Perinatal Forms Guideline 2

GENERIC CHARTING GUIDELINE FOR PERINATAL CARE PROVIDERS

INTRODUCTION

The issue of documentation of patient care has received considerable attention in the past few years for a variety of reasons. Trends in society such as increased consumer education, informed consent, expectations for a healthy baby, and an increasingly litigious society all contribute to increased risk management awareness on behalf of health care facilities. Risk management deals with the probability that a given risk will result in a poor outcome and then attempts to reduce that probability. The Canadian Medical Protective Association and British Columbia Health Care Risk Management Society (BCHCRMS) have indicated that labour-delivery is the area of greatest risk management concern in terms of perinatal care as this is the time and place that the majority of "critical incidents" culminating in litigation occur. Obstetrical claims are a significant concern in hospital risk management because they are virtually always cases that involve multi-million dollar claims due to the costs involved in caring for a compromised infant.

In 1995, the BCHCRMS undertook a detailed claims review of all its existing obstetrical claims files. Three areas of hospital risk appeared most frequently in these files including documentation by health care professionals working in labour and delivery units. While nursing documentation is directed by statutory regulations, legal principles, professional standards and agency policy, obstetrical risk management also requires nurses to be extra conscientious about the accuracy of their charting in the labour and delivery unit. Another factor that requires physicians and nurses to be extra conscientious of charting during the intrapartum period is the limitation period as it exists in British Columbia today. The limitation period is the legal time frame in which a lawsuit must be initiated following an incident that allegedly resulted in injury. In B.C. the limitation period for injuries involving minors does not start to run until the minor reaches the age of 19 years. This means that, assuming a child is injured at birth, legal action may not be initiated until 21 years after the birth (assuming a 2 year limitation period) or until 25 years after the birth in the event that an ultimate limitation period to 6 years applies. Accordingly, it is important to be able to rely on documentation since memories will inevitably have failed over such an extended period of time.

SUGGESTIONS FOR CHARTING FOR NURSES

I. Complete your charting remembering that charting serves three functions: the communication function, the legal function, and the provision of data for the B.C. Perinatal Database Registry.

II. Ensure that you are knowledgeable of the use of the British Columbia Perinatal Forms.

III. Review the policies for charting within your facility and ensure that you know and are

knowledgeable and comfortable with the type of charting used.

IV. Ensure that your charting is legible, contemporaneous (data recorded at the time), in chronological order of events, factual, concise, and congruent with hospital policy.

V. Intrapartum charting including assessment and monitoring of patient care problems should occur contemporaneously. If continuous electronic monitoring is used, charting may initially be completed on the fetal heart strip and later transposed to the Labour Admission and Partogram Record. Charting initially on the fetal heart strip is both convenient and appropriate. This issue will be addressed in more detail in Guideline 4.

VI. If charting cannot be done contemporaneously, a late entry should be made with the time of the event, the time of the entry, and the reason for the late entry.

VII. Ensure that any abbreviations used are approved abbreviations within your facility.

VIII. Ensure use of the signature record as per your facility policy.

IX. When interdisciplinary communication occurs, nurses should document what information was exchanged, what information or instructions were given in return, and what time the conversation took place.

X. Remember to be doubly conscientious about charting at the change of shift and on night shift.

SUGGESTIONS FOR CHARTING FOR PHYSICIANS AND REGISTERED MIDWIVES

I. Complete your charting remembering that charting serves three functions: the communication function, the legal function, and the provision of data for the B.C. Perinatal Database Registry.

II. Ensure that you are knowledgeable of the use of the British Columbia Perinatal Forms.

III. Informed Consent in compliance with FOI should be obtained at the first prenatal visit.

IV. Please remember to have a photocopy of the Antenatal Record sent to the hospital at 20 weeks gestation, and the Antenatal Record sent to the hospital at 36 weeks gestation.

V. Ensure that your charting is legible, in chronological order of events, factual, concise, and consistent where double charting is required. Any discrepancies in timing of events should be noted.

VI. When interdisciplinary communication occurs, care providers should document what information was exchanged and what information or instructions were given.

VI. For a normal intrapartum course, charting should occur contemporaneously (data recorded at the time), and be completed as soon as possible after the events, subject to the demands of patient care. When problems develop during labour and delivery, documentation of the assessment and management of these problems should occur contemporaneously.

REFERENCES

B.C. Health Care Risk Management Society. 1996. Obstetrical Claims Profile. Handle with Care, 1(7); p.1-6.

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