THE MIDWIFE’s STORY:
Does Your Charting Reflect Who You Really Are?

Karen Hays, DNP, CNM, ARNP
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Learning Objectives

Photos & Cartoons removed for this printed version.

• Discuss how the midwife’s documentation of client care meets the needs of at least 5 interested parties (in addition to the midwife) who depend on the chart to be accurate, complete, & timely.

• Describe at least 3 differences between charting by primary providers (MDs, MWs, ARNPs) & charting by other health care personnel (RNs, assistants).

• Identify at least 4 key aspects of the content of a chart note that should be incorporated into professional peer review or incident review to assist in determining the quality of the midwife’s care.

What’s the Point?

“Document carefully so that your actions are justified and your process for [midwifery &] medical decision-making is discernable....”

Carolyn Buppert, ARNP, JD (2011)
Who Else Might Read The Midwife’s Chart?

And what are they looking for?

- Other midwives who share clinic &/or coverage
- Consulting/Referral MDs & hospital staff
- Midwifery students
- Peer or Incident Reviewers
- JUA Practice Reviewers
- DOH Birth Center Reviewers
- Clients & their families

- WA State DOH
  - MAC (LMs)
  - ND, RN, ARNP, etc. boards
- Attorneys
  - Defense – for you
  - Plaintiff – for the client
- Health Insurance Company Auditors
- Criminal Justice System
Your Charting Style Provides Visual & Contextual Clues as to What Kind of Health Care Practitioner You Are

• *Independent* decision-maker, who practices under her own authority (within a scope of practice)

  vs.

• *Dependent* staff or personnel who cannot make “medical” diagnoses or implement a plan of diagnosis or treatment without order or sanction by other licensed health care providers.
# Provider vs. Personnel Charting

<table>
<thead>
<tr>
<th><strong>Providers</strong></th>
<th><strong>Personnel</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(MD, ND, DO, ARNP, LM, PA?)</td>
<td>(RN, CNA, birth assistant)</td>
</tr>
<tr>
<td>• Decision-making revolves around the <em>assessment</em></td>
<td>• Decision-making revolves around an episode of care</td>
</tr>
<tr>
<td>• Therefore charting revolves around the <em>assessment</em></td>
<td>• Charting revolves around tasks associated with that episode of care</td>
</tr>
<tr>
<td>• Responsible for</td>
<td>• Responsible for</td>
</tr>
<tr>
<td>– directing plan of care</td>
<td>– carrying out interventions</td>
</tr>
<tr>
<td>– assessing effects of the plan</td>
<td>– assessing effects of interventions</td>
</tr>
<tr>
<td>– following up on all client issues, treatments, no-shows</td>
<td>– passing tasks on to next person</td>
</tr>
<tr>
<td>– integrating holistic picture of care given over time</td>
<td></td>
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</table>
Provider vs. Personnel Charting

**Providers**

*Reason for visit*

**Information:** Subjective – client’s experiences & perspectives

**Objective** – physical exam, labs, ultrasounds, observations, ...

**Assessment:** Diagnosis, ICD-9, Summation, Evaluation, Professional Judgment

**Plan:** Usually 1 entry for each diagnosis + routine teaching + time until next contact

*Charting:*

Info → Assessment → Plan

*Repeat* (integrate)

**Personnel**

**Data:** Subjective, Objective, ‘Nursing Diagnoses’, Provider Care Plan

**Plan:** Tasks to accomplish during the episode of care

**Evaluate:** Can only record data

*Charting:*

split up between graphs, checklists, & brief narrative notes

*Report & Pass On*
Provider vs. Personnel Charting

**Providers**

Return PN Visit at 32 wks

**S:** Feels well today. c/o headache yesterday – went away w/ 1 dose Tylenol & sleep. c/o dysuria x2d, no fever, no back pain. Baby active q day. Started CBE – likes it.

**O:** See flow sheet – all WNL. Urine dip: 1+ proteinuria, 1+ leukocytes. No CVA tend.

**A:** 32 wk gest, doing well except possible UTI.

**P:** 1. Reviewed Birth Prep list.
   2. Rev’d s/sx PTL.
   3. Rev’d FM awareness, call if decreased.
   4. CCUA to lab. Disc’d s/sx UTI & pyelo. Rec’d double fluid intake, cranberry capsules. Consult if lab indicates UTI. Client will call in 3d for lab results.
   5. RTC x 2 wk, sooner prn concerns or problems.

**Personnel**

32 wks: Client had headache yesterday, none today. Took Tylenol, slept – no more H/A. Started CBE & likes it. Painful urination x2d; denies fever or back pain; no CVA tenderness. Urine dip 1+ protein & leuks today. CCUA to lab – client will call for results in 3 days. If results +UTI → consult. In the meantime, will double fluid intake & take cranberry capsules. Reviewed s/sx UTI, pyelo, PTL, birth prep list. Disc’d FM awareness & to call if decreased. RTC x 2wk, sooner if concerns or problems.

*Journal articles & continuing education modules that focus on charting for RNs do not include a complete picture of how independent Health Care Providers should chart.*
Provider Charting

It’s fine to use language that feels more authentic to the midwifery profession, or your personal practice style. But the organization of the provider’s chart note should remain fairly standard, with the assessments & actions readily apparent.

**Subjective** aka ‘Client’s experiences’, ‘Woman’s perspectives’

**Objective** aka ‘Exams & tests’, ‘Midwife’s observations’

**Assessment** aka Diagnosis, Impression, Appraisal, Summation, Midwife’s Evaluation, Professional Judgment

**Plan** aka ‘Actions & Teaching’, ‘Today’s & Future Activities’
Provider vs. Personnel Charting

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<td><strong>Client’s Experience:</strong> Feels well today. c/o headache yesterday – went away w/ 1 dose Tylenol &amp; sleep. c/o dysuria x2d, no fever, no back pain. Baby active q day. Started CBE – likes it.</td>
<td>32 wks: Client had headache yesterday, none today. Took Tylenol, slept – no more H/A. Started CBE – likes it! Painful urination x2d; denies fever or back pain; no CVA tenderness. Urine dip 1+ prot &amp; leuks today. CCUA to lab – client will call for results in 3 days. If results +UTI consult. In the meantime, will double fluid intake &amp; take cranberry capsules. Reviewed s/sx UTI, pyelo, PTL, birth prep list. Disc’d FM awareness &amp; to call if decreased. RTC x 2wk, sooner if concerns or problems.</td>
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<tr>
<td><strong>MW Exam:</strong> See flow sheet – all WNL. Urine dip – 1+ proteinuria, 1+ leukocytes. No CVA tend.</td>
<td></td>
</tr>
<tr>
<td><strong>Impression:</strong> 32 wk gest, doing well except possible UTI.</td>
<td></td>
</tr>
<tr>
<td><strong>Teaching &amp; Plan:</strong> 1. Reviewed Birth Prep list. 2. Rev’d s/sx PTL. 3. Rev’d FM awareness, call if decreased. 4. CCUA to lab. Disc’d s/sx UTI &amp; pyelo. Rec’d double fluid intake, cranberry capsules. Consult if lab indicates UTI. Client will call in 3d for lab results. 5. RTC x 2wk, sooner prn concerns/problems.</td>
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Provider Charting: Lots o’ Bits & Pieces

- First Prenatal Visit
- Return Prenatal Visits
  +/- checklists; +/- formalized screening
  (nutrition, depression, sexuality, ...)
- Extra Visits  (E&M – separate billing)
- Intrapartum & Newborn
- Postpartum/Newborn Visits
- Informed Consents
- Labs, ultrasounds, etc.
  – all dated & signed
- Contract, Financial stuff, etc.

The chart is a legal / business document separate from you & it is considered ‘factual’ evidence.
Provider Charting
1st Prenatal Visit & 1st Labor Assm’t

- **Client ID** – name, age, GP, occupation
- **Hx of Current Pregnancy** – Planned (or not), LMP, concep date, EDD, prev care, pregnancy s/sx, toxic exposures, ...  
  [For Labor Assm’t this is changed to charting the Problem List]
- **Dating** – prenatally if U/S already done; always include in labor note
- **Medical/Surgical Hx** – numbered, dates, current meds
- **Allergies** (+ reactions)
- **Family Hx** – HTN, diabetes, congenital anomalies, etc.
- **OB/Gyn History** – Pregnancies, Paps, BCM, STIs, repro system probs, lact hx
- **Psych/Soc Hx** – relationship (DV), family issues, psych dx & who manages, eating disorder, ETOH/drugs, homeless, ...
- **Physical Exam** – V.S., height, general, pelvic. [For Labor Assm’t this includes FHR, EFW, fetal presentation, cervical exam, amniotic fluid, ...]
- **Assessment** – Always includes “Appropriate for midwifery care”
- **Plan** – teaching & written info given, informed consents done, warning signs, labs sent or planned, next planned contact (clinic, telephone,...)
Provider Charting:  
1st Prenatal Visit, 1st Labor Assm’t, L&D Summary

• Summarize all info into one organized progress note – demonstrates that you pulled it all together & were able to make diagnoses/assessments based on this data. Makes your thought processes overt.

• Most important diagnosis for 1st PN Visit & Initial Labor Assm’t is “Appropriate for midwifery care.”

• These templates are similar to how OBs and CNMs chart – important info is all in 1 place & in a familiar provider format. Also documents your familiarity with important aspects of the client & your thought processes.
MAWS doesn’t have a chart form to promote an integrative note for the 1st Prenatal Visit (?)

The visit can be written free-hand or off a template (printed with blanks to fill in by hand, or in a Word document)
Provider Charting: Labor Assessments

The MAWS Labor Flow chart form does not promote adequate provider-level charting.
The MAWS Labor Summary & Newborn chart forms do this pretty well.
Late Entries & Correcting Errors

• Late Entries
  – OK to do within a few days
  – Identify it as a “Late Entry” with today’s date & time, then refer to the date of service that you are amending.

• Correcting Errors
  – draw a line through the erroneous info + initial & date at the end of the line

• Never ever alter a chart after you learn of any kind of claim or investigation. This is against the law – a crime in some states. If you have more you want to say, do so verbally with your attorney. Better to not write anything down.

Checklists

• Great to use as reminders & to decrease narrative charting.
• Each item must be described in a protocol or practice guideline, especially
  – teaching
  – consents
  – warning signs
• Items must be dated & initialed when implemented.
“Telephone Medicine”

• Katz et al. (2008)
  – Reviewed 32 lawsuits derived from telephone calls (most from internal medicine, OB, peds).
    60% paid damages. Average payout $519,000.
  – Categories of Errors that contributed to damages:
    1. Poor documentation 88%
    2. Faulty triage 84% - failure to identify seriousness, failure to communicate
    3. Lack of policies & protocols 38% - dropped messages, delayed responses
    4. Covering another provider’s calls 28% - no prior knowledge of patient, no chart available
Telephone Charting – Same!

*T.C. date/time*

**Info: Subjective** – client’s experiences/perspectives

  **Objective** – info from chart (*always* gestational age or wks pp),
  how voice sounds (good mood, nervous, crying, …)

**Assessment:** Diagnosis, Summation, Professional Judgment,

  Evaluation. OK to say “Possible” “Probable” “Differential Dx is …”

**Plan:**

1. Immediate MW or MD contact *or* Need more info (BP check, ultrasound, FM counting, etc.) *or* It can wait a day or more…
2. Warning signs to call back for
3. Time until next contact (& who will contact who)

**Charting:**

  Info → Assessment → Plan → Refer to T.C. in next clinic visit note?
Peer Review & Incident Review: What to look for

1. Chart notes start by framing the context for the visit (except ongoing intrapartum notes).

2. The new OB visit, each prenatal/postpartum progress note, & labor (re)evaluations q 1-4 hours include an Assessment based on subjective & objective data.

3. The Plan follows logically from the Assessment & includes time of next contact.

4. Next planned contact is explained if it did not occur.

5. All visits, intrapartum assessments & phone calls are promptly documented (if not, it’s explained).

6. Checklists are backed up by information spelled out in protocols.

7. No evidence of alteration of original chart entries.
Making the Transition to Electronic Records with Private Practice

Posted in: Work | Nov 22, 2010

Because midwives work in diverse settings with a variety of individual needs, Private Practice is designed for all types of practice styles, from the large group to the solo provider. The key to a functional practice management system is in having the flexibility to customize your system to support your existing workflow. Using this system doesn’t mean you need to change how you practice. Ideally, the system will simply allow you to make your current practice tasks easier to manage and support your current needs.
Communicating with Computers & Phones

• 1st obtain written client consent
• Email – encryption for identified personal health information (PHI)
• Texting – cryptic codes?
• Facebook, Twitter – written client consent of photo & text (and anyone else in the photos or named in text)
• Cloud Storage – encryption
Conclusions

Your only other option to charting is to videotape yourself during all clinical activities.

Chart like you are an *independent* Health Care Provider, because that is who you are. The story you tell should reflect your ability to **assess** your client’s health status.

“*Document carefully so that your actions are justified & your process for [midwifery &] medical decision-making is discernable....*”

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