Section 3: Client Records

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Section 3 - Client Records ~ WAC 246-329-140

Policy:

- Medical records shall be secured in a manner apart from public access in order to ensure client confidentiality, and shall not share those records except as allowed by local, State (70.02 RCW), and Federal guidelines.
- Staff will sign a Confidentiality Agreement.

Prenatal Record

Policy:

Client chart should include these complete histories:

- Social
- Family
- Medical
- Reproductive
- Nutritional
- Behavioral

Client chart should include:

- Initial physical examination (unless done by prior-care provider)
- Laboratory tests to screen for infectious and chronic conditions, and applicable informed consents
- Standard prenatal care panels
- Documentation of informed declination for any tests or procedures
- Formal evaluation of risk status **at initial visit** and at least once more **in each trimester** and **upon admission** in labor
- Documentation of childbirth preparation program for 1st-time unmedicated births
- Consultation reports, if applicable

Midwife must submit client chart to CFB for review, by 36 weeks, per Policies and Procedures Manual, Section 2 – *Client Admission to the Birth Center*

See the Prenatal Chart Review Checklist, in the *Appendix*, for components that should be in the client prenatal chart.

General Documentation Guidelines

The original labor/birth/postpartum chart will be kept at Center for Birth.

Documentation should include the following:

- The presence or absence of FHT accelerations or decelerations
- Fetal movement
- Frequency, duration, and strength of uterine contractions
- Cervical effacement, dilation, fetal station, and position at initial evaluation in the absence of ROM. Reassessment as clinically indicated, tracking progress per risk protocol
- Any interventions done to promote maternal or fetal wellness
- Medications provided, noting route, dosage, indication
- Membranes status /color of amniotic fluid
- Stages of labor, time of birth, and any maneuvers done to facilitate birth of the newborn such as shoulder dystocia maneuvers or nuchal cord management
- Estimated maternal blood loss
- Any laboratory studies performed
- Consultation and transfer if client no longer meets birth center risk criteria
    - Time of phone call
    - Name of person receiving call
    - Time and method of transfer
    - Final vital signs prior to departure
    - Names of people accompanying transferring client/newborn
    - A duplicate of the chart will be provided to the receiving facility
- Labor and birth summary

Refer to the following sections for details:

- ☐ **Admission/Labor Intake Chart Note**
- ☐ **Intrapartum Chart**
- ☐ **Immediate Postpartum Assessment**

Admission/Labor Intake Chart Note

Policy:

Credentialed midwife should compose an admission chart note that includes assessment of labor, maternal, and fetal status, unless client presents with birth imminent.

CFB Admission/Labor Intake Form may be used.

Procedure:

Credentialed midwife should write a chart note that covers the following details, or complete the CFB ***Admission/Labor Intake Form*** in hard copy or electronic format provided by CFB.

- Client name, DOB, parity
- Blood type and Rh
- Allergies
- BP baseline
- Hct, most recent
- GBS status
- HIV screen prenatally (Y/N)
- Partner and/or support people
- Significant Hx
- Admission date and time
- Labor onset time
- Contraction pattern and strength
- Status of membranes
- Vital signs
- FHT baseline
- Estimated fetal weight
- Fetal presentation
- FM?
- Dilation and station is examined
- Rest/hydration/nourishment status
- Client affect/coping
- Admitted (meets risk criteria?)?
- Assessment and Plan
- Names of students and/or birth assistants present

Intrapartum Chart

[This section also appears in Section 3: Client Record]

Policy:

Credentialed midwife will complete chart and related administrative and billing paperwork as soon as possible after birth, and submit to CFB.

Procedure:

- Complete labor flow
- Narrative or SOAP note should be written during the Intrapartum period as follows:
    - On admission
    - At least every 2 hours throughout labor
    - With occurrence of any significant event in labor
    - Delivery note
    - Discharge note
- Midwife is responsible for entering birth in the Birth Log
- Midwife will complete a Superbill and fax it to the billing service, as posted

Immediate Postpartum Assessment (5.2.K)

Policy:

MATERNAL ASSESSMENT

Maternal assessment should include the monitoring of vital signs done in a manner that does not interfere with bonding while still maintaining safety:

- At a minimum 3 sets of vital signs including blood pressure, pulse, and temperature:
  - One set within the first hour postpartum
  - One continuing set
  - One set prior to discharge from the birth center
- Assessment of fundus and lochia
- Encouraging oral intake, ambulation and voiding
- Assessment of maternal-infant interaction and bonding behaviors
- Increase in frequency of assessment and vital signs in the presence of risk factors (postpartum hemorrhage, maternal fever, syncope, etc.)
- Documentation of voiding before discharge from the birth center

NEWBORN ASSESSMENT

Newborn assessment, should include the monitoring in a manner that does not interfere with bonding while still maintaining safety:

- At a minimum three sets of vital signs
  - One set within the first hour
  - One continuing set
  - One set prior to discharge from the birth center
- Monitoring of newborn blood glucose and managing neonatal hypoglycemia consistent with national guidelines
- Increased frequency of assessment and vital signs in the presence of risk factors (e.g., abnormal vital signs or behavior, poor color or tone, poor breastfeeding)

Client Chart in Event of Transfer

Policy:

Client chart shall document the client transfer details to the highest degree possible

Procedure:

- Antepartum transfer/change of birth location plans: reason for transfer shall be noted in client chart and reported to CFB as part of Data Collection for statistics
- Intrapartum and postpartum transfers: an attempt will be made to obtain information regarding maternal intrapartum and newborn transfers. A copy of hospital delivery summary should be attained and placed in client chart

Ongoing Postpartum Care Client Record

Policy:

The credentialed midwife retains primary care for the postpartum client and newborn after discharge from Center for Birth, unless either have been transferred to another facility and another care provider is documented.

Procedure:

The following will be *documented* in the client's chart:

- A plan for self-care at home
- A plan for newborn care at home, including infant feeding education and support
- A plan is made for a follow-up visit for both mother and newborn
- A plan for neonatal screening tests or refusal
- A plan for neonatal hearing screening or refusal

A completed Birth Center Discharge Checklist serves to meet this charting requirement.

Record of Birth and Newborn Screening

Policy:
Credentialed midwives shall submit form attesting birth certificate has been filed with the State of Washington, and the infant has undergone the newborn screening.
Procedure:
By the conclusion of the course of care, but no later than the final submission of Statistics form to CFB, midwife shall complete and sign this form:

Birth Certificate Filing Confirmation

Client Name: _____

Baby Name: _____

Baby DOB: _____ / _____ / _____

Date Filed: _____ / _____ / _____

Certifier Name: _____

Newborn screening certification

☐ First newborn metabolic screening performed
☐ First newborn metabolic screening declined by parents

Provider Signature: _____
(or individual authorized to attest on behalf of the provider)

Data Submission for Statistics

Policy: Credentialed midwives shall submit the following form (available as an electronic form, or in hard copy format) at the conclusion of client care (6 weeks postpartum).

Procedure:

- The CFB Office Manager shall furnish credentialed midwives with a list of all registered clients at least biannually, and request that data forms be submitted.
- Credentialed midwives may submit data at their own convenience but no later than March 1st of a given year for the previous calendar year.

Data to be submitted to CFB:

Date of delivery or EDD if other outcome: _____/_____/ **20**_____
Client Name: Last _____**First** _____
Client DOB: _____/_____/_____

Primary Midwife Name _____

Complete this Form for Each Client that Registered at Center for Birth (CFB) (list provided):

☐ **Antepartum** transfer following Registration (e.g., for preeclampsia; breech; decision to home birth)
  ☐ Non-medical reason (client choice)
  ☐ **Clinical**/medical reason

☐ **Pre-Admit/Triage**, intrapartum transfer (began labor planning to deliver at Center for Birth but were not admitted)

☐ **Intrapartum** Transfer
  ☐ Intrapartum transfer, non-emergent
  ☐ Intrapartum transfer, **emergent**

☐ **No Transfer: Delivered** at CFB birth center

The Following Data Must Be Supplied for Each Client that Began Labor with the Intention of Coming to Center for Birth, Including *Pre-Admission Transfers (not antepartum transfers*.

Please Check All That Apply:

☐ NSVD - Cephalic
☐ NSVD – Breech
☐ Vaginal – *Operative*
  ☐ Forceps
  ☐ Vacuum

☐ Primary Cesarean

☐ Episiotomy
☐ 3rd Or 4th Degree Laceration

☐ Low Birth Weight (<2500g/5.5lbs)
☐ High Birth Weight (>4500g/10lbs)

☐ Delivered At <37 Weeks
☐ 5 Minute Apgar <7
☐ Antepartum Fetal Death (>20 Weeks GA)
☐ Maternal Death, Including Labor, Birth, And Up To 6-Weeks Postpartum (Include Deaths Not Related To Pregnancy/Delivery)

The Following Data Must Be Supplied for All Clients Admitted to *Center for Birth* Birth Center.

Please Check All that Apply:

☐ Postpartum transfer, CLIENT, non-emergent
☐ Postpartum transfer, CLIENT, **emergent**

☐ Newborn transfer (BABY) non-emergent
☐ Newborn transfer (BABY) **emergent**

☐ Intrapartum fetal death, occurring at birth center

☐ Intrapartum fetal death, occurring after transfer/at hospital

☐ Neonatal death (birth-to-28 days of age), following birth at BIRTH CENTER
☐ Neonatal death (birth-to-28 days of age) following birth at hospital (intrapartum transfer)

☐ (Later) Postpartum hospital admission *from home*, CLIENT, after discharge (from BIRTH CENTER or hospital) up to 6 weeks postpartum

☐ (Later)Neonatal hospital admission, BABY, after discharge (from BIRTH CENTER or hospital) up to 4 weeks of age (28 days of age)

Client Record at the Birth Center

Policy:

- Birth center clients shall sign a records release form as part of registering at CFB.
- Client records are property of CFB and clients have rights to access copies of their chart.
- A signed release is required for records to be sent to a third party.
- CFB shall maintain birth records for 3 years for maternal clients and 21 years for newborn clients.
- After ceasing operation, CFB will maintain or release records in a confidential manner according to the time frames above.
- Records shall be kept digitally or on MAWS or equivalent forms and copied prior to client transfer or discharge and are to include the following:
    - Demographic information
    - Client eligibility form, confirming low-risk status
    - All labor and immediate postpartum chart notes
    - Copies of prenatal records, including consultation reports
    - Client informed consent for care, service, treatment and signature indicating receipt of bill of rights
    - Documentation of any informed declinations and:
        - Administration or refusal of prophylactic eye ointment for the newborn,
        - Prenatal screening,
        - Rapid HIV test if indicated,
        - Intrapartum antibiotics for GBS per CDC protocol,
        - Newborn Hblg and hepatitis b immunization for hepatitis b positive women.
    - Documentation of birth registration per chapter 70.58 RCW.
    - Documentation of any sentinel birth defect report under chapters 70.58 RCW and 246-491 WAC.
    - Documentation of referral, transfer or care, emergency transport

Record Keeping

Policy:

Center for Birth shall maintain patient records in a way that ensures confidentiality and completeness, and shall not share those records except as allowed by local, State (70.02 RCW), and Federal guidelines .

Per **WAC 246-329-140**

1. The birth center shall maintain records for:
   (a) Adults - three years following the date of termination of services; and
   (b) Minors - three years after attaining age eighteen, or five years following discharge, whichever is longer.
2. The birth center shall:
   (a) Store records to prevent loss of information and to maintain the integrity of the record and protect against unauthorized use;
   (b) Maintain or release records after a patient's or client's death according to chapter 70.02 RCW, Medical records--Health care information access and disclosure; and
   (c) After ceasing operation, retain or dispose of records in a confidential manner according to the time frames described above.

Procedure:

- Prenatal records from credentialed providers will be filed in cabinet in lockable room until scanned for secure online storage. The cabinet will be identified as containing private files.
- L&D records from all births at Center for Birth will be saved in the same manner.
- All charts will contain patient's name, address, and phone number.
- The hand-written records shall be legible and written in black ink. It is important that each chart reflect all pertinent information relating to prenatal, labor, birth and recovery periods.
- Any administration of drugs or treatments should be clearly documented and signed by the midwife or birth assistant responsible.
- The records must also specify what arrangements have been made to obtain metabolic screening.
- There shall be a health record kept for each maternal and newborn patient.
- A copy of the L&D record and the maternal chart will be taken by the attending midwife to be placed in the patient's record at their office.
- The attending midwife is responsible for providing records to the pediatric provider.
- All original charting will be kept at CFB.

[CFB is in the process of converting all birth center client records to an EHR program (Practice Fusion) and expect this process to be complete by the site visit]