advice given.

At other times, a midwife may copy an entry from one client's record into another, as if it were a template. However this should be prohibited as errors can occur where all the information isn't corrected or changed to reflect the current client's information.
If the court were to see documentation that includes pre-written answers that had not been personalized or edited when the template was used, the entire record may be given less weight for accuracy in evidence.

TIP: When using templates, always start with a blank form. Only pre-record the headings, not possible answers. This will ensure that each field is completed specifically for the client.

Client Access to Medical Records

Clients have a right to access the medical records that pertain to their care. While the physical records are the property of the care provider, the client is entitled to access, examine, and receive a copy of their medical record upon request.[17] While there are exceptions, the entitlement generally extends to records compiled by the provider specific to the client.[18] It does not extend to records of third parties, or to records on other clients. A provider who refused a records request from a client would need to demonstrate compelling reasons for the refusal. Should you receive any records requests that you think may be for litigation purposes, please immediately contact the MPP.

[16] *Ibid*, at 23.
[17] *McInerney v. MacDonald*, [1992] 2 SCR 138, 1992 CanLII 57 (SCC).
[18] *Personal Information Protection Act* [SBC 2003] c 63 at s. 23

Further Resources

College of Registered Nurses of BC (CRNBC)
CRNBC offers several online resources for charting: nursing documentation standards,[19] a documentation web module,[20] and a documentation workbook for skills refreshing.[21] (Hint: you do not have to log in to CRNBC to see these documents. Hit "cancel" when the log in screen opens, then wait for the document or web module to load.)

Canadian Medical Protective Association (CMPA)
The CMPA provides an online medical-legal handbook for physicians.[22] This handbook offers extensive advice in reducing risk in practice including in charting. The Electronic Records handbook[23] provides useful information for using EMRs.

Healthcare Insurance Reciprocal of Canada (HIROC)
HIROC produced an excellent handbook on documentation for healthcare which provides a guide to best practices.[24]

[19] https://www.bccnm.ca/RN/PracticeStandards/Pages/documentation.aspx
[20] https://www.bccnm.ca/RN/learning/Pages/modules.aspx
[21] https://www.bccnm.ca/Documents/learning/modules/PSworkbook.pdf
[22] https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/com_16_MLH_for_physicians-e.pdf
[23] https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/com_electronic_records_handbook-e.pdf
[24] https://www.hiroc.com/getmedia/9b3d1ed1-b2e1-45fc-ae18-bfc998177d15/Documentation-Guide-2017.pdf.aspx

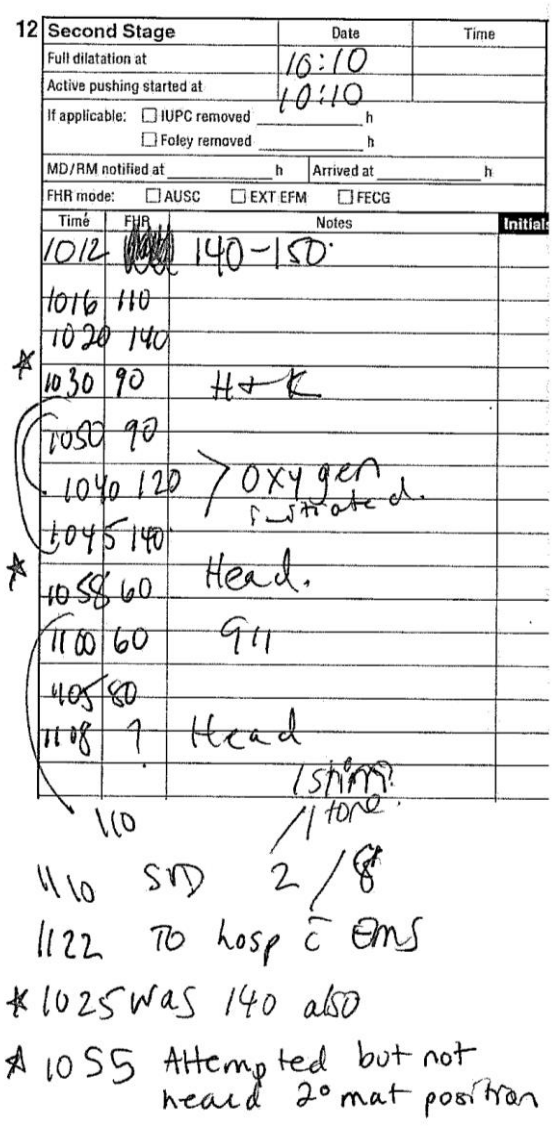
Test Your Knowledge

A multiparous client is in labour at home, with a planned homebirth. Labour progresses rapidly, and the midwife calls a second attendant who joins them at home. At 10:10, the client begins pushing. The fetal heart rate (FHR) is normal at first but the midwives begin to note decelerations to 110, then 90, after contractions. The woman is repositioned and pushing continues with improved heart rate. However decels return, now to 60, repetitive and prolonged. 911 is called for assistance and possible transport. Birth soon becomes imminent. The family is very concerned, the mother-in-law is anxious and crying, and the partner is asking many questions as the midwives encourage the client to push. The second attendant is unable to find a FHR in the last few minutes of the delivery. All appropriate steps of intrauterine resuscitation are taken.

At 11:10, the baby is born spontaneously. He is pale, has poor tone, no respiratory effort, minimal response to stimulation, and HR < 60. All of the appropriate steps of resuscitation are taken by the midwives. At one minute the baby's status is the same. At three minutes, PPV is discontinued as the baby is breathing spontaneously and the HR is 110. At five minutes, the midwives note that the baby is improving more, has respiratory effort, good tone, good response to stimulation, and is pinking slowly. The midwives reassure the family that the baby is stable. He is transported to hospital for post-resuscitation care and appears to be in good condition.

Several months later, the midwives receive a letter informing them the clients have filed a complaint with the BCCNM. They inform the MPP, and their records are sent to the BCCNM. The complaint includes allegations of mismanagement of labour, failure to recognize the emergency, failure to transport to hospital, and that the partner and mother-in-law have developed severe anxiety related to witnessing the delivery.

The following is the record of 2nd stage:



12 Second Stage | Date | Time

Full dilatation at — 10:10

Active pushing started at — 10:10

If applicable: ☐ IUPC removed ____ h ☐ Foley removed ____ h

MD/RM notified at ____ h | Arrived at ____ h

FHR mode: ☐ AUSC ☐ EXT EFM ☐ FECG

Time	FHR	Notes	Initials
1012	[illegible]	140-150	
1016	110		
1020	140		
★ 1030	90	H+K	
1050	90		
1040	120	> Oxygen initiated.	
1045	140		
★ 1055	60	Head.	
1100	60	911	
1105	80		
1108	?	Head	
		1 stim?	
		1 tone.	

110

1110 SVD 2/8

1122 To hosp c EMS

★ 1025 was 140 also

★ 1055 Attempted but not heard 2° mat position

Questions:

1. Is the documentation provided sufficient to prove the midwives provided appropriate care? If no, list all of the reasons why.

2. What could the midwives have done differently after the delivery to better document the care they provided?

3. If this baby had serious sequelae become evident in the future, the midwives may need to prove to a court that the care they provided met the standard of care and did not cause the injury.

   If the EMS had recorded the following, how would it compare to the midwives notes? How might it appear to a court?

   "Late entry: recorded at 11:45 after arrival and handover to pediatrician. Arrived at 11:12. Newborn being resuscitated by PPV by midwives. Offered assistance. At 11:15 newborn is pale, moving slightly, and minimal respiratory effort. Preparing to transport. Midwives continue to resuscitate with PPV. Pulse oximeter placed at 11:17. SpO2 86. HR 90. En route at 11:30"

Answers:

1. *No. While the appearance of the chart may appear "normal" for a homebirth, especially when there are emergencies, the documentation fails to meet standards of care that would be expected of the midwives. The documentation does not provide any information that indicates the midwives recognized the emergency, does not indicate treatments or procedures utilized to respond to emergency, does not clearly indicate the progress of second stage, is illegible at points, is incomplete, is not recorded contemporaneously, includes notes clearly written after the fact as additions, has improperly made corrections, does not make sense in parts, is not signed, and would not serve to refresh either midwife's memory of the events in the future.*

   Should a third party or court examine this charting, they would have a difficult time "seeing" a complete picture of what had occurred in second stage and at the delivery. As such, the midwives would have a difficult time proving that they had provided the elements of care that they would need to prove in order to not be found negligent.

2. *The midwives could convincingly argue that they were unable to chart details contemporaneously as they were dealing with an emergency. However, they would need to demonstrate through a late entry, ideally as a detailed note, the facts that were missing in the minimal charting recorded during the event.*

   To be most acceptable, the late entry should be made as close in time to the event as possible, be noted as the time that the entry was made and then the time that the event being recorded occurred, and be signed by the writer with a reason for the late entry noted. It should be written clearly in its own space and not squeezed in where it might have gone had it been written originally.

3. *The EMS note is notably inconsistent with the chart notes made by the midwives. As the scenario tells us, many of the EMS notes are incorrect. Yet, in comparison to the midwives notes, the EMS note is more complete and therefore may be accepted as evidence.*

   Specifically, the EMS note would raise questions about the timing of events as recorded by midwives, and as such the length of time the resuscitation occurred. Also it would raise question as to the correctness of the Apgars, written roughly by the midwives as 2 at 1 minute and 8 at 5 minutes, compared to something in the range of 3-5 at 5 minutes, based on the EMS note.

   If the newborn had long term sequelae, the court may find the EMS records more acceptable evidence of the newborn's state, despite the fact that the midwives did in fact provide care that met standards and that the newborn was in better condition than the EMS attendant (who may have little experience with newborns) noted. This may raise question as to the validity or correctness of the entire midwifery chart and documentation, and make their care difficult to defend.

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questions about the content of this Risk Note please contact the MPP at MPP@gov.bc.ca