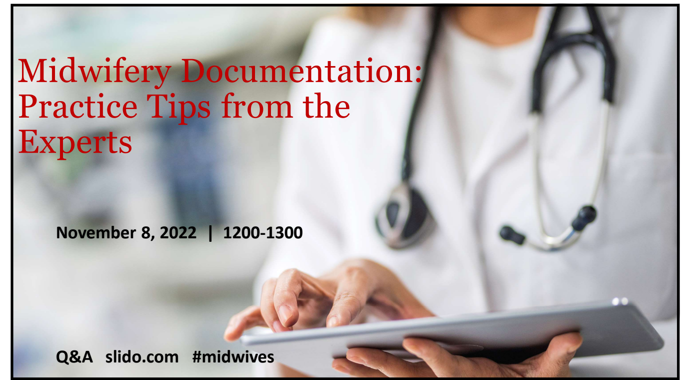

DISCLOSURES

Our faculty have no conflicts or affiliations to disclose

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QUIZ TIME / Q&A

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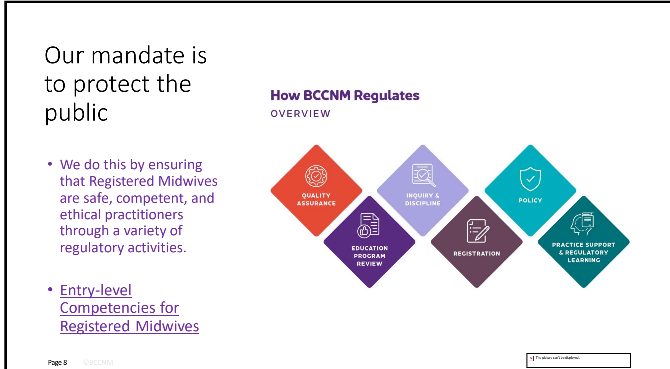
Up vote with

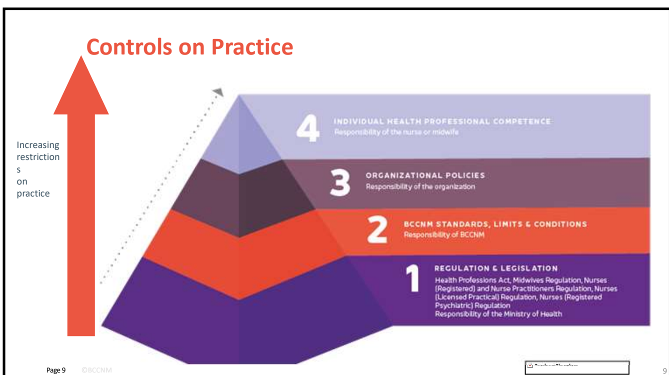
4

MEET OUR TEAM

5

1. Identify five common errors in documenting care and strategies to address them.
2. Describe helpful data, communications and documents to include in the medical record.
3. Outline the recommended standards to ensure your practice meets privacy, and legal legislation requirements.





Scenario #1

A client is requesting I provide a copy and transfer their records to another health care provider. What is the process and how do I document this?

BCCNM resources:

- *RM Standards of Practice*
- *BCCNM Bylaws: Part 6 Division 6, Client care records 192, Transfer, Destruction, Disposition of Client Care Records*
- *Guidelines for Electronic Communications to Transfer Client Information*

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Scenario #2

A client has Requested Care Outside Standards. Am I expected to provide care in this situation, and what should I document?

Resources:

- *Requested Care Outside Standards*
- *Policy on Informed Choice*
- Indications for discussion, consultation and transfer of care
- Policy on Medical Records

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POLL #1

Which of the following are common errors/ omissions in the health Record?

1. ICD , recommendations appropriately communicated
2. Missing intellectual footprint
3. No charting – missed opportunity for late entries
4. Disparities in details between team members
5. Failing to document transfer of care
6. All of the above

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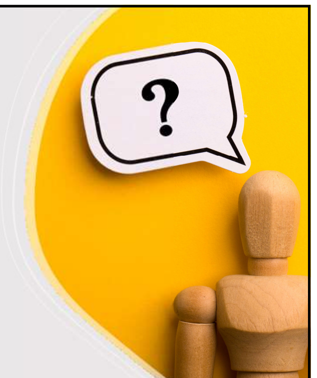
How are we documenting ICDs?

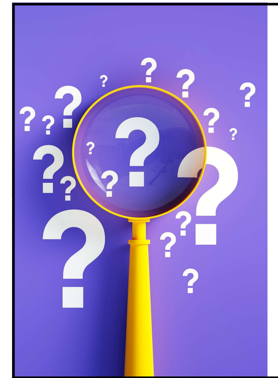
What is our role in offering choices versus making recommendations?

Does the medical record reflect that these were appropriately communicated?

How are we doing in Cerner/ Meditec?

The challenges of the EMR in acute care setting - ensuring you leave a **clear intellectual footprint.**





I was too busy to chart – how do I get it right? **Late entries**, their role and how and when to complete them

The nurse charted a different time/ date/ apgar/ fill in the blank. Avoiding disparities: Ensuring the medical record reflects **accurate data.**

Who is the MRP? Ensuring Transfer of Care is clearly **Communicated** and **Documented** in the medical record.

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INTRODUCING NINA - 40 Y.O. @ 38 WKS

- Booked at 32 wks - as favour - acquaintance of RM on 3 RM team
- Hx anxiety + trauma after Emerg CS 7 years ago for Abnormal FHR
- Seen by OB in preg – ICD TOLAC vs ERCS – plans ERCS @ 38.5 wks
- Aware AMA @ 40 yo Well, BP NAD, Neg GDS & GBS, US & Doppler NAD
- @ 37 wks switch - plans TOLAC - wants friend RM to attend birth
- OB OK with TOLAC – and rec IOL at 39 weeks w Balloon or Oxy w Balloon
- Nina declines - stretch and sweeps, ongoing term NST/ US and IOL
- RM Team huddle: Communication feels difficult, some concerns

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POLL #2

Your team is meeting for chart review. What do you decide about NINA?

1. Everything is fine – we are comfortable with Nina's wishes.
2. We cannot support only 1 RM on call. We can meet Nina's other expectations.
3. One of us should urgently meet with Nina to confirm understanding possible outcomes with the direction of care being chosen.
4. We are uncomfortable with this. Can we transfer this person to another provider?

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TIPS

- Follow BCCNM guidelines/standards on seeking care outside of standards
- With Higher Risk→ increase documentation of ICDs & understanding of resource/community limits
- Trauma Informed/Harm Reduction approaches critical, but NOT at expense of midwife's or practice's well-being

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TIPS

- Document limits of practice (e.g. if applicable - no privileges at nearest hospital and/or no TOLAC offered at Site X)
- Avoid unachievable expectations (e.g. group practice no guarantee Midwife friend will be on call when in labour)
- Consider detailed client- signed Birth Plan/Understanding of Limits of Care

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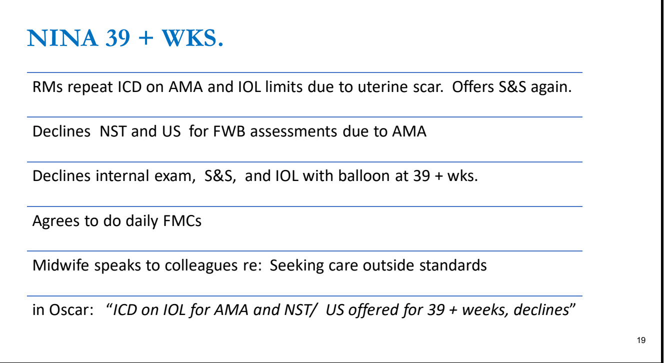

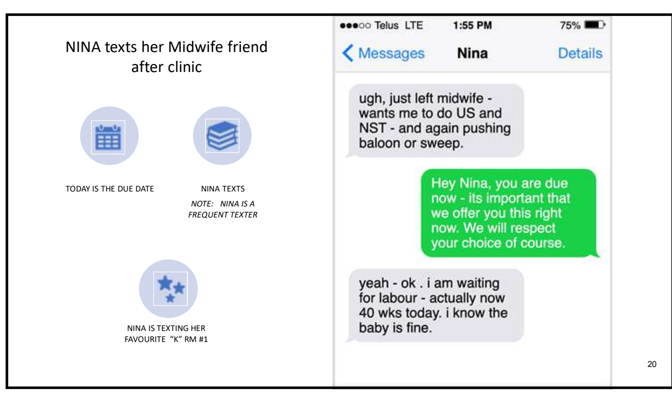

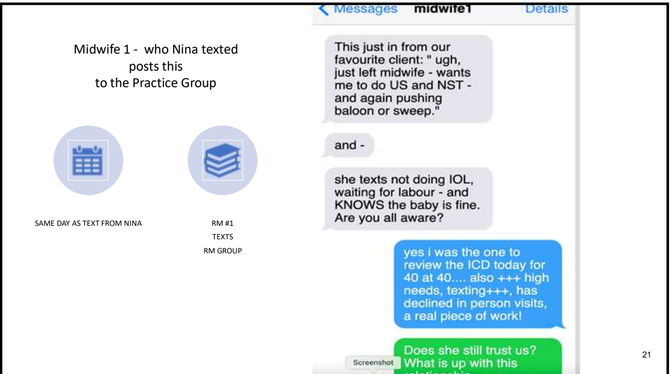

POLL #3

How do you manage the text conversations with Nina?

1. This won't happen to me - I don't accept texts from clients.
2. I respond with a phone call.
3. I text back. It depends – I usually chart the conversation.
4. I will import screen shots to EMR with SOAP note.

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NINA 41 +0 PAGES RM ON CALL

Leaking small amount clear fluid from 09:00

Fetus active, no signs of labour. GBS Neg. Won't come to hospital. Feels fine.

Home Visit - BP 110/70, HR 86, T 36.8C. ROM confirmed

Fetus ROT at 3/ 5 palpable above brim. FHR normal by IA.

Internal exam deferred as no labour and normal FHR

ICD – includes options for IOL, Fetal assessment. NST recommended. FMC.

Nina chooses expectant management, FMC, declines NST. Thinking about cocktail.

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OSCAR NOTE

Date, paged 09:30 – returned call 09:35 - 41w0d; 40 yo planning TOLAC

***S**: Hx of small gush of clear fluid at 09:00, no signs of labour. Reports FMF.*

***O**: Prior CS for abnormal FHR 7 years ago. Normal outcomes. GBS neg. Asked by this midwife to attend hospital re postterm 41wk at 40 YO - declined. HV at 10:30: Appears well, VSS. Uterus soft, non tender, no contractions. Fetus ROT 3/5 palp SFH 38 cm, FHR 150 bpm. Regular, no accels or decels = normal IA. VE deferred.*

Reviewed options incl NST and OB consult re: AMA at 41 wks. Wants to wait 24 hours to try to get into labour.

***A**: 1. AMA at 40 yo, 2. PROM at 41 wks, not in labour, GBS neg*

***P**: FMC, expectant management , client considering cocktail, plans TOLAC hospital birth, alert to S&S of chorio, **Contacted MPP.** OB on call aware. Electronic Sig / 11:07hrs*

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NINA 41 +1. 24 HRS LATER

RM calls Nina– no change in status, no signs of labour

RM recommends NST - consider oxytocin. Nina declines.

HV: BP is 130/85, HR 100, T 37C, uterus soft, ROT 3/5, FHR 175 bpm. repeat FHR 178 bpm. Last FMF last pm.

RM recommends transfer to hospital re abnormal IA. Nina agrees.

In Hospital: NST abnormal for > 80 min tachycardia, minimal variability and one prolonged deceleration.

Bishop score = 3. OB strongly recommends ERCS immediately. Nina consents.

BW: 3350 grams, IPPV for first 2 minutes. Apgars 4^{1} 7^{5}. 9^{10}. pH 7.04, PCO2 45, BE 11

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NINA'S HOSPITAL EMR

There was little time to document the care when the decision to go to the OR occurred.

Your colleague rounds the next day and gives you heads up that there is the consultant entry – no TOC in orders, and no clear history of what happened before and during care in hospital documented, Difficult to understand what happened.

You go to hospital on PP Day 2 to write late entry. Nursing notations for points on PSBC forms and partogram not consistent with your recall and the few notes made at the time.

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TIPS: MRP & TRANSFERS OF CARE

- Be clear and document who is MRP on admission and during stay if / when TOC occurs.
- TOC is recorded in the ORDERS with date/ time. Ensure consultant accepts and team and client is aware.
- Misunderstanding/lack of clarity over who is MRP usually hurts midwife, not OB and can damage client relationship
- Fluid or "popping in" relationship not always helpful. Very risky with some clients and/or in poor outcome cases

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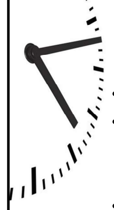

TIPS: LATE ENTRIES

- Late entries/dictations are acceptable but should be done ASAP.
- Timely late entries increase the impression they are credible. Longer the gap, more likely seen as self-serving, inaccurate or lacking credibility.
- Sign, time, date stamp late entries,
- Short rational for why they are late "providing care".
- Enlist others to complete parts of record where possible
  - second attendant; assigned RN;
  - Consider asking doula or family member if no one else available to note important times

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CONSISTENCY

- Check all provider records for accuracy ASAP, especially in poor outcome cases
- Make sure to sign off (and encourage others to do so) in hospital electronic systems (Cerner*)
- Never obliterate entries made in error
- Check others' entries and any consults for accuracy as soon as reasonably possible
- Make clarifying entry or dictation if needed as soon as reasonably possible

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POSTPARTUM

Newborn:

3 days NICU, pending cultures, home day 4

Nina – Physical recovery on track.

Emotional: Withdrawn

Seeing therapist re: trauma, depression

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FOLLOWING DISCHARGE

Request for newborn health records by co-parent re shared custody

7 years later Nina requests the midwifery records

DOCUMENTATION

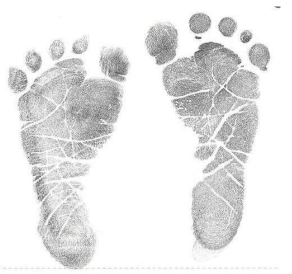
- Many legal claims focus on charting
- Document informed consent and refusals
- Import texts, emails and other communications
- Facts only in the medical record; be professional
- Maintain high charting standards regardless of client

INTELLECTUAL FOOTPRINT

Leave one!

The future you will be able to:

- See what you saw, and
- Know what you were thinking



DISCLOSURE TO CLIENT; LEGAL PRIVILEGE

Providing file to client (s. 23 PIPA)
*not required to provide information "protected by solicitor-client privilege" - s. 23(3)(a) PIPA

Two branches of solicitor-client (or legal) privilege

Keep both separate from the client records:
(i) notes made for lawyer; and
(ii) notes of discussions with lawyer,

RECORDS RETENTION AND LITIGATION

Time to file a legal claim: clock doesn't start ticking until claimant becomes an adult (i.e. turns 19) – at the earliest…

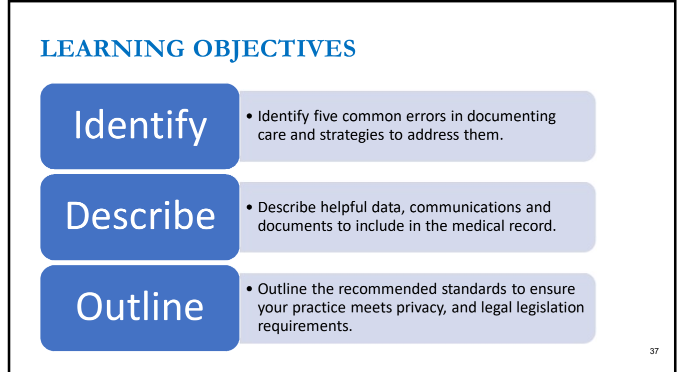
Possible extension under *Limitation Act* of a further 15 years

Claimant has at least 1 year to serve a filed claim

"medical records must be retained for a minimum period of sixteen years from either the date of the last entry or from the age of majority (19 years of age in British Columbia), whichever is later (i.e. 35 years), except as otherwise required by law." (BCCN&M "Policy on medical records")

Termination of Care

BCCNM	Follow Guidance – ideally by or before 36 wks
Atypical choices?	Document – clear, frequent, includes discussions and recommendations role for refusal of care forms.
Intellectual Footprint	Progressive intervention /limit setting / to justify termination; referral to other providers. Giving notice - continuing care during notice where possible
Community	MAY be easier in larger centre re: more options maternity practice, other midwives, OB-shared
Medical Record	Copies to hospitals, if client has GP inform no longer in care - no need to give detailed reasons Avoid possibility of any of nearby hospitals thinking you are still MRP or client misleading them


LEARNING OBJECTIVES
Identify
• Identify five common errors in documenting care and strategies to address them.
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