THE SCOTTISH WOMAN-HELD MATERNITY RECORD (SWHMR) PROJECT

USING THE SCOTTISH WOMAN-HELD MATERNITY RECORD:
GUIDANCE FOR MATERNITY PROFESSIONALS

For use with SWHMR Version 1.0 March 2004

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**ABBREVIATIONS AND ACRONYMS (for the SWHMR & Guidance)**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td>Artificial Rupture of Membranes</td>
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<tr>
<td>ASH</td>
<td>Action on Smoking and Health</td>
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<td>BCG</td>
<td>Bacillus of Calmette and Guerin</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BP</td>
<td>Blood Pressure</td>
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<td>C</td>
<td>Centigrade</td>
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<td>CEMACH</td>
<td>Confidential Enquiry into Maternal and Child Health</td>
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<td>CEMD</td>
<td>Confidential Enquiries into Maternal Deaths</td>
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<td>CESDI</td>
<td>Confidential Enquiry into Stillbirths and Deaths in Infancy</td>
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<tr>
<td>CF</td>
<td>Cystic Fibrosis</td>
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<td>CHI</td>
<td>Community Health Index</td>
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<td>CIN</td>
<td>Cervical Intraepithelial Neoplasia</td>
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<td>cm</td>
<td>Centimetre</td>
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<tr>
<td>CRAG</td>
<td>Clinical Resource and Audit Group</td>
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<td>CRN</td>
<td>Central Registration Number</td>
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<td>CPD</td>
<td>Cephalo-Pelvic Disproportion</td>
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<td>CSAGS</td>
<td>Confidentiality &amp; Security Advisory Group for Scotland</td>
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<td>CTG</td>
<td>Cardiotocograph</td>
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<tr>
<td>DDH</td>
<td>Developmental Dysplasia of the Hip</td>
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<td>DVT</td>
<td>Deep Vein Thrombosis</td>
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<td>EAS</td>
<td>External Anal Sphincter</td>
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<tr>
<td>EDD</td>
<td>Estimated Date of Delivery</td>
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<td>EGAMS</td>
<td>Expert Group on Acute Maternity Services</td>
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<td>eSWHMR</td>
<td>electronic Scottish Woman-Held Maternity Record</td>
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<td>g</td>
<td>gram</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HEBS</td>
<td>Health Education Board for Scotland (now Health Scotland)</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSE</td>
<td>Health &amp; Safety Executive</td>
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<td>IAS</td>
<td>Internal Anal Sphincter</td>
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<td>IPPV</td>
<td>Intermittent Positive Pressure Ventilation</td>
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<td>ISD</td>
<td>Information &amp; Statistics Division</td>
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<td>LMP</td>
<td>Last Menstrual Period</td>
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<tr>
<td>mls</td>
<td>millilitres</td>
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<td>NHS QIS</td>
<td>NHS Quality Improvement Scotland</td>
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<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<td>NSD</td>
<td>National Services Division</td>
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<tr>
<td>pH</td>
<td>potential of Hydrogen (a measure of the acidity or alkalinity of a solution)</td>
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<td>RCA</td>
<td>Royal College of Anaesthetists</td>
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<td>RCM</td>
<td>Royal College of Midwives</td>
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<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
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<td>SANDS</td>
<td>Stillbirth and Neonatal Death Society</td>
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<td>SCDS</td>
<td>Social Care Data Standards</td>
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<td>SEHD</td>
<td>Scottish Executive Health Department</td>
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<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<td>SPCERH</td>
<td>Scottish Programme for Clinical Effectiveness in Reproductive Health</td>
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<td>SRM</td>
<td>Spontaneous Rupture of Membranes</td>
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<tr>
<td>Acronym</td>
<td>Abbreviation</td>
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<td>SWHMR</td>
<td>Scottish Woman-Held Maternity Record</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UKCC</td>
<td>United Kingdom Central Council for Nursing, Midwifery &amp; Health Visiting</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VTE</td>
<td>Venous Thromboembolism</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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INTRODUCTION
This guidance document has been designed for maternity care staff using the Scottish Woman-Held Maternity Record (SWHMR).

It commences with a brief overview of the background to the SWHMR Project, and sets out the underlying principles that have shaped the development of the SWHMR. The overall structure and parts of the SWHMR are then outlined.

The remainder of the guidance focuses on the contents of each part of the SWHMR. It takes a page by page approach, and provides guidance on the specific items. Rationales for the content and format are given, together with additional resources and further reading. It is acknowledged that the use of the SWHMR in maternity care will also be informed by local and national guidelines and protocols.

THE SWHMR PROJECT
A unified maternity record for Scotland has been an aspiration for women, service providers and clinicians for many years (CRAG/SCOTMEG Working Group on Maternity Services, 1995; Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH), 1999). This goal has been underpinned by evidence from randomised controlled trials on the beneficial consequences of women holding their own maternity records (Elbourne et al., 1987; Lovell et al., 1987). It is also supported by women’s wishes to have access to maternity records that they understand (The Scottish Office Home and Health Department, 1993).

In 2001 the Scottish Executive Health Department (SEHD) published 'A Framework for Maternity Services in Scotland'. This document reiterated the case for a national, unified maternity record, and made it a priority through Principle 27:

‘There should be a national, unified and standardised woman-held maternity record that is available and accessible to both women and professionals.’
(SEHD, 2001a: 71)

This principle was elaborated by several local actions:

• a unified, multi-professional, woman-held maternity record should be developed and implemented throughout Scotland
• a standardised national record should incorporate result reporting and discharge information
• NHS Trusts should encourage women to contribute to their notes if they so wish;
• NHS Trusts must make sure that record keeping is an integral part of care
• Documentation of every episode of care must be recorded by the professional in good time, and dated and signed with a legible signature
• NHS Trusts should make sure that clear information is given to women locally about how they can obtain a copy of their maternity record.
(SEHD, 2001a: 71)

As part of the implementation of ‘A Framework for Maternity Services in Scotland’ (SEHD, 2001a), the SWHMR Project was established to design such a record. The SWHMR Project commenced in November 2002.¹

¹ The SWHMR Project commenced within the former Nursing and Midwifery Practice Development Unit. This became NHS Quality Improvement Scotland on January 1st 2003.
The aim of the SWHMR Project was to: ‘…..develop a national standardised woman-held maternity record integrated with an electronic record.’

A project to design an electronic record, the eSWHMR, was established within the Information & Statistics Division (ISD) of NHSScotland shortly after the SWHMR commenced. Details of the eSWHMR Project can be found below.

In order to meet the project aim, SWHMR Project objectives were to:
- establish a process for ensuring stakeholder involvement in the project
- produce a template record for wider consultation
- propose a pathway and guidelines for the record for wider consultation
- collaborate with the project group charged with producing an electronic version of the record to facilitate data entry and storage
- consult nationally on the proposals
- prepare a written report for the Scottish Executive.

Stakeholders have been involved in the SWHMR Project since its inception. The project was supported by a comprehensive Reference Group, comprising lay and professional representatives who receive, deliver or plan maternity care in Scotland.

All Scottish maternity units were invited to participate in the SWHMR Project at the outset. A survey on maternity record keeping and a request for (blank) maternity records were sent to each maternity unit. This generated an excellent response, and further details can be found in the SWHMR Project Final Report.

Analysis of the maternity records used in Scotland was instrumental in designing the draft SWHMR issued for national consultation. This analysis was supplemented by a range of relevant resources, such as research evidence and national guidelines, current requirements for national maternity data collection - the SMR02 (ISD, 2000 & 2002), and NHS Health Scotland publications.

National consultation on the draft SHWHR and draft SWHMR guidance was undertaken during February 2004. Further details can be found in the SWHMR Project Final Report.

It is important to note that the remit of the SWHMR Project did not extend to implementation. This activity is to be considered by SEHD.

The eSWHMR Project
A sister project to develop a prototype electronic version of the SWHMR commenced in early 2003 within ISD. The SWHMR and eSWHMR project teams have collaborated closely.

A companion secure electronic version of the SWHMR has many advantages. These include:
- facilitating data entry e.g. information need only be entered once onto the electronic system, and clear, legible copies can be produced
- acting as a back-up of information included in the SWHMR that is available in an emergency (even if the paper record is lost)
- promoting co-ordination of professional input across geographical and professional boundaries (by the use of a shared dataset)
- permitting extraction and integration of data from existing electronic systems, such as laboratory systems
• providing high quality data for planning and management at local and national levels.

The following were specified for the system:

• effective integration with the SWHMR, so that the paper record can be produced and updated directly from the eSWHMR
• an easy to use system that requires minimal training costs
• a web-based eSWHMR that is free to users in NHSScotland via the NHS Net (the private intranet belonging to the NHS) and uses standard personal computers
• accessibility from community and hospital sites
• security and confidentiality considerations e.g. password protection, determining which staff are allowed to access which data items, data storage, and electronic data transfer
• use of the national Unique Patient Identifier number.²

Many of these issues were already being addressed by the Scottish Birth Record (SBR) Project, also being undertaken within ISD. The SBR is a web-based system collecting data relating to newborn babies via the NHS Net. The eSWHMR Project has therefore adopted many of the facets of the SBR, and the two systems aim to be fully integrated. This will have advantages such as allowing staff to enter information concerning both mother and baby simultaneously.

A commercial firm with experience of developing maternity systems has been developing a prototype of the eSWHMR system.

Details of the Scottish Birth Record can be found at http://www.nhsis.co.uk/sbr/

UNDERLYING PRINCIPLES OF THE SWHMR

Focusing on normality
The SWHMR has been designed to promote pregnancy, childbirth and the postnatal periods as normal life events (Royal College of Midwives (RCM), 2000a; SEHD, 2002a). However, it also provides opportunities to document each woman’s particular needs, special features and plans for maternity care. The SWHMR therefore aims to be an appropriate and adaptable record for all women receiving maternity care within NHSScotland.

Encouraging holistic maternity care
Holistic assessment of women’s circumstances and needs, followed by appropriate planning and management, are vital elements of modern 21st century maternity care (SEHD, 2001a):

‘The planning and delivery of maternity services should focus on approaching each woman as an individual with different social, physical and emotional needs, as well as any specific clinical factors that may affect her pregnancy. Her pregnancy must not be viewed in isolation from other important factors that may influence her health or that of her developing baby.’

² This is the Community Health Index (CHI) number.
The SWHMR Project has attempted to meet this challenge by designing formats that record comprehensive and individual assessments at booking and during the antenatal, intrapartum and postnatal periods. These assessments can be used as a basis to document and communicate the planning, delivery and evaluation of holistic care for each woman, according to her needs (SEHD, 2001a).

Responding to diversity
The SWHMR intends to promote the planning and delivery of maternity care that is sensitive and responsive to diversity. Items in the SWHMR acknowledge variety within the cultural values, beliefs, attitudes, ethnic backgrounds and lifestyles of women and their families (SEHD, 2001a). The SWHMR intends to provide opportunities for maternity care staff to respond positively:

‘Working with diversity is not about categorising people as ‘different’, nor is it about treating them as special cases; it is about recognising and understanding each woman’s individual needs, so as to be able to provide the same high standard of care for everyone.’

(RCM 2000b: 1)

Promoting woman-centred maternity care
Many features of the SWHMR reflect the desire to promote woman-centred maternity care (RCM, 2001a). For example:

- use of accessible lay language. Research has indicated women’s wishes to have access to maternity records that they understand (The Scottish Office Home and Health Department, 1993)
- women are offered the opportunity to carry their SWHMR (SEHD, 2001a) during antenatal and postnatal periods
- women are encouraged to write in their maternity record (SEHD, 2001a) if they wish (i.e. in the designated parts of the Pregnancy Record and Postnatal Record).

Encouraging high standards of record keeping
Guidance from professional bodies for medical, midwifery and nursing staff indicates the importance of accurate, legible and contemporaneous record keeping that avoids abbreviations (General Medical Council (GMC), 2001; Nursing and Midwifery Council (NMC), 2002a; United Kingdom Central Council for Nursing, Midwifery & Health Visiting (UKCC), 1998). Each individual practitioner therefore has their own professional role to fulfil.

The SWHMR has been designed to encourage good record keeping practices by staff and students who provide maternity care. Examples include:

- A ‘Whose signature?’ sections, where all staff writing in the SWHMR should sign and print their name, and record their job title.
- Use of a large, sans serif font.
- Avoiding the use of abbreviations wherever possible, and stating them in full once in the text wherever they are first used.
- Clearly headed sections and sub sections.
- Spaces between individual items and lines of text which are large enough to promote clarity and accommodate hand writing.
• Wide margins to allow for hole punching and subsequent safe storage of the SWHMR.
• Numbered pages, so that if any pages become detached from the SWHMR they can be reinstated. Where continuation sheets are added which do not have page numbers, their place in the record can be identified by the title of the sheet and dated/timed entries.
• Space for the woman’s name and CHI number\(^3\) on the headers of each page to ensure that each page can be identified if it becomes detached from the SWHMR.\(^4\) For additional ease, the first six digits of the CHI are separated out so that date of birth can be easily identified (i.e. day/month/year).
• When the SWHMR is generated from the eSWHMR, details of a woman’s name and CHI number will automatically be printed onto the header of each page.
• The Central Registration Number (CRN) is still used within some parts of health records in NHSScotland for filing notes and for hospital laboratory systems etc. To accommodate this, a space for the CRN is included on page 2 of the Pregnancy Record.

Although the following recommendation has been proposed in relation to the care of premature babies, it also has high relevance for maternal and neonatal care in general:

‘Clinicians should conclude each patient contact with an explicit statement re their plan of care. This may be a simple endorsement of a previous plan, or a revision of the plan in light of changes in condition or a completely new plan.’

(Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), 2003: 146)

By adopting this practice within the SWHMR, maternity staff can promote good record keeping, clear communication and continuity of care.

**Encouraging high quality communication**

The importance of effective communication between colleagues within multidisciplinary teams, and with women, their partners, close relatives or carers has been stressed within professional practice (GMC, 2001; NMC, 2002b) and maternity policy (SEHD, 2001a). Communication skills are particularly important when obtaining a comprehensive maternal history, providing informed choice about care options and dealing with problems should they arise (SEHD, 2002a).

Unfortunately, research indicates that the communication skills of maternity staff remains an area of professional practice in need of attention (Stapleton et al, 2002a & 2002b; Kirkham et al, 2002). CEMD note that substandard care was difficult to evaluate in many of the cases undertaken for their work due to lack of access to key data from some records and case notes. However, lack of communication and teamwork were identified as key sources of substandard care (CEMD, 2001).

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\(^3\) A CHI number is allocated to every member of the public registered with a General Practitioner (GP) in Scotland. It is a ten digit number that is compatible with the NHS number system used in England and Wales. It contains the individual’s date of birth and gender is identifiable.

\(^4\) Space for an address has not been included on each page, as this is not needed for identification purposes; the woman’s full name and CHI are sufficient.
Many of the topics that may be broached whilst eliciting and recording a comprehensive maternal history and providing maternity care are of a highly sensitive nature (e.g. bereavement and loss in a previous pregnancy, domestic abuse, sexuality, cultural beliefs or substance misuse). This emphasises the need for maternity professionals to display excellent communication skills.

The SWHMR has been designed to assist maternity care professionals in this aspect of their role. For example, the order of contents in the Pregnancy Record has been structured to elicit general personal information and to get to know the woman before more intimate and potentially sensitive topics are introduced.

**Encouraging multidisciplinary maternity care**

‘Maternity services (...) should be delivered by multi-disciplinary and multi-agency teams with a clear understanding of professional roles to maximise the quality and comprehensiveness of care, ensuring safety for both mother and baby.’

(SEHD, 2001a: 64)

Cooperative multidisciplinary team working is integral to professional practice within healthcare, irrespective of the speciality (GMC, 2001; NMC, 2002b; UKCC, 1998).

The SWHMR has been designed to meet the need for a unified, multi-professional, woman-held maternity record (SEHD, 2001a). Such a record is vital for the delivery of comprehensive maternity care (SEHD, 2002a).

Examples of this include the ‘Special features and plans for care’ sections that are visible at the top of the centre pages of the Pregnancy Record. These sections aim to facilitate good written communication within the multidisciplinary teams caring for women and their babies. Professionals are encouraged to use these sections to highlight important information and plans for care during the antenatal, intrapartum and postpartum periods, and also for care of the neonate.

Other examples occur within the Maternity Summary Record, e.g. the sections on referrals, domestic abuse and child protection, which aim to prompt staff to maintain high standards of intra- and inter-professional teamwork and communication.

**THE SWHMR**

The SWHMR has been created in four parts, supplemented by relevant inserts and continuation sheets. The parts are:

- Pregnancy Record
- Labour and Birth inserts for the Pregnancy Record
- Postnatal Record
- Maternity Summary Record.

The SWHMR aims to provide a comprehensive record for all maternities in Scotland. However it is acknowledged that the SWHMR may need to be supplemented by locally generated documentation. Examples of such documentation include:

- booking referral letter

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5 Note: when the appropriate Labour and Birth Record inserts are added into the Pregnancy Record to create a combined antenatal and intrapartum record, the ‘Special features and plans for care’ sections remain visible at the top of the centre pages.
• prescription and administration of drugs
• prescription of intravenous fluids
• fluid balance
• consent for operative procedures
• an anaesthetic record
• care for babies in a neonatal unit (other than the SWHMR baby record)
• pregnancy loss (e.g. miscarriage, termination of pregnancy for fetal anomaly or stillbirth)
• women and babies who have problems with substance misuse
• risk assessment.

The following sections outline the parts of the SWHMR and provide a brief ‘pathway’ for its use in maternity care. This information is expanded in the remainder of the Guidance.

**Pregnancy Record**
This part of the SWHMR will typically be woman-held during the antenatal period. It is recognised, however, that some women may choose not to hold their Pregnancy Record. Maternity staff may also consider that in some individual cases (e.g. for vulnerable women) it may be more appropriate to retain the Pregnancy Record within a maternity unit or specialised clinic. This should be discussed with the woman. Such actions aim to promote confidentiality, enhance continuity of communication and care, and maintain the safety and integrity of the record.

The Pregnancy Record should be commenced at the booking appointment. The Best Practice Statement on Maternal History Taking (NHS Quality Improvement Scotland (NHS QIS), 2004a) provides a valuable resource completing this part of the SWHMR.

The following continuation sheets can be inserted into the Pregnancy Record where more extensive documentation of a woman’s obstetric history, antenatal appointments and/or antenatal assessments/admissions is required:

• Your previous pregnancies (continued)
• Antenatal appointments (continued)
• Antenatal assessments/admissions (continued)

When the woman goes into labour, the relevant Labour and Birth Record inserts are incorporated into her Pregnancy Record according to her needs (see below).

**Labour and Birth Record inserts**
The intrapartum part of the SWHMR comprises of a series of inserts. The number and type of inserts required will vary according to each woman’s individual circumstances. The inserts are all hole punched, and should be inserted into the Pregnancy Record before the ‘Whose signature?’ (page 11). They can be secured with the use of treasury tags. When inserted into the Pregnancy Record, each woman’s key details and the ‘Special features and plans for care’ sections remain clearly visible at the top of each page.⑥ The Labour and Birth Record comprises the following inserts:

• Labour and birth record: Initial assessment for spontaneous labour
• Labour and birth record: Induction of labour

⑥ When the eSWHMR is operational, full size A4 documentation can be used throughout the SWHMR with any important information being able to be printed (and updated) on the top of the pages.
• Progress notes: Labour and birth
• Partogram/Progress notes: Labour and birth
• Partogram/Labour and birth summary
• Labour and birth summary
• Details of caesarean section birth
• Details of assisted vaginal birth
• Details of third stage complication(s).

Once the intrapartum episode has been completed, the combined Pregnancy, Labour and Birth Record should be retained in the relevant maternity unit for secure storage, together with any CTG (cardiotocograph) tracing. The rationale for this is as follows. If the record is taken home by the woman (or kept at home following a home birth) and is not returned to the maternity unit, the detailed intrapartum information it contains is typically not duplicated elsewhere; consequently a new intrapartum record could not be repopulated.

When a home birth has taken place, the combined Pregnancy, Labour and Birth Record should be returned to the maternity unit at a suitable time shortly after birth.

Should a woman wish to discuss any issues about her pregnancy, labour or birth, her record can be accessed from the maternity unit at her request (as is currently the case).

Postnatal Record
The Postnatal Record will typically be woman-held. However, as with the Pregnancy Record, some women may choose not to hold their record, or it may be more appropriate to hold some records within NHSScotland premises whilst delivering postnatal care.

The Postnatal Record has been designed to enable each woman’s care to be documented, whether this is provided in a maternity unit, a community/home setting, or both.

A Baby Record has been designed which can be integrated into the mother’s Postnatal Record, or it can be used independently if the mother and baby are separated.

Pages 9 and 10 of the Postnatal Record comprise of an insert which relates to the mother’s chosen method of feeding. The appropriate insert should only be added following birth, when the mother has made her decision about feeding her baby. The inserts are:

• Breastfeeding your baby/Your questions or concerns/Thinking about your pregnancy, labour and birth
or
• Bottle feeding your baby/Your questions or concerns/Thinking about your pregnancy, labour and birth.

The following continuation sheets can also be inserted into the Postnatal Record as needed:

• Your progress (continued)
• Your postnatal care (continued)
The Baby Record comprises a three page record:

- Baby record/Your baby’s care
- Your baby’s progress
- Your baby's care (continued)/Consent for Newborn Blood Spot Screening.

The following continuation sheets can also be added to the Baby Record:

- Your baby’s care (continued)
- Your baby's progress (continued).

On completion of midwifery care, the Postnatal Record will be stored according to appropriate local arrangements until the six week postnatal check is undertaken (i.e. with the woman’s health record at her GP practice, or returned to the maternity unit). Following completion of the six week postnatal check, the Postnatal Record should be returned to the relevant maternity unit for safe storage with the rest of the woman’s SWHMR.

**Maternity Summary Record**

The Maternity Summary Record contains key information that will be important for each woman’s care. It will be held throughout the maternity episode by the most appropriate person (e.g. a named midwife) and at the most appropriate location (e.g. in community settings or at a maternity unit). This will be determined at local level. The summary has been designed to enable the delivery of co-ordinated maternity care (SEHD, 2001a).

Information for the Maternity Summary Record is routinely collected at booking (when the Pregnancy Record is commenced), and added to as pregnancy progresses and following birth. Key functions of this document include:

- a place to record sensitive information that is not contained in the woman-held parts of the SWHMR (e.g. according to a woman’s wishes, or concerning domestic abuse or child protection issues)
- a means of duplicating information to repopulate the SWHMR in case of loss
- to facilitate communication and continuity of care between professionals responsible for the woman’s care.

If additional space is needed to record entries in the Maternity Summary Record, it can be supplemented with the following continuation sheet:

- Maternity summary record (continued)

**General note on maternity records and the SWHMR**

Obstetric records should be retained for 25 years after the birth of the child (including a stillbirth) (The Scottish Office, 1993; UKCC, 1998).

As women are offered the opportunity of carrying their Pregnancy Record in the antenatal period, and their Postnatal Record following birth, the integrity and safety of the records is paramount. This is clearly indicated in the inside covers of these parts of SWHMR. Maternity care professionals are advised to ensure that information contained within these woman-held parts is duplicated elsewhere, so that a new maternity record could be repopulated with the appropriate information in case of loss or damage.
Finally, the importance of retaining not only maternity records but other documents related to maternity care is worth emphasising:

‘There should be a set of referenced, evidence-based Guidelines which should be dated, signed and reviewed on a regular basis, every one to three years. Past guidelines and protocols should be dated and archived in case they are needed for reference at a later date.’
(Royal College of Obstetricians & Gynaecologists (RCOG) & RCM, 1999: 1)

Ensuring that this activity is undertaken will assist in the retrieval and examination of case records for litigation and other purposes.
PREGNANCY RECORD

OUTER FRONT COVER

Guidance/rationale

- The confidential status of the Pregnancy Record is indicated in a prominent position. To promote confidentiality, personal details are not included on this outer page. Maintaining patient confidentiality is integral to high standards of professional practice within health care (British Medical Association (BMA) 1999 & 2002; GMC, 2001; NMC, 2002b).
- Should the Pregnancy Record be lost or mislaid, the action that the person finding the record should take is clearly stated and visible.
- The cover is of durable card to protect the important pages within.

INNER FRONT COVER

Guidance/rationale

- The untitled section that fills the top half of this page contains useful information for each woman about her Pregnancy Record.
- Women are invited to carry their Pregnancy Record to promote continuity of care.
- The importance of the Pregnancy Record is clearly stated, with the need to keep it safe, undamaged, and to report its loss to a relevant authority.
- Women are invited to contribute to their Pregnancy Record (SEHD, 2001a). The ‘pen in hand’ symbol indicates where they can do this. Maternity care staff should bear in mind that women may not be able to read/write in English, or they may have literacy problems which they may or may not disclose.
- There is a clear indication that the Pregnancy Record remains the property of the relevant NHS Board. Women are invited to request a copy if they so wish (SEHD, 2001a).
- The issues of use and protection of personal health information are raised. Protecting personal health information is a duty of all staff within NHSScotland (SEHD, 2003a; Scottish Executive, 2002a). Maternity care professionals should discuss these issues with each woman.

Resources & further reading

Protecting patient confidentiality within NHSScotland
http://www.show.scot.nhs.uk/confidentiality

NHSScotland (2003a)
The Confidentiality & Security Advisory Group for Scotland (CSAGS) (Scottish Executive, 2002a)
http://www.show.scot.nhs.uk/csags

The Data Protection Act 1998
SEHD (2000a) or the Data Protection Commissioners website:
http://www.dataprotection.gov.uk

Help and advice

Guidance

- Local contact telephone numbers should be inserted here.
Contact details

Guidance

- This section contains the names, bases/locations and phone numbers for key professionals providing care for each woman.
- Space for details of a social worker has been included in each record, in an attempt to reduce the potential stigma attached to this.
- Details of other key people who may contribute to a woman’s care can be entered in the spaces with the heading ‘Other contacts’. Examples include:
  - Advocacy worker
  - Community pharmacist
  - Community psychiatric nurse
  - Dentist
  - Dietician
  - Interpreter
  - Occupational therapist
  - Pharmacy (e.g. if on a Methadone programme)
  - Psychiatrist
  - Psychologist
  - Physiotherapist
  - Substance misuse liaison worker
  - Specialist clinic/clinician contact (e.g. for care of women with diabetes, substance misuse problems, medical problems etc).

Rationale

- During her maternity care, each woman will be supported by a variety of health or social care professionals according to her individual circumstances and needs (SEHD, 2001a; SEHD, 2002a). This section aims to ensure that women know who these staff are, and how they can be contacted. It will also assist communication amongst the multidisciplinary maternity care team.
- The use of a ‘named midwife’ has been advocated (SEHD, 2001a) to co-ordinate each woman’s care from confirmation of pregnancy though to parenthood.

Domestic abuse: sources of support and information

Guidance/rationale

- In addition to details of national support agencies, details of local support agencies for domestic abuse should be inserted for all women.
- This information has been included in response to guidance from CEMD (2001) and SEHD: ‘Service providers should consider routinely printing on the bottom of hand held records and co-operation cards, local information on services, emergency helplines and sources of help concerning domestic abuse’ (SEHD, 2003b: 15).

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7 Please note that the Maternity Summary Record contains a section to document issues of domestic abuse.
Plan of care for your pregnancy

**Guidance**

- This section aims to ensure that information about planned antenatal care is communicated between each woman and her maternity care team.
- Discussion of this section with women will be supplemented by information given in the section ‘Your antenatal care and planned place of birth’ on page 6 of the Pregnancy Record.

**Rationale**

- The plan of care for pregnancy should reflect the following principle: ‘Maternity Services should provide a woman and family-centred, locally accessible, midwife managed, comprehensive and effective model of care during pregnancy with clear evidence of joint working between primary, secondary and tertiary services.’ (SEHD, 2001a: 37).
- Explicit plans for antenatal care for all women (regardless of risk) should be established at NHS trust level (SEHD, 2001a). Suggested examples of antenatal care models for first time mothers and women having subsequent babies can be found in ‘A Framework for Maternity Services in Scotland’ (SEHD, 2001a: 40-41). These can then be applied on an individual basis.

**Resources & further reading**

National Institute for Clinical Excellence (NICE) (2003a & b)


Your appointments

**Rationale**

- Since this is integral to the Pregnancy Record, women have an accessible record of the dates, times and locations for their antenatal appointments.
- There is also space for women to jot down any comments or questions that they may have. The outcomes of any such discussions should be noted in the appropriate part of the Pregnancy Record, e.g. on page 9 in ‘Other information/plans/referrals etc’, on page 13 ‘Responding to your questions’, or on page 14 ‘Discussion of preferences for labour and birth/issues arising.’

Local information

**Guidance/rationale**

- This section can be customised, providing information tailored to local provision and each woman’s needs. It intends to ensure that women have accessible details of local services, including reproductive healthcare, health promotion and parent education programmes (SEHD, 2001a).
- Maternity services should be offered as close to the woman’s locality as possible (SEHD, 2002a).

Note on students

**Rationale**

- This statement aims to balance women’s needs, wishes and cultural requirements with professional demands to promote student learning. The nature and role of any students that a woman may encounter during her maternity care should be outlined with women on an individual basis.
Important information

Name/address details

**Guidance**

- Whilst these items are self-explanatory, they can alert maternity care staff to important information about a woman’s home circumstances. For example, she may be homeless, based at more than one address, living in temporary accommodation, or a refugee or asylum seeker. Further probing and/or assessment of a woman’s home circumstances and needs can follow, with appropriate care planned thereafter.

- Space has been included for two ‘other’ contact telephone numbers for women who work, for women who may often stay at an alternative location, and due to the increased ownership of mobile phones.\(^8\)

**Rationale**

- The terminology aims to be culturally sensitive and accessible to all women, i.e. the use of ‘surname/family name’, and ‘first name(s)’ as opposed to ‘Christian name(s).’

- Determining how each woman wishes to be addressed is a common courtesy that should be applied universally (Enkin et al, 2000).

- Changes in contact details constitute important information. They have been included to maintain communication between the woman and members of her maternity care team, particularly if emergency situations arise.

**Resources & further reading**

Asylum seekers and refugee women
James (2003); McLeish, Cutler & Stancer (2002); RCM (2003a)
http://www.onescotland.com
http://www.harpweb.org.uk/index.php

Homeless families
Sawtell (2002)

Addressing people correctly
Schott & Henley (1996) Chapter 14 ‘Getting people’s names right’

Your partner/supporter for this pregnancy

**Guidance**

- Enquiry about the woman’s partner or supporter should be sensitive and responsive to diversity. This approach is reflected in the language used in the Pregnancy Record. The woman may be in a heterosexual relationship, lesbian relationship or not in a current relationship. Therefore she may have a male or female partner, or be supported by a relative or friend. The pregnancy may involve surrogacy, or result from donor insemination.

**Rationale**

- Communicating a partner-friendly philosophy in maternity care: ‘Health professionals should recognise the important role of partners, and make sure they are encouraged and supported to take a full and active role in pregnancy and childbirth.’ (SEHD, 2001a)

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\(^8\) Inclusion of an email address may become increasingly useful for contacting women.
Despite media portrayal of the nuclear family as the norm, there is considerable diversity of family structure and family types in the UK (Dunn-Toroosian, 2003). Maternity services and staff need to anticipate this variety, create climates of openness and provide individualised, non-discriminatory care.

**Resources & further reading**

*Fathers*
Lewis & Warin (2001)
Fathers Direct/various contributors (2003)
Fathers Direct website: [http://www.fathersdirect.com](http://www.fathersdirect.com)

*Lesbian women/gay families*
Dunn-Toroosian (2003); Jackson (2003); RCM (2000b)

*Sexuality*

*Surrogacy issues*
RCM (1997)

**Emergency contact person/Next of kin**

*Guidance/rationale*
- This section aims to ensure that each woman’s next of kin can easily be contacted in an emergency situation. A space for an alternative contact person has been included if this person is not the named partner/supporter, or where a woman’s partner/supporter may not always be easily accessible.

**Other personal information**

*Ethnic group*¹⁰

*Guidance*
- An ethnic group has been defined as: ‘a group of people having racial, religious, linguistic and/or other cultural traits in common. The ethnic group to which a patient belongs is judged by the patient’ (ISD, 2000). The following ethnic groups are given in the current SMR manual:¹¹
  - White
  - Black Caribbean
  - Black African
  - Black Other
  - Indian
  - Pakistani
  - Bangladeshi
  - Chinese
  - Other Ethnic Group
  - Not known

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¹⁰ The issue of ethnic/family origins is raised in the ‘Blood Tests’ section on page 7 of the Pregnancy Record which includes haemoglobinopathies screening.

¹¹ It is acknowledged that the Census 2001 provides a more up-to-date and comprehensive means of recording Ethnic Group. This issue has been raised by the SWHMR/eSWHMR projects within ISD. It has been suggested that when changes are agreed to the national recording of ethnicity, a chart containing the revised Ethnic Groups could be issued with the SWHMR. This would enable women to select the ethnic group which they feel is most appropriate to them.
- Information refused

- Information on ethnic group may alert maternity care staff to women who may have particular needs due to:
  - Female Genital Mutilation (female circumcision)
  - Asylum seeker or refugee status.

**Rationale**

- Information about ethnic group is a legal requirement according to the Race Relations (Amendment) Act 2000 (Scottish Executive, 2002b).
- Women from ethnic minority groups often experience poor maternal health. The most recent Confidential Enquiries in Maternal Deaths in the UK revealed that women from ethnic minority groups were twice as likely to die as women in the white group, and many of these women spoke little English (CEMD, 2001). Acknowledging ethnic group, identifying and meeting individual needs, and evaluating service provision aims to improve the quality of maternity care.
- To address and eradicate the issue of institutionalised racism. This has been described as: ‘...the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people.’ (MacPherson, 1999: para 46.25 6.34)
- To encourage reflection on personal practice and local provision to address institutional racism in maternity care (CEMD, 2001; RCM 2000c).

**Resources & further reading**

*Female Genital Mutilation*
RCM (1998); Momoh, 2003

*Haemoglobinopathies*
Schott & Henley (1996)

*Race/racism/culture and maternity care*
RCM (2000c); Schott & Henley (1996); Sookhoo (2003)

*Ethnic record keeping and social care*
Scottish Social Care Data Standards (SCDS) Project (2003)

*Asylum seekers and refugee women*
James (2003); McLeish, Cutler & Stancer (2002); RCM (2003a)
One Scotland. Many Cultures: [http://www.onescotland.com](http://www.onescotland.com)
Health for Asylum Seekers and Refugees Portal: [http://www.harpweb.org.uk](http://www.harpweb.org.uk)

*Language usually used at home/help with interpretation, communication or advocacy*

**Guidance**

- These questions aim to identify the following:
  - women who do not speak English
  - women for whom English is not their first language
  - women who have other communication difficulties or who may require advocacy (e.g. deaf women who sign or lip read, or women with learning difficulties).
• Some people from ethnic minorities who have a good understanding of colloquial English may need help with the specialist language used in social/health care (SCDS, 2003).
• Where assistance is needed with interpretation or advocacy, the name(s) and contact details of relevant personnel can be inserted in the section on the inner front cover.
• Where women do not speak English, the use of family members (including children) as interpreters should be avoided (CEMD, 2001) to ensure that all women receive an equitable and appropriate service.

**Rationale**
• 'High quality communication between professionals and women and their families .. must be central to the provision of excellent maternity care.' (SEHD, 2001a: 69)
• 'All professionals must make sure that they communicate with women, and their families, in an open, friendly, courteous manner. They must make sure that they are fully understood and take account of the needs and wishes of women and their families.' (SEHD, 2001a: 69)
• 'NHS boards should make sure that interpreters (preferably female) are available for women from minority ethnic communities.' (SEHD, 2001: 61)
This provision should commence in the antenatal period and is particularly important to have in place during intrapartum care (RCOG & RCM, 1999).

**Resources & further reading**

*Guide to interpretation*
Sanders (2003)

*Advocacy*
Scottish Executive (2000a)

*Learning disabilities*
Scottish Executive (2000b)

**Current religion or faith**

*Guidance*
• This should be the current religion as declared by the woman (i.e. not necessarily the religion she was brought up in). A person’s religion often defines their cultural identity more than their nationality (SCDS, 2003).

*Rationale*
• To identify the current religion or faith practiced/held by the woman (SCDS, 2003) and elicit any requirements, so that maternity services and maternity care can be culturally sensitive.

**Resources & further reading**
Katbamna (2000); NHSScotland (2003b); Schott & Henley (1996)

**Other cultural issues**

*Guidance/rationale*
• This question aims to elicit any information on social conventions and customs, family structure, ceremonies, dress or diet, which will affect each woman’s maternity care needs (SCDS, 2003).
• To elicit important information so that culturally appropriate maternity care is planned with each individual woman.
‘Health professionals who work with disadvantaged clients need to be able to understand a woman’s social and cultural background, act as an advocate for women, overcome their own personal and social prejudices and practise in a reflective manner’ (CEMD 2001).

Resources & further reading
Culture/ethnicity
Schott & Henley, 1996
The Mary Seacole website provides information on cultural issues and also contains useful information from the MELTING (Multi-Ethnic Learning & Teaching In Nursing) Project
http://www.maryseacole.com

Occupation/Health and safety issues
Guidance/rationale
• This question aims to identify and address any health and safety needs that may affect a woman during her pregnancy (and afterwards if she chooses to return to work after her baby is born).
• The woman’s response to this question may also alert maternity staff to the following issues: unemployment; specific benefit/financial advice; and, in the case of young women, schooling/education needs. These can be documented in the section below.

Resources & further reading
Health & Safety Executive (HSE) website: http://www.hse.gov.uk
HSE (2003a & 2003b)
Safe and Healthy Working website: http://www.hebs.com/safeandhealthyworking
Safe and Healthy Working Advice line 0800 019 2211

Your home circumstances and support needs
Guidance/rationale
• This item contributes to a holistic assessment of each woman’s circumstances, incorporating social, physical and psychological needs (SEHD, 2001a).
• A variety of issues may be identified, and this section can be interpreted broadly. Needs should be addressed and information given/plans made can be documented in ‘Other information/plans/referrals etc on page 9 or ‘Information for you’ on page 13.

PAGE 3

Your previous pregnancies
Guidance
• Previous pregnancies should be documented in chronological order.
• Multiple births: a separate entry should be used for the birth of each baby whilst clearly noting that he/she is part of a multiple birth.
• Handling sensitive information and maintaining confidentiality: some women may prefer that their hand-held record does not contain details of previous
terminations. These may be omitted, however a full past obstetric history can be recorded in the Maternity Summary Record and/or the referral letter.12

- A woman who has experienced a previous pregnancy loss may wish to have the Stillbirth and Neonatal Death Society (SANDS) teardrop sticker inserted in her record, to alert maternity staff.
- Documenting a child’s full name can assist linkage of maternal and child records, and can be useful for issues of child protection.
- Similarly, asking if anyone else has care of any children that the woman may have aims to identify any child protection issues.
- The boxes for free text headed 'Details' should be used to document key information relating to the woman’s pregnancy, labour and birth, the baby at birth and the baby’s/child’s health now. Women may have strong positive or negative recollections and feelings about previous events that they wish to have recorded here. Women can be encouraged to reflect on their experiences of previous births and document them in ‘Your preferences for labour and the birth of your baby’ on page 15 of the Pregnancy Record.
- A continuation sheet, ‘Previous pregnancies (continued)’ is supplied with the Pregnancy Record for women who have had more than four previous pregnancies. Continuation sheets should be inserted in front of page 3, and securely fastened with treasury tags.

**Rationale**

- The language used in this section aims to be sensitive to the range of possibilities resulting from previous pregnancies, e.g. the woman may have experienced a previous miscarriage, termination, ectopic pregnancy or neonatal death. Examples of such language include 'date' (rather than date of birth) and 'pregnancy outcome' (rather than type of birth).
- An obstetric and neonatal history constitutes part of a comprehensive maternal history and contributes to risk assessment. Further details can be found in Appendix 2 of the Expert Group on Acute Maternity Services (EGAMS) Report (SEHD, 2002a) and Appendix E of NICE (2003a).

**Resources & further reading**

Stillbirth and Neonatal Death Society (SANDS) website: [http://www.uk-sands.org](http://www.uk-sands.org)

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12 The eSWHMR is being designed with the ability to record confidential information on screen which will not print out onto the Pregnancy Record if the woman prefers this.
• It may not always be possible to obtain a comprehensive family history, e.g. where the woman or the baby’s father are adopted or estranged from family members, or where details about the baby’s biological father are uncertain or unknown. Therefore an indication of ‘Don’t know’ has been included.

• The relevance of a positive family history will vary according to the proximity of the relative affected and the individual condition.

**Asthma or allergies**

• This question has been included to alert maternity care staff to a close family history of peanut allergy or allergies diseases such as asthma, atopic eczema or hay fever. Women with a positive history should be advised to avoid eating peanuts or foods containing peanut products during pregnancy and breastfeeding (NHS Health Scotland, 2002a).

**Diabetes**

• Staff should be alert to the risk factors for gestational diabetes (maternal obesity; family history of Type 2 diabetes; unexplained stillbirth/neonatal death in a previous pregnancy; large infant resulting from a previous pregnancy). (Diabetes UK, 2000 – accessed at http://www.diabetes.org.uk)

• Type 1 and Type 2 diabetes run in families and can emerge in individuals in whom genetic susceptibility is triggered by environmental determinants (Contact a Family website: http://www.cafamily.org.uk).

**Resources & further reading**

Scottish Intercollegiate Guidelines Network (SIGN, 2001)

**Genetic disorders**

• This question can help to identify any X-linked diseases (i.e. where males in the family are affected), or any dominant disorders with incomplete penetrance (i.e. where more than one member of the family is affected by a similar problem).

• Proxy measures may be helpful when asking women about this issue, e.g. has anyone in the family attended a genetics clinic. This can prompt genetic counselling and possible pre-natal diagnosis.

• **Cystic Fibrosis (CF)** This is an inherited autosomal recessive condition. The incidence in the UK population is 1 in 2,500 births. Screening of newborns for CF is undertaken within Scotland (NHSScotland, 2003c: 4). Within the UK population, 1 in 25 people is an asymptomatic carrier (NHSScotland, 2003c: 4).

• **Haemoglobinopathies (Sickle Cell & Thalassaemia)** These issues are considered in the ‘Blood tests’ section on page 7 of the Pregnancy Record.

**Resources & further reading**

‘Contact a family’ website: http://www.cafamily.org.uk ‘Patterns of inheritance’

**Taking a genetic history**


**Cystic Fibrosis**

Cystic Fibrosis Trust website: www.cftrust.org.uk

**Haemoglobinopathies**

http://www.kcl-phs.org.uk/haemscreening
**Sickle Cell and Thalassaemia**  
Sickle Cell Society website: [http://www.sicklecellsociety.org](http://www.sicklecellsociety.org)  
UK Thalassaemia Society website: [http://www.ukts.org](http://www.ukts.org)

**Pre-eclampsia**
- Women should be asked about a family history of pre-eclampsia (e.g. in a mother or sister) (NICE, 2003b: 102).

**Resources & further reading**
Action on Pre-Eclampsia website: [http://www.apec.org.uk](http://www.apec.org.uk)

**Blood clots (thrombosis)**
- ‘Women attending their first antenatal visits should be asked specifically about their personal and family history of Venous Thromboembolism (VTE) and whether any diagnosis was objectively confirmed. If this information is not available, the history of anticoagulant treatment should be investigated. Where prolonged anticoagulant therapy has been prescribed, in keeping with the management of VTE, it is prudent to assume that there has been a definite event. Patients with thromophilias appear to be at particular risk of VTE in pregnancy.’ (SIGN, 2002a: 30)
- ‘All pregnant women with a personal history of VTE (venous thromboembolism), or a family history in first or second degree relatives, should be offered screening for thrombophilias.’ (SIGN, 2002a: 30 – Recommendation Grade D)

**Tuberculosis (TB)**
- It is important to know whether a close relative or contact of the family is either receiving treatment for TB, or has received treatment for TB within the last 10 years (Hall & Elliman, 2003).
- It is useful to record whether a parent is from a country where there is a high prevalence of TB (i.e. defined as a prevalence of 40 or more cases per 100,000) (Hall & Elliman, 2003: 80).
- Inclusion of an item on TB aims to promote the health of mother and baby and also public health in the community. The baby may require BCG (Bacillus of Calmette and Guerin) vaccination.

**Resources & further reading**
*BCG vaccination* patient information leaflet can be accessed at: [http://www.show.scot.nhs.uk/nhslanarkshire/hq/disease/bcg/bcg1.htm](http://www.show.scot.nhs.uk/nhslanarkshire/hq/disease/bcg/bcg1.htm)

**Hip problems detected at birth or shortly afterwards**
- Developmental displasia of the hip (DDH) is the preferred term (rather than congenital dislocation of the hip) as the problem is not confined to dislocation, and it may develop and progress during the early months of life (Jones, 1998: preface).
- Risk factors include family history in a close relative (Hall & Elliman, 2003: 153-157), particularly mothers and siblings (Jones, 1998).

**Abnormalities present at birth**
This general question aims to detect any abnormalities which may require specialist care/screening/counselling etc in subsequent pregnancies. Some examples include:
- **Neural tube defects** - Inheritance pattern: Spina Bifida has some genetic predisposition. Where a couple have an affected child, there is a 1 in 25 chance of an affected pregnancy. For an affected person, the risk of an
affected child is also 1 in 25 (Source- Contact a Family website index of conditions entry for Spina bifida).

**Note:** history of a neural tube defect in a previous pregnancy should prompt an increased dosage (5mg) of folic acid from preconception period to end of the first trimester

- **Down's Syndrome** - Inheritance patterns: Most cases of Down's Syndrome are sporadic, but there is a small risk of recurrence in future pregnancies. Incidence is related to increased maternal age (the older the woman, the greater the risk of an affected child) (Source - Contact a Family website index of conditions entry for Down's Syndrome).

**Resources & further reading**
Association for Spina Bifida and Hydrocephalus: [http://www.asbah.org/](http://www.asbah.org/)
Down’s Syndrome Association [http://www.downs-syndrome.org.uk](http://www.downs-syndrome.org.uk)
Down's Syndrome Scotland [http://www.dsscotland.org.uk](http://www.dsscotland.org.uk)
Scottish Spina Bifida Association: [http://www.ssba.org.uk](http://www.ssba.org.uk)

**Learning disabilities**
- This general question aims to detect any learning disabilities which may require specialist care/screening/counselling etc in subsequent pregnancies.

**Serious mental illness**
- This question aims to identify risk factors for postnatal depression and puerperal psychosis. It refers to a family history of bipolar disorder\(^{13}\) or puerperal psychosis\(^{14}\) (SIGN, 2002b: 4).
- Maternity professionals may find proxy measures helpful when questioning women about the severity of illness, as some terminology may be unfamiliar to many women. For example: ‘Has anyone in your family ever been seen by a psychiatrist, been admitted to hospital or been put on medication for mental health problems at any time or specifically after childbirth?’

**Permanent hearing loss**
- This question helps to identify risk factors for the Universal Neonatal Hearing Screening programme (National Services Division – NSD, 2001).
- Relevant family history encompasses whether first degree relatives have permanent hearing loss (i.e. present from birth). The degree of loss is not important (NSD, 2001).

**Resources & further reading**
National Deaf Children’s Society website: [http://www.ndcs.org.uk](http://www.ndcs.org.uk)
NHSScotland (2002)
SEHD (2001b)

**Are you and your baby’s father blood relatives?**
- This question has been included as the incidence of autosomal recessive conditions in the baby will be increased if his/her mother and father are blood relatives.
- If the answer to this question is yes, the relationship should be specified.

\(^{13}\) Definition: ‘A major affective disorder characterized by episodes of mania and depression.’

\(^{14}\) Definition: ‘Puerperal psychosis, in almost all cases, is a mood disorder accompanied by features such as loss of contact with reality, hallucinations, severe thought disturbance, and abnormal behaviour.’ (SIGN, 2002b: 2)
Your health

Guidance/rationale
- Items in this section aim to identify health problems that will require specific attention during maternity/neonatal care, and also to assess and manage risk appropriately.
- The examples of morbidities and co-morbidities included in EGAMS (SEHD, 2002a: 32-43) have been used as a basis for this section. It should be noted that this list is not all-inclusive, and examples have been given for clarity. (See also NICE, 2003a: 34-35)
- General headings are used for each item. It is anticipated that the maternity care professional conducting the history taking would use these headings as prompts for further, detailed questioning.
- The descriptions of levels of maternity and neonatal care available within Scotland (SEHD, 2001a: 47-50) utilised within EGAMS (SEHD, 2002a: 15; 32-43) provide helpful guidance for exclusion criteria for plans for delivery.

Operations
- If the woman has had any significant surgery and a general anaesthetic, enter details of the procedure and date. The location at which the surgery was performed may be helpful in some cases. A history of pelvic, cervical and uterine surgery is particularly important (SEHD, 2002a: 33).

Problems with anaesthetics
- This question applies to previous general and regional anaesthesia. Examples include:
  - anaphylaxis
  - awareness
  - abnormal spinal, neck or facial anatomy
  - failed or difficult intubation
  - history of malignant hyperpyrexia
  - history of Suxamethonium apnoea
  - history of post-operative nausea and vomiting
  - severe postoperative pain
  - sensitivity to anaesthetic drugs.

- Guide for questioning re previous regional anaesthesia:
  - high spinal
  - unilateral block
  - failed spinal
  - hypotension
  - post Dural Puncture Headache.

Resources & further reading
National Obstetric Anaesthetic Database (NOAD) of the Obstetric Anaesthetists Association at http://www.oaa-anaes.ac.uk

Admission(s) to intensive care
- This is a useful alert for maternity care staff (particularly anaesthetists) to follow up cause of admission.
**Difficulties accessing your veins (difficult venous access)**
- This may be of particular importance for some women who have a history of injecting drugs, and where venous access is needed urgently.
- This question can also include needle phobia.

**Asthma or lung problems**
- This item aims to identify significant respiratory disease, such as:
  - Significant asthma - requiring previous hospitalisation or administration of parenteral steroid therapy
  - Chronic Obstructive Pulmonary Disease
  - Cystic Fibrosis (CF)
  - Congenital abnormality
- SIGN/The British Thoracic Society (2003: 47) have issued the following recommendation (Grade D): 'Monitor pregnant women with asthma closely so that any change in course can be matched with an appropriate change in treatment.'

**High blood pressure**
- This item aims to identify essential hypertension and hypertension in pregnancy/pre-eclampsia.

**Resources & further reading**
Action on Pre-Eclampsia website: [http://www.apec.org.uk](http://www.apec.org.uk)

**Heart problems**
- This item aims to identify cardiac disorders, such as:
  - acquired heart disease (ischaemic heart disease, cardiomyopathy);
  - congenital heart disease – corrected or uncorrected;

**Diabetes/thyroid disorders**
- This item aims to identify a current history of diabetes (Type I or Type II) or previous history of gestational diabetes. It also focuses on thyroid disease (hypothyroid or hyperthyroid), and can encompass endocrine disorders such as adrenal disease (e.g. Addison's). Thyroid disease will require close questioning as to the cause, any investigations and treatment.

**Resources & further reading**
SIGN (2001)

**Epilepsy/neurological problems**
- Pregnancies in women with epilepsy should be supervised in an obstetric clinic with access to a physician specialising in pregnancy (SIGN, 2003a).
- Women with epilepsy should be reassured that most will have a normal pregnancy and delivery (SIGN, 2003a).
- Information about the risks of epilepsy and anti-epileptic drugs in pregnancy and the need for folate and vitamin K should be given to all women of childbearing age and repeated at review appointments (SIGN, 2003a).
- Women should be made aware of the risks of uncontrolled seizures both to themselves and to the fetus (Grade D Recommendation, SIGN, 2003a).
- Pregnant women with epilepsy should be encouraged to plan ahead before the birth, particularly in relation to breastfeeding and safe practice in caring for the child. Infant safety should be paramount (SIGN, 2003a).
• All pregnant women with epilepsy, whether or not they are on medication, should be notified, with their consent, to the UK Pregnancy Register (Tel 0800 389 1248) (SIGN, 2003a).

• Other neurological disorders that can be identified from this item include:
  - Myalgic Encephalomyelitis
  - Multiple Sclerosis
  - Spina bifida/hydrocephaly

Resources & further reading
Epilepsy Scotland: Helpline 0808 8002200 www.epilepsyscotland.org.uk

Blood transfusions
• This is essential information. Details on the cause and extent of the transfusion will be useful.

Blood clots/clotting problems
• This item aims to identify haematological disease or coagulation abnormalities, for example:
  - Thrombocytopenia
  - Aplastic anaemic
  - Thrombophilia
  - Disseminated intravascular coagulation
  - Rhesus iso-immunisation including Kell
  - Von Willebrands
  - Haemoglobinopathies
• This item also aims to identify previous deep vein thrombosis (DVT) or pulmonary embolus.
• Thrombosis and thromboembolism are the leading causes of direct maternal deaths (CEMD 2001). Assessment for VTE (venous thromboembolism) risk factors should be a regular feature of care during pregnancy (SIGN, 2002a: 30 - Recommendation - Grade D).

Kidney or urinary problems
• This item aims to identify renal disease, renal failure, impairment or dialysis or renal transplant.

Liver problems or hepatitis
• Examples include liver transplant and Hepatitis A, B or C.

Gastro-intestinal disorders
• This item aims to identify significant gastro-intestinal disorders, e.g. cholelithiasis, fatty liver of pregnancy, Crohn’s disease, ulcerative colitis or hepatobiliary disease.

Problems with fertility or your reproductive system
• This item aims to identify previous/current fertility problems and assisted reproduction (possibly in this pregnancy).
• It should also incorporate any history of malformations of the reproductive/genital tract.

Vaginal infections
• This question aims to identify infections such as genital herpes, Group B Streptococcus, syphilis, Chlamydia, gonococcus or Candida.
Mental health problems (including depression)

- This item includes significant mental illness such as:
  - diagnosed schizophrenia
  - manic depressive psychosis
  - postnatal depression\(^{15}\) (SEHD, 2002a: 32-48).
- and risk factors for puerperal psychosis:
  - history of puerperal psychosis\(^{16}\)
  - pre-existing psychotic illness (especially affective psychosis) of severity requiring admission to hospital (SIGN, 2002b: 4).

- 'Procedures should be in place to ensure that all women are routinely assessed during the antenatal period for a history of depression.' (Recommendation – Grade A: SIGN, 2002b: 4)

- 'All women should be screened during pregnancy for previous puerperal psychosis, history of other psychopathology (especially affective psychosis) and family history of affective psychosis.' (Recommendation - Grade D: SIGN, 2002b: 5)

- When discussing the issue of mental health problems, questions using proxy measures can be helpful to determine the severity of illness, as some terminology may be unfamiliar to many women. For example, 'Have you ever been seen by a psychiatrist, been admitted to hospital or been put on medication for mental health problems at any time or specifically after childbirth?'

- SIGN good practice point: 'Psychological and biological risk factors for postnatal depression and puerperal psychosis should be recorded in the antenatal period in a routine and systematic fashion.' (SIGN, 2002b: 4)

- SIGN good practice point: 'Pregnant women and their partners should be given information during the antenatal period on the nature of postnatal mood disorders and puerperal psychosis.' (SIGN, 2002b: 4)

- Women with particular needs arising from mental health problems should have appropriate access to the full range of maternity care (SEHD, 2001a).

- SIGN Good practice point: 'Women with positive risk factors for puerperal psychosis should receive specialist psychiatric assessment antenatally.' (SIGN, 2002b: 5)

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\(^{15}\) Definition: ‘Postnatal depression is regarded as any non-psychotic depressive illness of mild to moderate severity occurring during the first postnatal year. However, for a significant proportion of women, the illness may have its onset in the antenatal period. It is important to distinguish postnatal depression from “baby blues”, the brief period of misery and tearfulness that affects at least half of all women following delivery, especially those having their first baby. It is also important that the term postnatal depression should not be used as a generic term for all mental illness following delivery.’ (SIGN, 2002b: 2)

\(^{16}\) Definition: ‘Puerperal psychosis, in almost all cases, is a mood disorder accompanied by features such as loss of contact with reality, hallucinations, severe thought disturbance, and abnormal behaviour.’ (SIGN, 2002b: 2)
Genetic disorder
- Examples of genetic disorders include Marfan’s Syndrome and Ehlers-Danlos syndrome.

Resources & further reading
Marfan’s Syndrome
Marfan Association UK website: http://www.marfan.org.uk

Ehlers-Danlos Syndrome
Ehlers-Danlos Syndrome support group website: http://www.ehlers-danlos.org

Cancer of any kind
- This relates to any previous malignancy (CEMD, 2001: 212 and Ch 13).

Problems with bones or joints
- This item aims to identify any musculo-skeletal disorders, e.g. trauma to pelvis, kyphosis, significant connective tissue disorders, developmental dysplasia of the hip (DDH),\(^{17}\) lupus or talipes.

Disabilities
- This question encompasses any sensory disability, physical disability or learning difficulties. Women should be able to self classify any disability that they may have.
- A woman may require the services and support of an advocacy worker. Advocates need to be independent, and health professionals may not fit into this category (Scottish Executive, 2000a).
- ‘NHS Boards should have systems in place so that women with special needs, such as physical and learning disabilities and mental health problems, have appropriate access to the full range of maternity care.’ (SEHD, 2001a: 61)
- Research indicates that disabled women often receive inadequate maternity care and support in their parenting roles (Morris, 2003; Wates, 2003).

Resources & further reading
RCM (2000d)
Disability, Pregnancy & Parenthood international: http://www.dppi.org.uk
The Disabled Parents Network: http://www.disabledparentsnetwork.org.uk

Open question re health
- This aims to identify and address any outstanding concerns that a woman may have regarding her health in the broadest terms, or in relation to her pregnancy.

\(^{17}\) Use of the term developmental dysplasia of the hip (DDH) is preferred to use of the term congenital dislocation of the hip. DDH encompasses a broader range of conditions, and recognises the importance of the relationships between dysplasia of varying degrees and the stability of the joint.
Other health-related questions

Rationale

- Public health and health education are key areas within maternity and midwifery care which can enhance long-term health (RCM, 2000a; RCM, 2001b; SEHD, 2001a).
- There is a need to ensure that women’s basic health needs are not overshadowed by information on medical and technological aspects of their pregnancies (Crafter, 2002).

Folic acid

- This item checks whether each woman has received and followed advice on folic acid supplementation and dietary folates from preconception until the end of the first trimester to help prevent neural tube defects. (NB The basic defect which causes neural tube defects (spina bifida, anencephaly etc) has occurred in the first four weeks post conception. Therefore folic acid supplementation is only effective within this period).
- The appropriate dosage of folic acid for the individual woman can be checked; i.e. usually 400mcg daily, but 5mg for women who are epileptic, diabetic, or who have had a neural tube defect in a previous pregnancy (SIGN, 2003a; SIGN, 2001: section 8.4).

Resources & further reading

NHS Health Scotland leaflet and card; ‘Folic acid during the pre-conceptual/antenatal periods’. See the maternity section of the Health Promoting Health Service sub-site of the NHS Health Scotland website:

http://www.hebs.com
http://www.healthpromotinghealthservice.com

Association for Spina Bifida and Hydrocephalus: http://www.asbah.org/
Scottish Spina Bifida Association: http://www.ssba.org.uk

Cervical smear/colposcopy referral

- If the woman is over 20 years of age (i.e. eligible for a triennial cervical smear test), record the date (month/year) and result of the last test. The date that the next cervical smear is due should also be noted (note: this may be a routine recall or a repeat at a specified time interval. Any specific requirements should be documented in the ‘Special features and plans for care’ sections at the centre of the Pregnancy Record.
- Record any colposcopy referrals and outcomes (i.e. treatment, level of Cervical Intraepithelial Neoplasia (CIN), plans for action) and refer as appropriate.

Body Mass Index (BMI)/weight at booking/height

- BMI is calculated as follows: weight in kilograms divided by height in metres squared.
- Obesity (i.e. BMI of over 30kg/m2) in pre-pregnancy or early pregnancy is a risk factor for venous thromboembolism that merits consideration of postpartum prophylaxis (SIGN, 2002a: 33).
- Women with a BMI of less than 20 or greater than 32 should exit from Levels 1a-d of intrapartum care as indicated in EGAMS (SEHD, 2002a: 32).
- Calculation of BMI should be done as part of a full risk assessment (CEMD, 2001; SEHD, 2001a). Women with a high BMI should be given advice about
sensible weight reduction, including diet and exercise; they should be referred to a dietician to optimise their BMI where appropriate (CEMD, 2001; SPCERH, 2001a).

- Women with a height of less than 150cms should exit from maternity units providing Levels 1a-d of intrapartum care (SEHD, 2002a).

Special Dietary Needs
- This item aims to prompt a general discussion and assessment of diet. It also aims to identify, document and address any specific dietary needs, e.g. women who have a vegan or vegetarian diet, teenagers with specific needs, or women who follow dietary requirements due to their religion (Schott & Henley, 1996).

Resources & further reading
The Centre for Pregnancy Nutrition at the University of Sheffield provides information for women on healthy eating and food safety before and during pregnancy, and whilst breastfeeding. It also has a database containing scientific papers on pregnancy nutrition for health professionals and researchers.
http://www.shef.ac.uk/pregnancy_nutrition/
Helpline 0845 130 3646 (local call)
Food Standards Agency website: http://www.foodstandards.gov.uk

Dental health
- To assess each woman’s current dental health status, advise on the effects of pregnancy on teeth and gums and promote good oral hygiene.
- To provide information on free dental care during pregnancy and for one year afterwards and issue the Maternity Exemption (FW8) form (please see the ‘Information for you’ section on page 13 of the Pregnancy Record).

Alcohol
- Current advice from NHS Health Scotland (2002a) is to limit alcohol consumption to one or two units, once or twice per week. (See also NICE, 2003b)
- A brief guide to the alcohol content of common alcoholic drinks is provided. More extensive details of the alcohol content of beverages can be found in Annex 1 of SIGN (2003b).
- Excess alcohol intake can result in adverse fetal outcomes and fetal alcohol syndrome. Alcohol problems may affect the woman’s mental health.
- Typical weekly alcohol consumption (in number of units) is an (optional) requirement for SMR02.

Resources & further reading
SEHD (2002b)
http://www.alcoholinformation.isdscotland.org/alcohol_misuse/ALhomepage
Smoking cigarettes and passive smoking

- All pregnant women who smoke should be informed of the dangers of smoking to the fetus and themselves, and be advised to stop smoking. This information must be given at the earliest possible opportunity in the pregnancy.
- ‘Pregnant smokers should, as far as possible, be offered structured, face-to-face, one-to-one behavioural support at locations and schedules to suit them.’ (From Recommendation 3 of the Smoking Cessation Guidelines for Scotland, Action on Smoking and Health (ASH)/NHS Health Scotland, 2004a)
- Women who are exposed to passive cigarette smoke should be advised of the dangers of this during pregnancy, and the postnatal period (i.e. increased risk of cot death). Information and strategies to eradicate exposure to passive smoking can also be offered (see also health and safety question on page 2 of the Pregnancy Record).
- Women who have recently stopped smoking may still need support to prevent relapse. They may benefit from the assistance of a specialised smoking cessation service.

Rationale

- Cigarette smoking is the single largest modifiable risk factor for pregnancy-related morbidity and mortality and is a major cause of health inequalities.
- Pregnant women were identified as a priority group for smoking cessation interventions in the public health white paper, ‘Towards a Healthier Scotland’ (SEHD, 1999) and the recently published Smoking Cessation Policy for Scotland (ASH/NHS Health Scotland, 2004b: recommendation 7).
- Pregnancy is an ideal time for women and their partners who smoke to consider quitting – they are eager for information, have access to health services, and are often keen to make changes to their lifestyle (Department of Health, 1998).
- Reliable data on smoking in pregnancy is needed at a local level to help delivery and monitoring of interventions. The SWHMR will enable detailed data to be collected (ASH & NHS Health Scotland, 2004b: Recommendation 6).

Resources & further reading

ASH Scotland website: http://www.ashscotland.org.uk
NICE (2003b: 46-48); RCM (2002a)

Prescribed medication

- This item aims to identify and assess current/recently discontinued use of prescribed medication. As few medicines have been demonstrated to be safe in pregnancy, this should be limited to cases where the benefits outweigh any risks (NICE, 2003a).

Non-prescribed medication/substances

- This item aims to identify the use of any medications or substances by the woman during her pregnancy that have not been prescribed to her or that have been taken on an ‘over the counter’ basis, e.g. vitamin supplements (other than single folic acid supplements), herbal/preparations, aromatherapy products, or Chinese medicines.
- This is in order to identify any risks and provide information/guidance.
Resources & relevant reading
Complementary therapies
RCM (1999)
Food Standards Agency website: http://www.foodstandards.gov.uk

Substance misuse

- This section provides a basic assessment of current or past substance misuse. The contents fulfil new (optional) requirements for SMR02. Please note that substance misuse includes alcohol.

- If the woman does have problems with substance misuse, she will require detailed assessment and specialist care for her and her baby during pregnancy and afterwards. In such instances it is anticipated that specialist local documentation will supplement the SWHMR (see, for example, Whittaker, 2003).

- SMR02 guidance re the injection of illicit (street) drugs: i.e. whether the woman has ever been administered illegal drugs (e.g. heroin, amphetamines), by self or by another, using a hypodermic needle/hypodermic syringe. Include also inappropriate injection of prescribed drugs (e.g. diazepam).

- Injection of drugs increases the risks of blood borne virus infections (Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C). The final two questions in this section aim to identify women at greatest risk due to their injecting, or the actions of a previous/current partner.

Resources & further reading
Scottish Executive (2001)
Siney (1999)
Whittaker (2003) ‘Substance Misuse in Pregnancy: A resource pack for professionals in Lothian’ can be accessed at: http://www.nhslothian.scot.nhs.uk (this gives access to the front page for the four NHS Lothian sites. Select the Lothian NHS Board site and either click on the quick link or select from the ‘publications’ drop-down menu at the top of the site.)
See also the ISD site: http://www.drugmisuse.isdscotland.org
Age
- Maternal age is included as is an exit criteria from Level 1a-d care in EGAMS (SEHD, 2002a: 32) (i.e. primigravida of <16 or > 40; multigravida of >40).

Agreed EDD (Estimated Date of Delivery)
- This should only be entered when the ‘When is your baby due’ section has been completed, and an agreed EDD confirmed with the woman.

Blood group
- This information is particularly important in emergency situations. It should include the Rhesus status.

Thrombosis risk
- Risk factors should be identified at booking. The SWHMR facilitates this e.g. being overweight/ BMI calculated as over 30 kg/m2; past history of PE and/or DVT and a family history of thromboembolism (CEMD, 2001: 67).
- All women should be regularly assessed for VTE risk factors during pregnancy, at surgery and after delivery (CEMD, 2001; SIGN, 2002a). (See space for ‘Revised thrombosis risk after birth’ in the SWHMR Labour and birth summary.)
- CEMD (2001) recommend that each maternity unit develop its own guideline, based on existing national guidelines, which can be applied within the requirements of their own unit.

Allergies
- This item aims to identify any allergies, particularly any potential sources of anaphylaxis. If the woman has a positive history, the substance and its effects need to be determined (e.g. medications or latex) and clearly documented.

Special features/Plans for care (pages 6 & 7)
- Documentation of special features and plans for care aims to facilitate clear communication between the woman and the members of her maternity care team.
- These important details are always visible in the centre pages of the Pregnancy Record. Their accessible location will be useful in emergency situations.
- For clarity, this section has been sub-divided for the antenatal period, the intrapartum and postpartum periods, and specific notes for paediatricians.
- It is acknowledged that for women and/or babies who have significant needs, this section provides limited space for key information only to be noted. These key entries should refer maternity care staff to dated and signed entries within the SWHMR where further details and plans can be found.
- Relevant information relating to care of the baby should be duplicated as necessary within the ‘Special features and plans for care’ section within the Baby Record.
- All pages inserted between pages 6 and 11 of the Pregnancy Record, are ‘cut down’ so that the important details/special features and plans for care remain visible. (This includes the Labour and Birth inserts of the SWHMR.)
When is your baby due?

**Guidance/rationale**

- The comments/details box can be used to document any relevant information relating to the woman’s menstrual or contraceptive history which may affect the provisional calculation of her estimated date of delivery (EDD), or any vaginal bleeding (which may require referral).
- The ‘Agreed EDD’ box should only be completed when sufficient information has been ascertained. A provisional EDD can be entered initially, based on last menstrual period (LMP) dates and menstrual cycle. Calculation of the EDD should be in accordance with recent advice on routine ultrasound scanning before 24 weeks of pregnancy (NHS QIS, 2003 & 2004b).
- The maternity care professional determining the agreed EDD should do this with the woman’s understanding and agreement. Once calculated, the agreed EDD should be used by all maternity staff caring for the woman. It should not be changed unless a clear error in calculation has been made. The agreed EDD should be inserted in the box at the top left hand corner of page 6.

Your antenatal care and planned place of birth

**Guidance**

- The EGAMS report indicates that all women should be booked by a midwife and assigned to an appropriate level of care, as defined by risk assessment and management principles (SEHD, 2002a).
- Plans of care for pregnancy and birth should be made by the woman and her maternity care professional(s). They should take into account each woman’s needs and preferences, a comprehensive maternal history, management of risk and evidence based care (SEHD, 2001a; SEHD, 2002a; Tucker et al, 1996).
- Plans for antenatal care and birth may need to change due to reassessment of risk and/or maternal preferences. The Pregnancy Record allows for any such changes to be clearly documented.

**Rationale**

- Every woman should have the opportunity to choose an appropriate lead professional for her maternity care (SEHD, 2001a). For the majority of low-risk pregnancies, the midwife should be the lead professional (SEHD, 2001a).
- Research has indicated that for low risk women, routine antenatal care can be provided by midwives and general practitioners, and is associated with many beneficial outcomes (Tucker et al, 1996).
- ‘Women have the right to choose how and where they give birth. This choice should be supported by high quality information and evidence-based clinical advice that allows them to take part in the decision-making process.’ (SEHD 2001a: 51)

**Resources & further reading**

*Home birth*

RCM (2002b; 2002c & 2003b)
Blood tests and other tests

Guidance

- The gestations at which blood tests are offered will be subject to local guidance. SEHD (2001: 40-41) provides such details within a suggested consensus antenatal care plan for first time mothers and those having a subsequent baby.
- Gestations when blood tests are offered can be entered in the ‘Plan of care for your pregnancy’ section on page 1 of the Pregnancy Record.
- Women need to be informed of the tests they are being offered. Details of many of the blood tests can be found in the NHS Health Scotland publications listed in on page 13 of the Pregnancy Record.
- Haemoglobinopathies screening is included in this section. The question on ethnic/family origins is a temporary measure. Further details will be provided when an ongoing NHSScotland Project on haemoglobinopathies is completed. It is also recognised that haemoglobinopathies do not feature in the following:
  - information leaflet on blood tests in pregnancy for women (NHS Health Scotland, 2003a)
  - list of antenatal blood tests that require written consent (see page 16 of the Pregnancy Record).
- Written consent is required for certain blood tests offered during pregnancy. Consent forms are included on page 16 of the Pregnancy Record.
- Where a woman declines a test or it is not required (as identified in her maternal history), this should be clearly documented in the ‘Date taken/indicate if declined’ column.
- A print-out of the results of blood tests should be inserted in the section on page 17 of the Pregnancy Record.
- Entries in the ‘Results/Action’ column can be entered as ‘normal’ or ‘action needed.’ Where actions are needed, they should be documented in the ‘Antenatal appointments’ section on the following pages.

Rationale

- ‘A comprehensive antenatal diagnostic and screening service should be available and offered to women in order to detect, where possible, any maternal problems or fetal abnormalities at an early stage.’ (SEHD, 2001a: 44)

If you have Rhesus Negative blood

Guidance/rationale

- This item aims to identify those women who are Rhesus negative, so that the implications of this status on them and their babies can be discussed, together with anti-D prophylaxis (see NICE, 2002).

Pages 8 & 9

Antenatal appointments

Guidance/rationale

- The content of the antenatal appointments section is based on the consensus antenatal care plan for first time mothers and those having a subsequent baby (SEHD, 2001a: 40-41) and NICE (2003a & 2003b).
• A column for routine weighing has not been included. ‘Routine weighing during pregnancy should be confined to circumstances where clinical management is likely to be influenced.’ (NICE, 2003a: 61) Where routine weighing is required, this can be recorded in the ‘Other information/plans/referrals etc’ section, together with the rationale.
• Weight at 36 weeks gestation has been included as this is useful information for anaesthetic staff should a general anaesthetic be required for delivery.
• Completion of the ‘Urinalysis’ column should be informed by the evidence contained within the NICE clinical guideline on antenatal care (NICE 2003b).
• Additional ‘Antenatal appointments (continued)’ sheets can be inserted into the Pregnancy Record between pages 8 and 9 as needed.
• Note: as the SWHMR is a multidisciplinary record, entries can be made by any health professional providing care at an antenatal appointment. Examples of such professionals include health visitors, physiotherapists, anaesthetists and dieticians as well as midwives, general practitioners and obstetricians.

PAGE 10
Antenatal assessments/admissions
Guidance/rationale
• This section is used for recording details of antenatal assessments if the woman is admitted to day assessment or inpatient facilities during pregnancy/non-labouring admissions.
• Additional ‘Antenatal assessments/admissions’ (continued) sheets can be inserted into the Pregnancy Record after page 10 as needed.

PAGE 11
Whose signature?
Guidance/rationale
• This self explanatory section aims to promote good record keeping. All staff writing in the SWHMR should sign and print their name, and record their job title. This will compile a permanent and comprehensive record of all staff who provided/documentated maternity care for each woman. This can facilitate later scrutiny of maternity records for the purposes of case review, audit or litigation should these be necessary.

Please note: inclusion of the ‘Whose signature?’ sections does not negate the need for high standards of individual record keeping. Each entry made in the SWHMR should be signed, dated (and timed as required).

When making the first entry in a record, the person signing should also clearly print their name and role.

PAGE 12
Your ultrasound scans
• As indicated, the layout and contents for this section are still to be confirmed. This will be informed by the Health Technology Assessment Advice 5 ‘Routine ultrasound scanning before 24 weeks of pregnancy’ (NHS QIS, 2003 & 2004b). Please see Recommendation 5 in the SWHMR Final Report.
Note re Antenatal breastfeeding checklist
• An antenatal breastfeeding checklist will form part of the Pregnancy Record, inserted prior to the current page 13. (Please see Recommendation 6 in the SWHMR Final Report.) This will be devised according to the United Nations Children’s Fund (UNICEF) UK Baby Friendly Initiative guidance. A sample antenatal checklist is available at http://www.babyfriendly.org.uk/guid-ant.asp
• This is to comply with the (UNICEF) UK Baby Friendly Initiative, and the recently launched Draft Clinical Standards for Maternity Services (NHS QIS, 2004d), which require evidence that maternity units have achieved, or are working towards, UNICEF/World Health Organisation (WHO) baby friendly status as an essential criteria.

Information for you
Guidance
• Women should receive a copy of the publications listed in this section as a basic minimum. Additional resources should be provided according to individual need and documented in the ‘Others’ section.
• Maternity care staff can alert women to the ‘Further help, information and useful addresses’ section contained within ‘Ready, Steady Baby!’ (NHS Health Scotland, 2002b).

Rationale
• This section aims to promote access to information, services and other useful resources for women and their partners/supporters during pregnancy and afterwards (SEHD, 2001a). The Pregnancy Record has been designed to promote awareness of these resources without duplicating information.
• Correct use of seat belts during pregnancy: ‘All pregnant women should be given advice about the correct use of seat belts as soon as their pregnancy is confirmed.’ (CEMD, 2001: 227) The current edition of ‘Ready, Steady, Baby!’ does not contain this information, however it has been raised as an issue for inclusion in the next edition (see Appendix D of the SWHMR Final Report). In the meantime, the Pregnancy Record can be used as a vehicle to address this important public health issue.

Resources & further reading
Breastfeeding resources
NHS Health Scotland (2003b & 2003c)

Health promotion
‘Ready, Steady, Baby!’ is available online at: http://www.hebs.com/readysteadybaby

Benefits information
A comprehensive source of benefits information is available at: http://www.tiger.gov.uk
Seat belts
CEMD (2001: 227) provides the following recommendation for use of seat belts in pregnancy: ‘Above and below the bump, not over it.’
'Three-point seat belts should be worn throughout pregnancy, with the lap strap placed as low as possible beneath the ‘bump’, lying across the thighs with the diagonal shoulder strap above the bump and lying between the breasts. The seat belt should be adjusted to fit as snugly as comfortably possible and, if necessary, the seat should be adjusted to enable the seat belt to be worn properly.'
The diagrams indicating correct and incorrect use of seat belts in pregnancy given in CEMD (2001: 228 – figure 14.1) are a useful resource for staff when advising women.

PAGES 14 & 15

Your preferences for labour and the birth of your baby /Preparing for birth – what to pack in your bag
Guidance
• Women who have literacy problems or who do not write English will need assistance with this section. Such women may prefer maternity care staff, a partner, friend or advocate to document their needs and preferences following discussion.
• Women’s preferences for labour and birth may be strongly influenced by their beliefs, social conventions, religion/faith etc (see page 2 of the Pregnancy Record) and any previous pregnancies (see page 3 of the Pregnancy Record).

Rationale
• 'Women have the right to choose how and where they give birth. This choice should be supported by high quality information and evidence-based clinical advice that allows them to take part of the decision-making process' (SEHD 2001a: 51).
• The audit of maternity services in Scotland 1998 recommended that: ‘…the maternity record incorporates a section where the women and her carers can jointly record preferences in a care or birth plan.’ (SPCERH, 1999: 7)
• ‘NHS Boards …. should consider …. professionals making sure that informed discussion between the woman and her lead professional takes place to allow the woman to design, devise and draw up an individual Birth Plan.’ (SEHD, 2001a: 37)

PAGE 16

Consent for blood tests offered in pregnancy - Down's Syndrome and Spina Bifida/Blood group, full blood count & infectious diseases
Guidance/rationale
• This page is self-explanatory. The consent forms are current drafts in national use.

Resources & further reading
SEHD (2002c); NHS Health Scotland (2002b & 2003a)
Letters/Your test results

Rationale

- ‘A standardised national record should incorporate result reporting and discharge information.’ (SEHD, 2001a: 71) This will promote continuity of information and maternity care.
- Examples of letters include discharge summary letters from antenatal admissions (the eSWHMR is being configured to provide these), or letters which are copied to women/health professionals to summarise specialist review and plans for care.
- Where actions on test results are needed, this should be noted on page 7 and actions undertaken should be recorded on page 9 of the Pregnancy Record.
MATERNITY SUMMARY RECORD

Most of the content of the Maternity Summary Record is self-explanatory. It should be started by the maternity care professional that commences the Pregnancy Record.

Relevant guidance, rationales and resources/further reading can be found in the corresponding items within the Pregnancy Record. Any additional guidance, rationales or resources/further reading are given below.

PAGE 1

- Two entries for surname/family name, first name and ‘Likes to be called’ have been included in the Maternity Summary Record. They have been positioned so that they are prominent whether the document is stored in landscape or portrait form.

Health issues/special features (including regular medications)/Plans for care/Planned type of antenatal care/place of birth/Change(s) to planned type of antenatal care/place of birth
- These items should be completed after the Pregnancy Record has been completed; i.e. following a holistic maternal history, when risk assessment has been undertaken, and when plans for care formulated and discussed with the woman. It is recognised that plans may change in response to the dynamic process of pregnancy, so space has been allocated to allow for this.

PAGE 2

Referrals
- This space should be used to indicate referrals within health and social care, e.g. to social work, physiotherapy, dietetics etc.
- Detailed information about the referral should be included in the ‘Further information/details of maternity care’ section within the Maternity Summary Record. Alternatively, copies of referral letters could be attached.

Domestic abuse
- All health care professionals should be aware of the importance of domestic abuse as a health issue. Their responses to women who have experienced physical, psychological or sexual abuse should be non-judgemental and supportive (CEMD, 2001).
- ‘Health professionals should also look at whether they have personal issues around domestic abuse and should address these issues, which can include: personal experience; fear; lack of knowledge; stereotyping; and a belief that domestic abuse is not a health care issue.’ (SEHD, 2003c: 3)
- CEMD (2001: 15) have advocated that, ‘All women should be routinely asked about domestic violence as part of their social history, and should have the opportunity to discuss their pregnancy with a midwife, in privacy, without their partner present, at least once antenatally.’
- Discussions should take place in safe, quiet and confidential spaces, which allow women opportunities to speak to health professionals on their own (SEHD, 2003b).
• Comprehensive guidance on raising and documenting issues of domestic abuse is available (SEHD, 2003b & 2003c). The following guidance is particularly pertinent: ‘If a woman discloses, it may be helpful to distinguish between recording injuries, which must be done, and recording disclosure of domestic abuse, which requires her permission.’ (SEHD, 2003c: 5)

• The entry on domestic abuse within the Maternity Summary Record acts as a means for communicating to colleagues that the issue has been raised at least once in private with the woman, and recording any information given/actions taken.

Resources & further reading
Glasgow Violence Against Women Partnership website: http://www.gvawp.org.uk (NB this website allows anyone accessing it to ‘cover their tracks’ so that subsequent users of the computer would not know who has accessed the site.)

Child protection
• All health professionals need to be aware of their responsibilities towards the care and protection of children (Scottish Executive, 2002c).
• Appropriate referrals will be needed within health and social care.
• The Report of the Child Protection Audit and Review has recommended the following: ‘There needs to be a new approach to tackling the risks and needs of the most vulnerable. As a first step this should start with assessments of the needs of all new-born babies born to drug- or alcohol-misusing parents; parents who have a history of neglecting or abusing children and parents where there have been concerns about previous unexplained deaths in infancy. The inter-agency assessment and subsequent action plan in respect of each child should clearly state:
- standards of child care and development milestones the child is expected to experience or achieve
- resources to be provided for the child or to assist the parents in their parenting role
- monitoring that will be put into place along with contingency plans should the child’s needs fail to be met.’ (Scottish Executive, 2002c: 15)
• The Report of the Child Protection Audit and Review also includes a useful discussion of what constitutes child abuse and neglect (Scottish Executive, 2002c: 36).

Resources & further reading
Scottish Executive (2001)
SEHD (2000b)
http://www.scotland.gov.uk/childprotection

PAGE 3

Directions to home
• This section will be particularly useful in remote and rural areas, providing important information if needing to attend to the woman in an emergency situation.

Resources & further reading
Maps of the woman’s home location can be accessed at http://www.streetmap.co.uk
Booking completed by
- Gestation at booking can be useful in alerting maternity care staff to women who book late. CEMD (2001: 45) identified that 20% of the women who died from direct and indirect causes booked after 20 weeks gestation. A disproportionate number of these women were from ethnic groups other than white.

Further information/details of maternity care
- Maternity care staff can use this space on pages 3 and 4, and the A4 inserts - ‘Maternity Summary Record (continued)’ - to record details of assessment, planning, delivery and evaluation of maternity care.
- Some information recorded here may be highly confidential, e.g. issues of domestic abuse that a woman does not wish to be documented in her Pregnancy Record or details of case conferences/child protection issues. Maternity care professionals will need to ensure that appropriate referrals are made and information communicated with the relevant members of the maternity (health and social) care team.
- Any non-attendance at antenatal appointments/not in at home visits and subsequent follow up could be documented here.
- Each dated entry should be signed by the member of staff, with the first entry being accompanied by the printed name and designation.
LABOUR AND BIRTH RECORD INSERTS

Note: Using the Labour and birth record inserts
The SWHMR Labour and Birth Record has been designed as a series of inserts to be added into the Pregnancy Record (after page 10). The inserts should be commenced when either labour begins or the woman is about to undergo induction or elective delivery.

As already noted, the inserts required will vary according to each woman’s needs. Similarly, additional local documentation may be needed on an individual basis (e.g. an epidural record, anaesthetic record or operative consent form).

The importance of retaining comprehensive maternity records and copies of related documents can not be over-emphasised:

'It has become crucial, not only for medico-legal purposes but also for good clinical practice, to have in place systems to document and record clinical decisions and events. The archiving of all data, including out of date protocols, is absolutely vital. The careful storage of cardiotocographs, partograms and anaesthetic records should be mandatory. One individual, perhaps the risk manager, should be responsible for ensuring appropriate methods are adopted.'
(RCOG & RCM, 1999: 5)

Woman-friendly language and the Labour and Birth Record
As already noted, the SWHMR aims to promote woman-centred maternity care by the use of accessible, lay language, and giving women the opportunity to carry parts of their maternity records and write in them if they so wish.

The Labour and Birth Record inserts differ slightly from the woman-held parts of the SWHMR used in the antenatal and postnatal periods. The inserts for labour and birth are primarily a record used by maternity care professionals. Their purpose is to assist:

• communicating key information clearly and concisely
• planning, delivering and evaluating care
• capturing a comprehensive and contemporaneous account of labour, birth and the immediate puerperium.

Attempts have been made to use unambiguous language and terms in common use by healthcare professionals. Wherever possible, abbreviations have been avoided.

Whose signature? section – promoting good record keeping
When the Labour and Birth Record pages are inserted into the Pregnancy Record, they are immediately followed by the ‘Whose signature?’ section on page 11. This location aims to prompt maternity care staff writing in the SWHMR during the intrapartum period for the first time to print and sign their name, and state their job title. A reminder about use of the ‘Whose signature?’ section is included at the top of each ‘Progress notes: Labour and birth’ page.

Labour, birth & after your baby is born: Special features and plans for care/Notes for paediatrician
As already highlighted, important information and plans for care will be documented here according to the individual needs of mothers and babies. Whilst information may
have been documented at various stages during pregnancy, new information and plans may need to be recorded during labour and around the time of birth. Examples of important information which could be communicated include:

- Date and time that a group and save blood specimen has been taken and sent to the laboratory as an urgent specimen.
- Date and time of cross matching a number of units of blood at the blood bank.
- Date and time when ambulance control and a receiving maternity unit have been informed of an imminent transfer of mother and/or baby.
- Date and time when a neonatal unit has accepted an impending admission.

Labour and birth record: initial assessment for spontaneous labour

**Guidance/rationale**

- This insert aims to provide a comprehensive means of:
  - assessing a woman who is thought to be in spontaneous labour
  - ensuring discussion and documentation of her preferences for labour and birth in light of this assessment
  - planning her immediate care, based on this assessment and discussion.
- This insert has been designed to be relevant for women giving birth in settings appropriate to low risk or high risk care, for example planned home birth, community maternity units or consultant-led maternity units.

**Abdominal examination**

- The spaces allocated within this section are large enough to document findings from the abdominal palpation of a twin pregnancy. A space has been included to document maternal pulse. Prior to any form of fetal monitoring, maternal pulse should be palpated simultaneously with auscultation of the fetal heart rate to differentiate between the two (NICE, 2001a).

**Other observations/information on assessment**

- This free text box provides space to record any additional assessment findings. For example the woman may be relaxed and feel she is coping well in labour; she may be distressed as she has been unable to contact her partner; she may have problems with substance misuse and be concerned about not having taken her methadone due to nausea and vomiting.

**Vaginal examination**

- If a vaginal examination is to be part of the initial assessment, it should be documented here.
- Fetal heart rate should be auscultated prior to the vaginal examination and afterwards, hence spaces for this have been included.
- Providing information to women and their partners is an integral part of maternity care. It assists decision making and informs consent, which may be given verbally or in writing as appropriate. A prompt has been included here to ensure that:
  - the woman has been informed of the need for a vaginal assessment
  - the procedure has been explained in full
  - her verbal consent has been given.
- Any vaginal examination is an intimate and potentially distressing event for a woman. The traumatic impact of sexual abuse and implications for childbirth remain important and frequently neglected aspects of maternity care (Barlow & Birch, 2004; Gutteridge, 2001; Squire, 2003).
- A comments section has been included to document any additional relevant information from the vaginal examination. Examples could include evidence of
female genital mutilation, presence of genital herpes or an unusual vaginal discharge.

**Discussion of preferences for labour and birth**

- This section refers to the woman’s preferences, which she has been invited to document antenatally on pages 14 and 15 of the Pregnancy Record or in a birth plan. The member of staff should document that discussion of preferences for labour and birth has taken place with the woman (and her partner/supporter as appropriate), noting any changes.

- Some women may not have completed the section on pages 14 and 15 of the Pregnancy Record or devised a birth plan by the time labour commences. This may be due to a variety of reasons such as premature labour, anxiety, language difficulties or problems with literacy. In such circumstances, the member of staff caring for the woman should:
  - sensitively invite discussion of options and preferences
  - offer to document the woman’s wishes on pages 14 and 15
  - sign, date and time any entry made on pages 14 and 15
  - summarise the above actions in this ‘Discussion of preferences for labour and birth’ section.

**Plans for initial care following discussion with the woman**

- This space should be used for documenting immediate plans for care, including intentions for monitoring fetal heart rate. Any subsequent changes to the method of monitoring fetal heart rate and the rationale for this should be indicated in the ‘Progress notes: Labour and birth’ sections.

**General guidance for using this insert**

- Signature, date and time details have been included in several key sections of this insert. This is for circumstances where more than one member of the maternity care team contributes to the initial assessment.

- Should more space be needed to record any aspect of the initial assessment for spontaneous labour, this can be documented on a ‘Progress notes: Labour and birth’ insert.

- As labour establishes, ‘Progress notes: Labour and birth’ inserts and the partogram/labour and birth inserts will be required.

- If a woman is assessed and found not to be in established labour, a new ‘Labour and birth record: Initial assessment for spontaneous labour’ insert can be commenced later as needed.

**Labour and birth record: Induction of labour insert**

**Guidance/rationale**

- This insert has been designed to record initial details for an induction of labour.

**Indication for induction**

- For inductions due to pregnancies that have lasted beyond 41 completed weeks gestation, a prompt has been included to check whether a membrane sweep has been offered/performede (NICE, 2001b).

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18 Details of the procedure should be documented in the ‘Antenatal appointments’ or ‘Antenatal assessments/admissions’ sections on pages 8 and 9 or 10 of the Pregnancy Record.
Initial assessment

- This section has been included to assess fetal well-being immediately prior to induction.

Abdominal examination

- See entry for abdominal examination for the ‘Labour and birth record: Initial assessment for spontaneous labour’.

Cervical scoring

- The modified Bishop’s score (or Calder score) has been used, as this is the cervical scoring system of choice, as advocated by NICE (2001b).

Initial method of induction

- Please note: This section is for recording the initial method of induction only. It is acknowledged that many inductions require the use of more than one dose of prostaglandins, amniotomy and an Oxytocin infusion. Inductions will follow local protocols/guidelines as applied to each individual woman’s case. (See also the inherited clinical guideline for induction of labour – NICE, 2001b.)
- As the induction progresses, further details of the process and any medications/actions prescribed should be documented in ‘Progress notes: Labour and birth’ inserts, and the partogram commenced as needed.
- The use of an Oxytocin infusion will require additional local documentation, e.g. prescription for the intravenous infusion and a fluid balance chart.

Discussion of preferences for labour and birth

- This section refers to the woman’s preferences, which she has been invited to document antenatally on pages 14 and 15 of the Pregnancy Record, or in a birth plan.
- The member of staff should document that discussion of preferences for labour and birth has taken place with the woman (and her partner/supporter as appropriate), noting any changes.
- Some women may not have completed the section on pages 14 and 15 or devised a birth plan. This may be due to a variety of reasons such as anxiety, language difficulties or problems with literacy. In such circumstances the member of staff caring for the woman should:  
  - sensitively invite discussion of options and preferences  
  - offer to document the woman’s wishes on pages 14 and 15  
  - sign, date and time any entry made on pages 14 and 15  
  - summarise the above actions in this ‘Discussion of preferences for labour and birth’ section.

Plans for continued process of induction following discussion with the woman (including monitoring)

- This space should be used for documenting plans for care/the induction process, including intentions for monitoring fetal heart rate.
- Any subsequent changes to the method of monitoring fetal heart rate and the rationales for this should be indicated in the ‘Progress notes: labour and birth’ sections.
General guidance for using this insert

- Signature, date and time details have been included in several key sections of this insert, in the event that more than one member of the maternity care team contributes to the initial assessment and induction.
- Should more space be needed to document any aspect of the initial induction of labour, and as the induction progresses, details can be recorded in 'Progress notes: Labour and birth' inserts.
- As labour progresses, a partogram should be commenced.

Progress notes: Labour and birth inserts

Guidance/rationale

- These inserts enable maternity care staff to enter details about the labour and birth as it progresses. They are complemented by the partogram.
- A reminder re good record keeping practices has been included.
- These inserts do not have page numbers, however their order can be determined by dating and timing all entries. All pages contain identification details in the form of the woman’s name and CHI number in the event of them becoming detached from her record.

Partogram inserts

Guidance/rationale

- This familiar format aims to facilitate the recording of a summary of progress during labour.
- One page of the partogram insert is backed by a ‘Progress notes: Labour and birth’ page, whilst the other page of the partogram is backed by the start of the ‘Labour and birth summary’ page.

Hours of labour

- Should a labour continue beyond 20 hours, an additional partogram insert should be commenced.
- There are vertical divisions within the partogram for one hour, 30 minutes and 15 minutes, according to items along the horizontal axes.

Date

- Should a labour take place before and after 12 midnight, the two dates should be recorded as required; e.g. for a labour that occurs between 22.00 on 31.3.05 and 08.17 on 01.04.05.

Fetal heart rate

- Bold lines are used to indicate the range of a reassuring baseline, i.e. between 110 and 160 beats per minute (NICE, 2001a).

Contractions

- A guide for documenting the duration of the contractions is included. The strength of the contractions, as determined by the woman or palpation by a member of maternity care staff, could be considered to be a subjective judgement. This can be documented in entries the ‘Progress notes: Labour and birth’ inserts.

Maternal observations

- The frequency with which maternal observations will need to be recorded and documented will vary according to each individual woman’s needs. For
women requiring more frequent assessment, a locally generated intensive monitoring chart may be needed.

Labour and birth summary inserts
- The majority of items are self explanatory, however guidance on certain entries follows.

Placenta, cord & membranes
- The comments section can be used for documenting findings considered relevant such as a retroplacental clot, calcification, infarction, velamentous insertion of cord, odour to placenta or membranes suggestive of infection/swab taken etc.

Most senior midwife present at birth
- This item has been included as it is an SMR02 requirement (ISD, 2000).

Perineum/Perineal suturing
- The importance of accurate identification and classification of any perineal damage sustained at delivery has been highlighted by the RCOG (2001). They note that: ‘occult damage to the anal sphincter mechanism is common following vaginal delivery and may lead to anal incontinence later in life. Current recognition of third- and fourth- degree tears only identifies a small percentage of damaged anal sphincter muscles.’ (RCOG, 2001)
- The RCOG (2001) has issued a guideline for the management of third and fourth degree perineal tears. One important recommendation is that such repairs should be undertaken in an operating theatre, under regional anaesthesia, as this is likely to be associated with improved outcomes. Whilst the degree of perineal damage should be indicated in this section of the ‘Labour and birth summary’, a comprehensive account of management should be documented on a ‘Details of third stage complication(s)’ insert.
- Documentation of details of perineal suturing should reflect RCOG guidance (2000a).
- The ‘Supervised by’ box for perineal suturing need only be completed where supervision/instruction has taken place.

Day of delivery
- This has been included to inform any relevant audit activity within maternity care. Day of delivery may be significant as outcomes of pregnancy may reflect staffing levels and activity. It constitutes an item within the Expert Advisory Group on Caesarean Section in Scotland caesarean section audit (SPCERH, 2001a).

Location (of delivery)
- This should be recorded, e.g. name of maternity unit, home, ambulance or alternative location. A baby born before arrival at a maternity unit can also be noted here, alongside the location.

Indication (for delivery)
- The indication for an assisted or caesarean birth (as stated on the relevant insert) should be recorded here. This box need not be completed for an unassisted vaginal birth.
Resuscitation performed by
- The details of all personnel present at the resuscitation should be included. Should more than two people be present, this should be documented in the resuscitation details section (together with the roles undertaken by the personnel).

Baby details: Skin-to-skin contact
- Maternity services should promote, support and sustain breastfeeding (SEHD, 2001a). Early skin-to-skin contact is known to encourage breastfeeding.
- This item complies with the requirements of the UNICEF UK Baby Friendly Initiative. All babies should be offered skin-to-skin contact, irrespective of whether the mother intends to breastfeed (UNICEF, undated).
- The duration of skin-to-skin contact should be recorded. UNICEF recommends a minimum duration of 30 minutes, although a mother may request to end this at any time. (See UNICEF UK Baby Friendly Initiative: http://www.babyfriendly.org.uk)

If general anaesthesia
- This section provides a brief summary which may be useful for all staff (particularly anaesthetists). As already noted, whenever a woman has had a procedure under anaesthesia, her SWHMR should be supplemented by a full anaesthetic record.

Blood transfusion/products received
- A note of any blood transfusion or blood products received should be recorded here. This brief summary will be supplemented by fuller documentation such as prescription and fluid balance charts and an anaesthetic record.

Maternal observations
- Space has been included to record two sets of postnatal observations for women who are essentially well immediately after birth. Women requiring more intensive monitoring in the immediate postnatal period will require additional documentation; e.g. a locally generated intensive monitoring chart.
- A space has been included to note urinary function after birth; e.g. indicating when the woman has spontaneously passed a good volume of urine or that she has a catheter in situ following caesarean section.

One-to-one midwifery care
- In recent years there has been much evidence for, and endorsement of, one-to-one support by a midwife during labour (Hodnett, 2000; RCOG & RCM, 1999; SPCERH, 2001a; SEHD, 2002a). A Framework for Maternity Services in Scotland has stated that: ‘One-to-one midwifery care should be given to women during labour and childbirth in order to make sure they have individualised attention and support, preferably with continuity of carer.’ (SEHD, 2001a: 50)
- This item aims to capture data relating to one-to-one midwifery care for audit and research purposes.
Discussion of labour and birth/preferences met
- This item has been included to mark the start of a period of reflection on experiences of pregnancy and childbirth (SEHD, 2001a) which will continue into the postnatal period.\textsuperscript{19} It is acknowledged that the woman may not have any issues to discuss at this point, however an early opportunity should be provided.
- Women’s understandings of events around pregnancy, labour and birth are important. A survey conducted by Graham \textit{et al} (1999) into women’s involvement in decision-making re delivery by caesarean section indicated that over half the women reported no ‘debriefing’ regarding the reason for their caesarean section before leaving hospital.

Revised thrombosis risk after birth
- Each woman’s risk should be reassessed and appropriate actions taken. (See Annex A: Guidelines for thromboprophylaxis in vaginal deliveries in CEMD, 2001)
- The revised risk should be documented in the space allocated in the first entry of ‘Mobility, exercise and preventing blood clots’ of the ‘Your progress’ section on page 3 of the Postnatal Record.

Details of assisted vaginal birth insert
Guidance/rationale
- This insert has been designed to facilitate good recording practices for assisted vaginal births according to the RCOG (2000b) guidelines. Examples of such items include: indications for the procedure, anaesthesia, personnel present, level of head assessed abdominally and vaginally.
- The majority of items are self explanatory, however guidance on certain entries follows.

Instruments used
- All relevant boxes should be ticked, indicating the instruments used.

Procedure/suturing
- When details of suturing are entered here, the ‘Perineal suturing’ section on the ‘Labour and birth summary’ insert does not also require completion.

Postoperative instructions
- This section aims to promote clear communication between maternity care staff and ensure that all women receive timely and appropriate care. For example, thrombosis risk is reassessed at the end of the delivery, and appropriate measures should be prescribed and undertaken (see CEMD, 2001: Annex A).

Details of caesarean section birth insert
Guidance/rationale
- This insert aims to promote the recording of comprehensive details of births by caesarean section.

\textsuperscript{19} See ‘Thinking about your pregnancy, labour and birth’ insert on page 10 of the Postnatal Record.
• When completed in full and supplemented by an anaesthetic record,20 the Pregnancy Record and relevant labour and birth inserts should provide all the suggested individual data items for a comprehensive audit of caesarean section (SPCERH, 2001a).21 Examples of these items include the degree of urgency of caesarean section according to the (Royal College of Anaesthetists (RCA)/RCOG criteria (see SPCERH, 2001a), cervical dilatation at the time of delivery and decision-to-delivery interval time.

• The majority of items are self explanatory, however guidance on certain entries follows.

Intra-operative vaginal blood loss

• A prompt for the ‘floor’ member of staff to check under the drapes for hidden per vaginum blood loss has been included. This item was identified as a lesson to be learnt from the Scottish Confidential Audit of Severe Maternal Morbidity (SPCERH, 2003a).

Postoperative instructions

• This section has been included to promote communication between members of the multidisciplinary team, and the delivery of appropriate care. These details will need to be communicated between obstetric, anaesthetic, midwifery and recovery unit staff.
• Details of thromboprophylaxis against thromboembolism in cases of caesarean section can be found in CEMD (2001: Annex B).
• A prompt has been included to ensure that all postoperative instructions and relevant prescriptions have been documented, and a member of medical staff should sign to confirm this.22

Details of third stage complication(s) insert

Guidance/rationale

• This insert has been designed to facilitate good record keeping following the identification and management of any complications in the third stage of labour.

• One recurring lesson to be learnt from the Scottish Confidential Audit of Severe Maternal Morbidity (SPCERH, 2003a: 3) was as follows: ‘Poor documentation was a recurring theme, especially regarding events in theatre, fluid charts, and actions by anaesthetic staff. Abbreviations should be avoided.’ All staff should be mindful of the need for high standards of record keeping.

• The majority of items are self explanatory, however guidance on certain entries follows.

Location of management

• This has been included to prompt identification of the most appropriate place for management of the complication(s) and for audit purposes. For example, in its guideline for the management of third and fourth degree perineal tears, the RCOG (2001) recommends that such repairs should be undertaken in

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20 An anaesthetic record should include the following details: site of spinal/epidural, position of patient, gauge of needle, agent administered, any technical difficulty encountered and the anaesthetic time (SPCERH, 2001a).

21 In time, these items could be flagged within the eSWHMR for downloading and printing in a completed audit sheet format.

22 It is however recognised that both obstetric and anaesthetic staff will have input into postoperative planning.
theatre under regional anaesthesia. Such measures are likely to be associated with improved outcomes.

**Personnel present**
- A significant number of people may need to be present during the management of third stage complications. This is reflected in the space allocated to record those present.
- When the complication being managed consists of a third or fourth degree perineal tear, the uniform classification suggested by the RCOG (2001: 3) may be useful for identifying the degree of damage:
  - second degree: injury to the perineum involving perineal muscles but not involving the anal sphincter
  - third degree: injury to perineum involving the anal sphincter complex (EAS - external anal sphincter and IAS - internal anal sphincter)
    - 3a: less than 50% of EAS thickness torn
    - 3b: more than 50% of EAS thickness torn
    - 3c: IAS torn
  - fourth degree: injury to perineum involving the anal sphincter complex (EAS and IAS) and rectal mucosa.

**Designated note keeper appointed**
- The identification of such a person in theatre for contemporaneous recording of events is an example of good practice from the Scottish Confidential Audit of Severe Maternal Morbidity (SPCERH, 2003a).

**Suturing**
- Documentation of details of perineal suturing should reflect RCOG guidance (2000a & 2001).
- Whenever details of suturing are entered here, the 'Perineal suturing' section on the 'Labour and birth summary' insert does not also require completion.

**Instructions following management of complication**
- This section aims to promote clear communication between maternity staff so that women receive timely and appropriate care following management of third stage complications. For example, documenting instructions for an oxytocic infusion following a postpartum haemorrhage, or the need for broad-spectrum antibiotics intra-operatively/postoperatively and laxatives postoperatively in the case of repair of a third or fourth degree perineal tear (RCOG, 2001).

**Resources & further reading**
Scottish Audit of the Prevention and Management of Emergencies in Labour (SPCERH, 2001b)
POSTNATAL RECORD

Using the SWHMR at local level
Once the intrapartum episode has been completed, the Postnatal Record can be commenced. A summary of the antenatal period, labour and birth is integral to the Postnatal Record, in the form of details in the ‘Postnatal discharge summary’ section on page 2.

This part of the SWHMR aims to aid communication between each woman and the professionals providing her maternity care in the postnatal period. The Postnatal Record has been designed for use in (and across) maternity unit and home settings. It has been designed to be woman-held, where the woman chooses and where appropriate.

The postnatal part of the SWHMR record has been designed to be woman-friendly and encourage their contributions. This represents a significant change for record-keeping in the postnatal period.

The baby record has been designed as a series of three inserts (supplemented by continuation sheets as necessary), which can be inserted into the main Postnatal Record. This has the advantage of being removable if mother and baby have to be separated (e.g. on admission to a neonatal unit, if the baby is to be adopted or in the case of a stillbirth). In cases of multiple births, additional baby inserts can be added.

The Postnatal Record aims to be a core record, suitable for all women and babies receiving care in NHSScotland. However, as already noted, additional documentation may need to be generated at local level to supplement the SWHMR. Examples for the Postnatal Record include:

- following caesarean section: charts for monitoring fluid balance and to record the use of patient controlled analgesia
- in cases of substance misuse: assessment sheets for signs of neonatal abstinence syndrome.

Note: Definition of the postnatal period
The UKCC has defined the postnatal period as:

‘a period of not less than ten and not more than 28 days after the end of labour, during which the continued attendance of a midwife on the mother and baby is required.’
(UKCC, 1998: 9)

The midwife’s role in postnatal care therefore usually ends at or before day 28. The midwife then transfers care to the health visitor. A health care professional (often the woman’s GP) will conduct a postnatal assessment at around six weeks following birth. This completes the maternity episode.

Note: The evidence-base for postnatal care
Postnatal care has been identified as ‘under-valued and under-resourced’ (RCM, 2000e: 8). It is also acknowledged that evidence for best practice is lacking, and some areas have not been explored in any depth (RCM, 2000e). This presents an ongoing challenge in maternity care. However evidence is slowly growing, as demonstrated in the recent RCM recommendations (RCM, 2000e) and research conducted by Bick et al (2002).
Note: For guidance and rationales on the following sections in the Postnatal Record, please refer to the guidance and rationales given for the Pregnancy Record:

- outer front cover
- inner front cover
  - Contact details
  - Domestic abuse: sources of support and information
- page 1 ‘Whose signature?’

PAGE 1

Your postnatal care

Guidance/rationale

- This section will probably be used most often when the woman is at home, so that she has a record of the date, time (sometimes approximate, as indicated), location and reason for a visit from/to a health professional.
- ‘Midwives, Health Visitors, GPs and Professions Allied to Medicine should adopt a flexible approach to postnatal care, working in partnership with women and other agencies. This will make sure that the most appropriate and experienced professional is the care provider at any given time according to the needs of the woman and her baby’ (SEHD, 2001a: 54).

PAGE 2

Postnatal discharge summary

Guidance/rationale

- This page is self explanatory. It provides a useful summary of the antenatal and intrapartum periods. When the eSWHMR is operational, several copies of this page can be printed for additional copies as needed (e.g. for a GP, Health Visitor and community midwife). In the meantime, the completed page could be photocopied.

PAGES 3 & 4

Your progress

Rationale

- This assessment has been designed with the following features in mind:
  - To promote health and prevent or detect and manage ill health in the postnatal period (SEHD, 2001a).
  - To facilitate flexible and individualised care in the postnatal period, according to each woman’s needs (SEHD, 2001a). i.e. an assessment may need to be performed daily or more than once a day in the early postnatal period, and thereafter every few days if the woman is well.
  - To facilitate a comprehensive and holistic assessment. This in turn should enable appropriate care to be planned, delivered and evaluated.
- Although a finite amount of space has been allocated for each assessment, any further details, planning or evaluation of care can be continued in a dated/timed entry in the ‘Your postnatal care’ pages which follow.
• The items in the postnatal assessment are essentially self explanatory, however the following rationales, guidance, resources and further reading may be helpful.

**Date/time**
• The date and time have been included as the woman may require more than one assessment during a 24 hour period. A reminder has been included to use the 24 hour clock, in accordance with good record keeping practices.

**General wellbeing and pain assessment**
• This broad terminology intends to cover a variety of aspects of each woman’s emotional, physical and mental health. Her wellbeing may be influenced by many of the following:
  - tiredness
  - diet and hydration
  - support from partner, family or friends
  - co-existing mental health, physical health or social problems
  - reflections on pregnancy, labour and birth
  - adjustment to parenting
  - ‘baby blues’
  - postnatal depression.
• Comprehensive, multi-professional, multi-agency services should be available to women who have, or who are at risk of, postnatal depression and other mental illness (SEHD 2001a). The SIGN Guideline on Postnatal Depression and Puerperal Psychosis provides a comprehensive resource for this (SIGN, 2002b).
• Pain assessment should span the whole postnatal assessment.

**Mobility, exercise and preventing blood clots**
• Women should be informed of how to prevent DVT in the postnatal period, and of signs and symptoms to which they should be alert. Maternity care staff need to be involved in these activities too. (See SIGN, 2002a: Chapter 9) The revised postnatal thrombosis risk is a prompt for this.
• Assessment, discussion and management of oedema may be relevant.
• Some women may require referral for physiotherapy in the postnatal period (e.g. following caesarean section), or they may require continued physiotherapy for ongoing problems such as symphysis pubis diastasis.
• Women will require information on postnatal exercises to strengthen abdominal and pelvic floor muscles.

**Fundus/Blood loss**
• These assessments aim to identify normal involution and any signs of infection, potential post partum haemorrhage and retained placenta/membranes etc.
• Women will require information on what is normal, and when/how to seek advice. **Note: women should be alerted to the ‘Help and advice’ contact number(s) on the inside cover of the Postnatal Record.**

**Resources & further reading**
PAGES 5 & 6

Your postnatal care

Guidance

• These pages allow details of postnatal care to be planned, documented and evaluated on an individual basis. This section can include referrals etc.
• Further inserts for ‘Your postnatal care (continued)’ can be added to the Postnatal Record as needed.

PAGE 7

Your health after the birth

Rationale/guidance

• ‘Maternity services should provide postnatal care to facilitate the transition to motherhood by making sure that ill health is prevented or detected and managed appropriately. Women and their partners should be supported to make a confident and effective transition to parenthood.’ (SEHD, 2001a: 53)
• ‘NHS Boards should develop and implement a strategy to maintain any positive health gains made in pregnancy through appropriate professional support in the postnatal period. This should include advice on healthy diet, smoking cessation, alcohol consumption, substance misuse and physical activity.’ (SEHD, 2001a: 53)
• The majority of items on this page are self explanatory, however guidance on certain entries follows.

Blood tests/other tests and results

• This section can record any investigations/tests, and also act as a prompt to follow up results. This may be particularly helpful if a woman is discharged home, so that community staff can be informed of any outstanding test results.

Smoking cigarettes and passive smoking

• Smoking status during pregnancy (as recorded following birth) is an SMR02 requirement (ISD, 2000).
• This question can act as a prompt for further smoking cessation advice for women who are still smoking in the postnatal period.
• Reducing the risk of cot death: Information on the harmful effects of passive smoking should be provided for all women.
• Reducing the risk of cot death: Advice against bed sharing with babies should also be given if one or more parents smoke.

Sexual health and contraception

• Sexual health appears to be a neglected area within maternity care. There is perhaps an assumption that the topic may be discussed within contraception.
• This item puts sexual health clearly on the agenda. Examples of topics for discussion are included. Discussion should be individualised and non-judgemental. It should be sensitive to issues of sexual orientation and alert to issues such as sexual abuse.
Postnatal check
- The importance and nature of a postnatal check should be discussed with each woman. This can be done with the information included in the section ‘Your six week postnatal check’ on page 11 of the Postnatal Record.
- The woman should be made aware of the arrangements for her postnatal check, e.g. a hospital appointment with a consultant obstetrician to be posted to her at home following a third degree tear, or the woman to make arrangements to see her own GP following a normal pregnancy, labour, birth and puerperium.

Other health issues: details, information given and referrals
- This general section can be used to note any other health issues identified or raised by the woman or maternity care staff.

PAGE 8

Feeling confident with your baby

Rationale
- This page intends to facilitate the transition to confident parenting on an individual basis. It recognises that needs differ, and that confidence and skills develop over time. Women and their partners may need assistance from a range of staff providing maternity care as well as family and friends. This page allows for clear recording/communication of when and how needs have been addressed.
- ‘NHS Trusts should make sure that high quality care is provided both in the maternity unit and at home to facilitate the transition to motherhood;’ and ‘NHS Trusts should make sure that each home visit with mother and baby is used as an educational opportunity.’ (SEHD, 2001a: 53)
- The ‘pen in hand’ symbol indicates that women can write on this page.
- The content of this page also aims to encourage partners or relevant others (e.g. baby’s grandparents if the Mum herself is young/not supported by a partner) to (re)gain knowledge, skills and confidence.
- Much of this information should build on the education, discussion, information and resources given in the antenatal period (see ‘Information for you’ on page 13 of the Pregnancy Record).
- The ‘Information for you’ section at the bottom of this page can be used to record any additional written resources that have been provided.

PAGE 9 (insert)

Note: There is a choice of two versions of the insert that forms pages 9 and 10 of the Postnatal Record, depending on the mother’s chosen method of feeding (as determined after birth). The appropriate insert should therefore be added in the postnatal period.

Breastfeeding your baby

Rationale/guidance
- ‘Maternity Services should promote, support and sustain breastfeeding. Women should be informed of its benefits, while being supported in their chosen mode of infant feeding.’ (SEHD, 2001a: 58)
• ‘All maternity units should adhere to the principles of the UNICEF/WHO Baby Friendly Hospital initiative through structured programmes of education and support for mothers and professionals.’ (SEHD, 2001a: 58)
• Every woman should have received information and resources on the benefits of breastfeeding in the antenatal period. This postnatal insert therefore aims to build on her existing knowledge and skills to promote successful breastfeeding.

Resources & further reading
NHS Health Scotland (2003b; 2003c)
‘Sterilising baby feeding equipment’
‘Sharing a bed with your baby’ available at: http://www.babyfriendly.org.uk/parents/leaflets.asp
‘Baby-Led Feeding – a resource for parents and health professionals'
Simpson Memorial Maternity Pavilion – a resource available at: http://www.baby-led-feeding.com

Bottle feeding your baby
Resources & further reading
• This insert has been designed to ensure that each woman receives comprehensive support and advice, tailored to her individual needs and those of her baby.

Resources & further reading
Note: these resources are available to download in a range of languages

PAGE 10

Your questions or concerns
Guidance/rationale
• This section is self explanatory. Women are encouraged to use it if they wish, according to their individual needs. Examples of issues or worries that they may have are given.
• Maternity care staff should check this section and discuss women’s queries or anxieties as part of ongoing postnatal care. Staff should also record when and how any questions or concerns have been addressed, and sign/date each entry.
Thinking about your pregnancy, labour and birth

**Guidance/rationale**
- ‘Women and their partners should be given the opportunity to reflect on their experiences of pregnancy and childbirth in the postnatal period with a health professional.’ (SEHD: 2002a: 58)
- The RCM (2000e) notes that there is often confusion between terms used for this aspect of care, and that some are inappropriate. They highlight that ‘listening’ to women is not the same as ‘debriefing’ (a structured psychological intervention known as ‘Critical Incident Stress Debriefing’).
- Note: the ‘Labour and birth summary (continued)’ insert contains an initial prompt for maternity care staff to encourage women to reflecting on events, and have any initial questions answered/issues aired.
- Maternity staff should check this section regularly to determine whether any issues have been documented. Staff should also record when and how any questions or concerns have been addressed, and sign/date each entry.

PAGE 11

Your six week postnatal check

**Guidance/rationale**
- This section is self explanatory. At the completion of postnatal midwifery care, the midwife should ensure that she/he has completed the ‘Special features identified during midwifery care’ section. This should be done in consultation with the woman. Examples of special features could include:
  - poor pelvic floor tone (and measures being undertaken to rectify this, e.g. pelvic floor exercises and referral for physiotherapy)
  - third degree tears requiring consultant obstetrician follow up
  - postnatal anaemia requiring oral iron therapy and full blood count at the postnatal check.
- Where no special features have been identified, the midwife should state ‘none’ and sign/date this entry.
- On completion of midwifery care, the Postnatal Record will be stored according to appropriate local arrangements until the six week postnatal check is undertaken (e.g. with the woman’s health record at her GP practice, or returned to the maternity unit).
- Following completion of the six week postnatal check, the Postnatal Record should be returned to the relevant maternity unit for safe storage with the rest of the woman’s SWHMR.
BABY RECORD

Note: Spaces for the names and CHI numbers for Mum and baby have been included to assist identification of both records.

Initial examination

- This is usually performed by the midwife shortly after delivery. If a baby has been born in a maternity unit and will be discharged home before the detailed examination can be undertaken, or where a home birth has taken place, the Best Practice Statement on Routine Examination of the Newborn (NHS QIS, 2004c) gives information on items to be included in this initial examination.
- This section starts with a security check for the transfer of babies within/between maternity units. It also aims to prompt discussion with parents on particular security and safety issues.

Detailed examination

- This examination is usually undertaken between 6 and 24 hours of birth (but certainly before 72 hours of age). Further guidance re the content and conduct of this examination can be found in the Best Practice Statement on Routine Examination of the Newborn (NHS QIS, 2004c)

Weight chart

- This self explanatory section has been included to record the baby’s weight. This will be done according to individual circumstances/maternity unit policies (Sachs & Oddie, 2002).

Your baby’s care

- This section is self explanatory. Further space is provided on the ‘Your baby’s care (continued)’ page (with the consent for newborn screening on the reverse). Continuation sheets headed ‘Your baby’s care (continued)’ can be inserted as needed.

Your baby’s progress

Guidance/rationale

- This chart has been designed to promote the documentation of a comprehensive baby assessment.
- Assessments/entries should be made according to each individual baby’s needs.

Temperature/Route

- As with other aspects of a baby assessment, temperature recordings should be made according to each individual baby’s condition. The route by which the temperature was taken should be recorded.

Feeding: type, frequency (and volume if bottle feeding) and condition of mouth

- This section aims to be suitable for Mums who are breastfeeding and/or expressing or bottle feeding. The space allocated to this section is deliberately large. This aims to enable a detailed and comprehensive assessment, which will be particularly needed for babies who may be experiencing feeding difficulties.

23 The initial and detailed examination sections have used the existing format within the Scottish Birth Record and the Best Practice Statement, ‘Routine Examination of the Newborn’ (NHS QIS, 2004c).
• The section has been designed to act as an integral assessment and record of feeding, as opposed to a separate 'feed chart'. Analysis of many of the feed charts in use nationally revealed that inadequate space is often allocated for a comprehensive assessment of feeding and feed attempts. The SWHMR proposes a substantial space allocated to feeding within an overall timed and dated assessment of the baby. The wording used in this section aims to promote a comprehensive assessment of feeding/feed attempts, so that any difficulties can be identified and addressed promptly.

• The level of detail, and the number of entries entered here should be appropriate to each baby’s needs.

Skin: including buttocks and cord
• This section aims to promote the recording of comprehensive assessment of the baby’s skin (including buttocks, cord, skin folds, digits and nails etc), and any advice on skin care or bathing given, or actions taken, e.g. millia (milk spots), bruising, erythema toxicum and examination of the fingertips and toes for rag nails or paronychia. The condition of the cord, presence of a cord clamp, and any actions necessary can be discussed with parents and documented.

Eyes
• Any abnormalities should be noted and discussed with parents, together with relevant advice given.

Wet nappies
• This terminology has been used as it is familiar and woman friendly. The baby's state of hydration can be assessed and discussed with the parents, and the presence of any urates or pseudo-menstruation can be noted and discussed.

Dirty nappies
• Again the wording has been used as it is familiar and woman friendly. The colour, nature, frequency and consistency of stool can be assessed, and other items could include the presence of a meconium plug.

Consent for Newborn Blood Spot Screening for Phenylketonuria, Congenital Hypothyroidism & Cystic Fibrosis
• Written consent is required for the newborn blood spot screening for Phenylketonuria, Congenital Hypothyroidism & Cystic Fibrosis.
• Parents should have received a copy of the parents guide to the screening test during pregnancy (see under the 'Information for you' section on page 13 of the Pregnancy Record), and had an opportunity for discussion with a relevant health professional. This consent form checks that this is happened.
• National guidance for health professionals undertaking the newborn bloodspot screening test has been issued (NHSScotland, 2003b).
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