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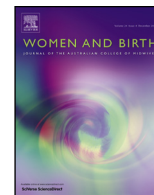

Review article

Making midwifery work visible: The multiple purposes of documentation

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ABSTRACT

Background: Midwives have a professional, ethical and legal obligation to effectively and thoroughly document the care provided to women and the decisions made within the partnership relationship. To appreciate the best approach to documenting midwifery care, it is important to first understand the purpose of midwifery documentation.
Aim: The aim of this article is to explore the literature in relation to the purposes of midwifery documentation.
Method: A literature search was performed using the CINAHL and Pubmed databases. Hand searching of reference and citation lists was employed to deepen the literature pool.
Findings and discussion: No research articles with a midwifery focus were found addressing the purpose of documentation. Broader searching of literature from other healthcare fields was drawn on to identify the contribution of record keeping to: partnership and continuity of care; communication between health professionals; improved standards of care; audits and clinical reviews; research and education; the visibility of midwifery work; the reflective practices of midwives; professional accountability; the legal record of care; the narrative record of experience for women.
Conclusion: The purpose of midwifery documentation is complex and multi-factorial, involving much more than the recording of clinical and legal details of a woman's care. Midwifery documentation may potentially enhance the maternity care experience for women, support the role of the midwife, positively impact collaboration between health professionals, and contribute to organisational processes and research. Further research is needed to clarify how to address the documentation priorities of women and midwives, within the context of the maternity record.
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Statement of significance

Problem or issue

Documentation is a key element of midwifery practice.

What is already known

There is a paucity of midwifery literature to guide midwifery record-keeping processes.

What this paper adds

Exploration of the comprehensive purposes of midwifery documentation and identification of the need for midwifery specific research to guide practice.

1. Introduction

Midwives understand that pregnancy, birth, mothering and, by extension midwifery, have the potential to be powerfully transformative in the lives of women and their families.[1] As a description of the maternity care experience, midwifery documentation is multi-dimensional and complex. Midwives have a professional, legal and ethical responsibility to thoroughly and accurately record the care provided to their clients, the information shared between woman and midwife and the decisions made within the midwifery partnership.[2–4] However, it is clear that the documentation process can be challenging for midwives in practice.[5,6] In order to identify how midwives can best achieve an effective clinical, legal and structural approach to this critical aspect of practice, it is necessary to first explore the purpose of midwifery record-keeping and to thoroughly understand why midwives ought to document to a high standard. This article offers a discussion of the multiple purposes of midwifery documentation.

2. Background

There is an obligation for midwives to document a meaningful, useful, and thorough record for each and every midwifery contact and these documentation processes and requirements vary between countries and health jurisdictions. In Aotearoa/New Zealand, documentation practices are guided by both regulatory and professional bodies. For example, the Midwifery Council of New Zealand (MCNZ) determines professional and regulatory expectations for midwifery documentation, and the New Zealand College of Midwives (NZCOM) has developed standards, guidance and professional support for midwifery documentation. MCNZ Competencies One and Two of the 'Competencies for Entry to the Register of Midwives'[3] and NZCOM Standards of Practice three and four[2] address the responsibility of the midwife to document comprehensive and informative clinical notes of their care, advice, discussions, and the plans and outcomes arising from these. Additionally, legislative frameworks for midwifery practice describe the requirement for midwives to record a comprehensive care plan for each woman[7] and define how information must be collected, stored and accessed.[8–10]

Record-keeping is recognised as an area for improvement across many health professions[11–14] and a lack of adequate documentation is cited in the majority of decisions arising from complaints against midwives in Aotearoa/New Zealand (http://www.hdc.org.nz/). Whilst responsibility for these deficits in practice generally falls to the individual practitioner, there is a paucity of evidence for what constitutes good documentation practice. This contributes to difficulty in the provision of professional guidance for midwives in this area.

In order for midwives to understand how best to address the professional, legal and clinical aspects of record-keeping, they must first clearly understand the purpose of midwifery documentation. This understanding will inform the development of professional guidance which represents the interests of all relevant parties. Exploration of the objectives of the maternity record also affords each midwife an opportunity to develop professional understanding of the importance and relevance of documentation in their work, and how it contributes to the provision of excellent care to women and babies.

3. Method

The intention was to undertake an extensive search of the literature relating to the purpose of midwifery documentation. To this end, the following search terms were entered into the CINAHL and Pubmed databases, with a specified time frame of 1990 to 2016: (midwif* AND (purpose* OR reason* OR intent* OR object*) AND (document* OR note* OR record*) NOT nurs*).

Initially 271 entries from CINAHL and 370 entries from Pubmed were identified. These articles were evaluated on the basis of title, key words and the content of the abstract.

From the initial search of 641 articles, just seven were found with a midwifery focus which referred to the topic of interest.[4,5,15–19] However, none discussed the topic in detail and none described research which specifically explored the purpose of midwifery documentation. These articles could not, therefore, form the basis of the identification of themes relating to midwifery documentation, and it became necessary to draw on literature from other healthcare fields. This was achieved via hand searching of the reference lists of the seven articles and citation lists of the databases. These articles and their respective reference lists increased the pool of literature available for further exploration (see Appendix A).

Articles which incorporated discussion of the purpose of documentation, within the health profession of focus, were included in the broad pool of literature and the themes explored below were drawn from the selected literature.[20] The articles were scrutinised and repetition of topics was identified. These topics were then sorted into categories[21] and, where a minimum of three authors identified the importance of a category, the category was

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