

Guidance for planning and recording a plan of care

The standard of practice as judged by professionals, in conjunction with the views of the family, is reflected in the quality of record keeping by the midwife.

The content and style needs to reflect the principals set out in the NMC 'Guidelines for records and record keeping' (1998) and demonstrate that you have honoured your professional and legal *duty of care*.

The purpose of this template is to standardise the approach to documentation that is particularly important when complications or emergency situations arise, it is not to dictate the style of record keeping. "Good record keeping is a mark of the safe and skilled practitioner" (NMC 1998) and results in transparency surrounding judgements, decision-making regarding the care planned, the care provided, outcomes and communication between the family and professional carers.

A detailed assessment needs to be undertaken to assess maternal and fetal conditions and progress of labour if applicable. The information gained from an abdominal and vaginal examination needs to be recorded in such a way to enable comparative data analysis to be undertaken at the time of subsequent reviews of maternal and fetal conditions. The record on abdominal examination needs to include findings on inspection, palpation re lie, presentation, position, the attitude of the presenting part and descent in relation to the brim of the pelvis. A record of internal examination will include information on the cervix, the relation of the presenting part to the ischial spines, the position as determined by sutures and fontanelles, the presence or otherwise of caput and/or moulding, state of membranes and liquor if appropriate. To facilitate comparative analysis the abdominal examination should be recorded sequentially to the vaginal examination.

From the information gained a plan of care appropriate for the individual mother and baby should be recorded. This plan may be personalised according to each family and individual midwife and should include reference to the environment of care, family involvement in decisions and rationale for the plan of care.

A decision on frequency of maternal and fetal observations needs to be included in the plan and a time frame set for systematic review. More frequent observations must be made and recorded should deviations from normal occur, and the care-plan updated in the light of changes in maternal or/and fetal conditions.

At all times when mother/parents request information or where options of care are offered, information and evidence presented should be recorded, with the families response. This will demonstrate their informed choice.

A systematic approach to reviewing the plan of care, in conjunction with medical staff when applicable, will provide evidence to support decisions made, advice given and communication with the multi-professional team and when seeking specific medical or supervisory opinion. Telephone discussions and information/advice exchanged should be included in the documentation. (see template).

Source: Adapted from C Ryan 'Independent Midwife Guidance' 2005

Template for Systematic Review of Progress in Labour

A systematic reflective approach should be adopted when planning and reviewing care and transferring care from one professional to another. Midwives should employ a reflective questioning approach to the following:

What evidence do I have that demonstrates this labour is progressing?

Are there any factors from the past obstetric/medical/social history; or present external/environment features that may or are influencing the progress of this labour? If so what changes do I need to make to the plan of care, & rationale for them?

Are the contractions increasing in length, strength and frequency? Is this based on maternal behaviour or information elicited only or includes palpation of the contractions that has also determines fundal dominance?

Are maternal observations, behaviour and conversations congruent with the type of contractions being assessed?

Have I enough evidence to determine if this labour is established, or in the latent or active phase? If not when will I consider reviewing progress and making a decision?

On further abdominal palpation, has the presenting part increased in flexion/descent in relation to uterine activity? Is this evident from pelvic palpation related to a previous abdominal palpation and/or in addition to internal examination? Is there clinical indication to perform an internal examination?

On vaginal examination has the following information been elicited: the state and dilatation of the cervix, the station of the presenting part, position and attitude of the baby, presence or otherwise of caput and/or moulding, state of membranes and liquor if appropriate? When should further examinations be planned?

If a judgement on descent per abdomen is being considered in the late first/second stage of labour have I confirmed by an internal examination the fetal landmarks to determine position, station, the degree of moulding and caput, which may influence my judgement on progress on labour? If not do I need to consider at this time gaining permission to make a further assessment

What evidence do I have that this mother remains healthy during labour?

How do the initial observations made in labour compare with antenatal assessments? In the light of past history and current assessment do I need to increase the frequency of any observations? If not I must remember to include my rationale for no additional observations in my plan of care.

If determining that labour is showing a sign of deviation, have I now got enough evidence to assure me this mother's medical condition is not compromised? Do I need to confirm this by urinalysis and/or Temperature/Pulse/ Blood-Pressure recordings? Do I need to review the care plan? Do I need to seek medical advice? When will I make my next assessment?

What evidence do I have that this unborn baby remains healthy during labour?

In relation to the progress of labour is auscultation frequent enough to reassure me of fetal well-being? What other evidence do I have? Colour of the liquor, fetal movements, heart rate variability? Do these observations support or refute my judgement? Do I need to undertake a CTG make any changes, seek advice or summon medical aid?

Have I used a systematic approach to analyse the CTG record in the context of the following criteria: baseline rate, baseline variability, presence or absence of accelerations/ decelerations, relationship of these to contractions (if any), classification of decelerations if present (early, late, variable)?

Have I made comparisons when serial CTG are undertaken or with a continuous trace in labour that spans many hours so that decisions are not based on a period of fetal monitoring in isolation of the whole picture?

Have I included comparative analysis on fetal well being in relation to maternal physiology in my record keeping?

Using a systematic approach to reviewing care is integral to the practice of midwifery and a number of midwives indicated that it would assist them to have a template for guidance on planning and reviewing care. This template may assist the teaching of students in the clinical workplace to help with the closure of the theory practice gap.

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