19 February 2016

Draft guide on documentation and record keeping

Thank you for the opportunity to comment on the Council's draft guide on documentation and record keeping. I note that the intention of the guide is to provide high level guidance to midwives.

As you will be aware, the Health and Disability Commissioner is charged with promoting and protecting the rights of health and disability services consumers, as set out in the Code of Health and Disability Services Consumers' Rights. One of the Commissioner's functions under the Health and Disability Commissioner Act 1994 is to make public statements in relation to any matter affecting the rights of health or disability services consumers.

I support the development of high level guidance regarding documentation from the Midwifery Council. As you note, the standard of documentation by midwives is frequently a concern when complaints about maternity services are considered by HDC.

I make the following observations regarding the document in its current form.

I consider that the first sentence should refer to the importance of *clear and accurate* documentation and record keeping. I note the reference in the second sentence to clinical notes forming an important component of any investigation or complaint regarding practice. However, I suggest that a rationale for comprehensive records should focus primarily on their central importance in ensuring continuity of care and the provision of a safe and seamless service to women and their babies. I also note that although record keeping is part of the competency standards for midwives, reference to that professional obligation is not included in the guide and I consider that it should be incorporated.

The third paragraph regarding the storage and retention of records appears to be out of place and perhaps more appropriately belongs in the later section headed "Professional record keeping/storage includes".

In relation to the second sentence of the fourth paragraph I note that there may be other times where the sharing of records may be necessary, other than when the welfare of the mother and/or baby is at risk, and suggest you consider amending that sentence to reflect this.

It may be helpful for the document to differentiate between the legal requirements for record keeping provided for by various pieces of legislation and by good practice guidelines. For example, paragraph 5 states that "It is accepted in midwifery practice that women have a right to access their health information…" This is not particular to midwifery practice, but is a right that individuals have pursuant to the Privacy Act 1993. You may also find it helpful, if you have not already done so, to obtain comments on this document from the Privacy Commissioner. I also note that the Privacy Act 1993 is not in the list of relevant documentation.

I consider that the list of things that should be documented (section headed “Professional documentation includes”) could be more prescriptive, e.g. “All midwives must keep clear and accurate patient records that include:” I recommend that the requirement to document observations should be included in that list. It may also be helpful to set out how often observations should be recorded.

In addition, I suggest that consideration is given to referring to the specific documentation requirements set out in the Ministry of Health Guidelines for Consultation with Obstetric and Related Medical Services (2012) for when a woman declines a referral, consultation or transfer of clinical responsibility.

While I appreciate that this guide is an attempt to provide high level guidance, I am of the view that a bit more detail may be helpful. This could be done, for example by express incorporation of the kind of information and documentation requirements anticipated by the documentation and record keeping audit tools.

Thank you again for the opportunity to comment on the guide. I trust my comments are helpful.