The Effective Representation of Midwifery Care in Documentation: A Delphi Study

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A thesis submitted in fulfilment of the degree Master of Midwifery at Otago Polytechnic, Dunedin, New Zealand

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I, **Bridget Kerkin** of . solemnly and

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Abstract

The documentation of midwifery care is widely accepted as a critical component of midwifery practice. This documentation serves a variety of purposes. At a minimum it represents the care provided to a woman, childbearing person and/or baby, by the midwife. It may enhance coordination of care provision, highlight the priorities and decision-making of the woman or childbearing person and the midwife, and promote communication between them, and with other health professionals. Effective health records will support audit and practice review processes and contribute to research and education. However, optimal practice in relation to the documentation of midwifery care is not clearly defined in Aotearoa New Zealand, or elsewhere in the world. Evidence is lacking to support midwives to understand the most effective approach to documenting the care they provide. Therefore, clarification of midwifery practice priorities for documentation is warranted.

The research question, developed from initial exploration of the existing pool of literature, was "*What content should be included in midwifery documentation to effectively represent the care provided?*" A modified Delphi methodology was used to explore the opinion of expert midwives in relation to this research question. Three survey rounds were completed, with the data from the first two surveys analysed to develop consensus-seeking statements which were presented to participants in the third, and final, survey.

Consensus was achieved on 70 of these 93 individual consensus-seeking statements. The rich commentary contributed by the participants also developed understanding of the complex factors contributing to the practice of midwifery documentation. The opinions of these expert midwives emphasised that the impact of the context of care provision cannot be underestimated. Prioritisation of the provision of safe, individualised care, and autonomous midwifery decision-making to achieve this, was identified as a principal focus.

Dedication

This work is dedicated to my mother, Darien Joy Kerkin.

We need women who are so strong that they can be gentle, so educated that they can be humble, so fierce that they can be compassionate, so passionate that they can be rational, and so disciplined that they can be free. We need uncommon women (Kavita N. Ramkas).

You were an uncommon woman, mum. I miss you.

Acknowledgements

To the participants who contributed to this research, thank you! Your wisdom has supported and guided me on this journey. You have provided our profession with an important body of knowledge.

To the pregnant and birthing women, childbearing people and new mothers I have worked with throughout my career. Thank you for sharing your families and experiences with me. It is from you I have learned, and continue to learn, how to be a midwife.

To my thesis supervisors:

- Associate Professor Vicki Van Wagner - Vicki, you have such enviable insight. I have nothing but admiration for your work and it has been a privilege to have you contribute to this research journey
- Associate Professor Jean Patterson - Jean, you have a formidable mind and an exquisite sense of humour. I have made the most of both. It has been an honour to work with such an experienced researcher, academic and supervisor. I'm thrilled your contribution has been woven throughout my master's experience
- Professor Sally Baddock - Sally, I am in awe of your ability to simultaneously offer challenge and reassurance. You have a way of communicating which is fundamentally respectful and encouraging, but which inspires a desire to do the best possible job. You have been endlessly patient, and I am eternally grateful.

To my midwifery people, past and present, I am thankful for you every day. You are many – and you will know who you are – but a special thanks to Judi and Suzanne who have walked alongside me throughout the highs and the lows of midwifery, and have shared the type of unconditional acceptance and love that perhaps only midwifery sisters can understand.

And last, but certainly not least – thanks and love to my family for your patience as I have struggled my way through this work. To my sisters, Julie and Christine, who manage somehow to simultaneously keep me humble but offer me endless support. My beautiful, inspiring daughters, Aisling and Kaea. I could not be more proud of the women you have grown into. My talented, energetic son, Foy. I am in awe of your dedication and abilities. And Roger, who is my rock. I quite literally could not have done this without you.

Statement of commitment to diversity and inclusiveness

I am committed to supporting the development of awareness of diversity, and the use of inclusive language to celebrate diversity. Some time has passed since I first commenced this thesis journey, and my own awareness of the importance of the use of inclusive language has developed over this time. When writing the surveys for data collection in this project, for instance, I used only "woman" and "women" and, in presenting my survey questions I have represented them as the participants received them. I have also reproduced my participant's quotes as they wrote them, without altering any gendered language.

It is my intention that every person receiving and providing midwifery care would see themselves reflected in the work I have produced here. I hope I have achieved this through the use of non-gender specific language, alongside the use of the terms "woman", "women" and "mother".

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Explanation of descriptors for midwifery documentation

Varied terms are used, in literature, to reference the documents arising from the recording of care provided to a person receiving a healthcare service, or the act of documenting this care. In Aotearoa New Zealand, it is common to use the terms 'record keeping' and 'documenting' interchangeably to describe the writing of the record.

'Documentation', 'clinical notes' and 'record' (may also be preceded with an explanatory term such as 'health') are commonly used to describe the resulting documents produced. These terms may also refer to an electronic record.

In this thesis the terms for the outcome of documenting the care provided, and the act of writing it, are used interchangeably to avoid repetition.

Chapter One: Introduction

Choosing midwifery documentation as an area of exploration

I am able to pinpoint the exact moment that triggered my decision to undertake a detailed exploration of the documentation of midwifery care.

I was on the phone in my kitchen, and I had recently facilitated a workshop for midwives in my local region to support them in their documentation practices. A midwife who had attended the workshop phoned me to clarify the definition of a retrospective documentation entry. I didn't entirely know, I explained to her, but I would find out if possible and get back to her. And so, I went on a search for this tibit of information and…. I couldn't find a clear answer. In the process of trying to respond to this query, I realised I was not locating answers to many of the questions I had about documentation. Also, I could not pin down an authoritative source for midwives in Aotearoa New Zealand to turn to for answers to their own midwifery record keeping questions.

The next step was a wider, international search. I was convinced there was clear guidance for practitioners somewhere, based on solid evidence. Naive? Certainly. Successful? Certainly not. What I discovered was that international practice guidance for midwives provided by professional organisations was based on the advice and instruction of legal advisors. The legal advisors quoted the professional requirements framed by the Nursing and Midwifery professional organisations. Textbooks, in turn, seemed to quote both the legal advisors and the professional organisations!

This circular practice guidance was initially perplexing and confusing, and then quite frustrating. In fact, it left me with many unanswered questions. For example, what was the origin of the advice I had used as the basis of my teaching of undergraduate midwifery students, and the development of my workshops for registered midwives?

The Health and Disability Commissioner (HDC) frequently criticised the documentation practices of midwives (http://www.hdc.org.nz/). The development of this criticism is supported by expert midwife advice which brought me to consider how midwives providing expert opinion to the office of the HDC knew to advise about documentation practice. Further, where were midwives in practice turning to for information about how to document their care effectively? And, was it really appropriate to rely on lawyers to direct our practice guidelines? Given the distinctive nature of midwifery care, and the associated development of unique midwifery relationships, is the use of the maternity record also unique? Should midwives define their own practice guidance in this area?

Midwifery practice in Aotearoa New Zealand

Midwifery in Aotearoa New Zealand was redefined in 1990 when political action arising from a partnership between midwives, women and childbearing people restored midwifery practice autonomy (Nurses Amendment Act 1990: Information for Health Providers, n.d.). At this time, midwives were awarded a specific midwifery scope of practice which extended their capacity to provide holistic midwifery care to women or pregnant people throughout the childbearing experience. This autonomous midwifery practice was now able to be provided without the need for input from medical professionals unless the woman or childbearing person's circumstances became complicated in some way (Midwifery Council of New Zealand, n.d.).

Midwives in Aotearoa New Zealand continue to work in partnership with their clients, in a maternity service which prioritises continuity of care. Each midwifery relationship is developed within the context of our bicultural nation and with acknowledgment of Māori as tangata whenua (people of the land). Midwives offer an individualised, woman or person-centred service, and the Midwifery Scope of Practice (Midwifery Council of New Zealand, n.d.) enables

them to provide all care for mother, childbearing person and baby during an uncomplicated pregnancy, labour, birth, and postnatal period. This includes prescribing, ordering tests and investigations, and conducting other aspects of care required for uncomplicated childbearing experiences. In addition, midwives work collaboratively with their obstetric colleagues when care of the woman or childbearing person, and the coordination of the care, moves outside the midwifery scope of practice (New Zealand College of Midwives, 2015).

The majority of midwives in Aotearoa New Zealand work as employed (core) midwifery staff within district health board (DHB) hospital facilities or birthing centres, or as self-employed community, case-loading midwives, offering continuity of care midwifery services to women and childbearing people from early pregnancy through to the postnatal period.

In the 2019 Midwifery Workforce Survey (Midwifery Council of New Zealand, 2019) 36.21% of midwives identified their primary employment as community case-loading midwifery and 50.56% of midwives identified their primary employment as core midwifery. Regardless of their working environment, midwives undergo a rigorous annual recertification programme, a component of which is the requirement to work across the Midwifery Scope of Practice (Midwifery Council of New Zealand, 2019).

Documentation of midwifery care

The Midwifery Council of New Zealand and the New Zealand College of Midwives (NZCOM) provide regulatory and professional expectations for midwifery practice in Aotearoa New Zealand. Both organisations address the responsibility of the midwife to effectively, and thoroughly, record the care provided to their clients.

Standards Three and Four of the Standards of Midwifery Practice (New Zealand College of Midwives, 2015) and Competencies One and Two of the

'Competencies for Entry to the Register of Midwives' (Midwifery Council of New Zealand, n.d.) direct New Zealand midwives to document thorough and meaningful clinical records at each and every contact with a woman or childbearing person. In addition, there are legislative frameworks informing midwifery practice with regard to documentation. For example, the Ministry of Health outlines the requirement for community midwives to develop and maintain a comprehensive care plan for each of their clients (Maternity Services: Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000, 2007). Legislation defined by the Ministry of Health, Ministry of Justice and the Privacy Commissioner describes how healthcare information is to be collected, stored and accessed (Health (Retention of Health Information) Regulations 1996, n.d.; Health Information Privacy Code 2020, n.d.; Privacy Act 1993, n.d.).

To assist midwives to reflect on their own record keeping practices, the Midwifery Council provides an audit tool for midwives, associated with advice based on these legislative requirements for documentation of healthcare records (Midwifery Council of New Zealand, 2018). While this professional guidance is useful, and does support the work of midwives, the evidence base (aside from legislation) from which it has been derived, is not apparent. Despite this absence of accessible evidence for midwifery practice documentation, there appears to be international consensus that the recording of care provided by healthcare professionals is critically important and fulfils a number of purposes (Jefferies et al., 2012; Saranto & Kinnunen, 2009; Scott, 2017).

The purpose of documentation

Seeking clarity about the purpose of midwifery documentation necessitates an international multi-disciplinary exploration. There are several reasons for this approach:

a) As previously established, there is little literature available which addresses midwifery documentation specifically

b) There is a scarcity of literature arising from the New Zealand context

c) Internationally, midwifery professional and legal frameworks are provided by nursing and midwifery professional guidelines and legislation; and

d) There is significant exploration of record keeping in other health professions, and particularly in nursing

The discussion of midwifery documentation which follows is informed by international literature from a variety of healthcare fields. While this is necessary to provide the basis for an effective understanding of the topic, it is important to recognise the differences between midwifery and other healthcare professions (Guilliland & Pairman, 2010; Kerkin et al., 2018) which might impact on record keeping processes.

As continuity of midwifery care forms the foundation of the maternity service of Aotearoa New Zealand (New Zealand College of Midwives, 2015), it is possible that the documentation of midwifery care may be unique, reflecting this fundamental focus. Additionally, this documentation of the progress of mother, childbearing person and baby, during their maternity care, might act to enrich the continuity of care relationship. The maternity record may highlight the midwife's recognition of their client's priorities, the development of the baby, and the evolution of the childbearing family (Kerkin et al., 2018; Laitinen et al., 2010). Therefore, midwifery documentation may influence the development of the partnership between a woman or childbearing person and a midwife (Miller & Wilkes, 2015) by promoting their communication opportunities, and affirming their mutual understanding of the developing care plan (Brown et al., 2015; Hart et al., 2003).

In the context of continuity of care, the midwifery record will enhance tracking of care provision (Blair & Smith, 2012) and form a record of experience for both the midwife and the client (Butler et al., 2006; Symon, 2016). Additionally, the clinical notes will support the transition of care between health professionals (Tornvall & Wilhelmsson, 2008) particularly, when a woman or childbearing person is involved with a number of midwives, or a multi-disciplinary team (Law et al., 2010; Pezaro & Lilley, 2015). Effective documentation in these circumstances will promote communication between health professionals (Broderick & Coffey, 2013) and may improve collegial interactions and relations (Tornvall & Wilhelmsson, 2008). It can help reduce the likelihood of information being missed when a woman, childbearing person or baby experience care which is shared between healthcare providers (Zegers et al., 2011).

When health records accurately reflect the care provided, they contribute to effective auditing practices and the review of clinical outcomes (Pezaro & Lilley, 2015). Data can be collected to enhance understanding of service provision and may also contribute to funding processes and service planning (Baskaran et al., 2013; Davis et al., 2000). Similarly, clinical notes can support research and education (Jowitt, 2007). When documentation is thorough and complete, it allows for the collection of information which informs our understanding of care outcomes, and the practices which may contribute to these. Further, accurate records support the development of aspiring healthcare professionals as they contribute to education and professional knowledge (Cheevakasemsook et al., 2006; Laitinen et al., 2010).

Documentation forms a source of evidence (Scott, 2017) when health professionals are called to account for the care they have provided. This record keeping also allows for reflection on practice and constitutes a form of measurement of practice against quality, and professional, standards (Asamani et al., 2014; Cheevakasemsook et al., 2006). Thus, effective documentation

demonstrates and supports the practitioner's accountability for their practice (Blair & Smith, 2012; Scott, 2017) and commitment to consumer rights (Jefferies et al., 2012).

Healthcare records constitute an account of the care provided and decisions made (Griffith, 2007; Kärkkäinen et al., 2005) by the health professional and the person receiving the health service. In thorough clinical notes, the care recipient's decision making can be clearly recorded, and this allows other healthcare providers involved in the care to tailor their service most effectively. Ideally, this should improve the experience of care, and make the client's preferences and priorities more visible (Kärkkäinen et al., 2005; Laitinen et al., 2010). Thus, effective record keeping holds the potential to articulate and improve the visibility of the work that health professionals do (Fleming, 1998; Pearson, 2003). It is seen by many to hold inherent value as a component of the work of healthcare providers, and as a clinical practice in itself (Jefferies et al., 2010).

It is obvious then that, at its best, midwifery documentation fulfils a number of important purposes which, may enhance the safety of the mother, childbearing person and baby (Jefferies, Johnson, Nicholls, Langdon, et al., 2012; Pezaro & Lilley, 2015; Wang et al., 2015), and contribute to the associated wellbeing of their wider whānau and community. In contrast, there may be significant implications for the health and safety of mother, childbearing person, whānau and baby when documentation is poor (Gunningberg & Ehrenberg, 2004; Kent & Morrow, 2014).

Despite the importance of the documentation of healthcare services, there is potential for midwives to experience confusion as they navigate the realities of practice, professional expectations, and the medico-legal environment of maternity care. Jefferies et al. (2010) explain that the value of appropriate written representation of care "as an important source of reference in the health-care system is undermined because there is much confusion about the

exact nature of quality…documentation" (p. 112). Further, clarification of optimal approaches for record keeping processes is more important than ever given the international focus on development and implementation of electronic health records.

Looking to the future: Electronic health records

There is a plethora of research assessing the implementation of electronic health records and practitioner compliance with, and experience of, their use (Kent & Morrow, 2014; Saranto & Kinnunen, 2009; Wang et al., 2014).

The potential advantages of electronic health records are broad, and include the sharing of information and ease of access to relevant data (Brooke-Read et al., 2012; Wang et al., 2014). They may service to inform healthcare recipients and enhance their ability to participate in their own care. Further, electronic health records might lead to more efficient recording of information (Casey & Wallis, 2011) with associated reduction in the amount of time spent documenting. This may allow more time to spend with clients (Kent & Morrow, 2014) and improve outcomes for those receiving health services (Collins et al., 2013; Dykes et al., 2006; Lindberg & Anderson, 2014). Efficiency in documentation may also result in improved accuracy of the healthcare records, and easier review and audit of practice.

Fawdry et al. (2011) warn, however, of the importance of careful implementation of electronic health records and the need for systems to integrate these effectively. They explain that computer systems tend to be rigid compared to the flexibility of paper-based records and suggest that the usefulness of the record, along with the output from the system, are only as good as the data entered. Likewise, Kent & Morrow (2014) describe the need for "a fully supported implementation process and appropriate technology" (p 45) for electronic health records to be effective.

Standardisation of language is important in electronic records (Prideaux, 2011), as is the need for standardised content and structure of the records (Hayrinen et al., 2008; Zegers et al., 2011). A lack of consistency will result in ambiguity and undermine the usefulness not just of the record (De Groot et al., 2019), but also the safety of the people receiving the health service (Jefferies et al., 2011). Complex electronic records might interfere with access to information which is essential to the appropriate provision of care (Stevenson & Nilsson, 2012). For instance, there is the potential, in a structured, inflexible electronic record for the holistic care and the expertise of the healthcare provider to become less visible (Kelley et al., 2011; Tornvall & Wilhelmsson, 2008). Additionally, the relationship between the person receiving care and the person providing care may be negatively impacted by the process of using electronic health records and strategies may be needed to mitigate this effect (Lanier et al., 2017).

To summarise, while electronic health records provide the potential for an accessible, consistent, and stream-lined approach to documentation processes, there is also the possibility of inflexibility, and the disconnection of relevant content. These considerations underscore the need for clarification of the most appropriate approach to record keeping practices in advance of, and to support, the widespread implementation of electronic health records.

Conclusion

International multi-disciplinary literature clarifies our understanding of the purpose of healthcare records, and their potential association with the quality and safety of the care provided. If we apply the results of this research to midwifery practice in Aotearoa New Zealand we can conclude that midwifery documentation, as the record of the maternity care journey of women, childbearing people, and babies, has the potential to enhance outcomes, experience and communication. At its best it is a protective mechanism for women, childbearing people, midwives, allied health professionals and

institutions, and the midwifery profession. It can be a useful source of research and audit data and may contribute to individual professional development, and the development of the midwifery profession. There appears to be international consensus about the importance of thorough and meaningful documentation of healthcare service provision, but absence of an evidence base to support the development of midwifery practice in this area.

Aim and purpose of the study

The purpose of this study is to support registered and student midwives to document the care they provide in an effective, useful, and appropriate way. The aim of the research is, therefore, to provide midwives with a foundation of knowledge to clarify what serves as appropriate documented evidence of care in midwifery practice. Thus, the specific research question is *"What content should be included in midwifery documentation to effectively represent the care provided?"*.

Overview of the thesis chapters

There are five chapters in this thesis:

The introductory chapter, **Chapter One**, identifies the topic of interest and why it is important, clarifies the research question, and discusses midwifery practice considerations related to documentation.

Chapter Two offers a review of international literature addressing the content of midwifery documentation. Given a lack of directly relevant literature, a broad perspective is taken to further contextualise the research project.

Chapter Three explores the theoretical considerations and modified Delphi methodological framework of the study. The research paradigm is explored, and the research method explicated.

Chapter Four includes presentation of the statements of consensus from the surveys of expert opinion, along with the narrative contributions of the participants.

In summation, **Chapter Five**, provides a discussion of the results and draws the exploration of the topic to a conclusion, offering implications for practice and further research.

Chapter Two: Background and review of the literature

Having established the importance and relevance of effective midwifery documentation, the purpose of this chapter is to review existing literature and determine the extent of current evidence which informs our understanding of optimal content in the documentation of midwifery care. The research question of interest being: *"What content should be included in midwifery documentation to effectively represent the care provided?"*.

Literature search

The following search terms were entered into the PUBMED, CINAHL and Google Scholar databases, with a specified time frame of 1990 to 2019:

midwi* AND (effective* OR content OR ideal) AND (document* OR note* OR record* OR chart*)

This time frame was chosen for pragmatic reasons, and to reflect the practice environment following the 1990 legislative changes which restored midwifery autonomy in Aotearoa New Zealand.

Results for review were restricted to English language publications, with the search terms found in the title or the abstract. A summary of the findings from each database is detailed below:

The literature search elicited the following initial results:

CINAHL: 677 initial results

PUBMED: 582 initial results

Google Scholar: 297 initial results

Duplicated publications were discarded and the abstract of each unique item of literature was reviewed. If there was not sufficient detail in the abstract to

ascertain whether the article was of relevance to the topic of interest, the full article was accessed. Through this process, the following results were obtained:

CINAHL: 37 documents relevant to the topic

PUBMED: 14 documents relevant to the topic, of which 3 were unique to this search

Google Scholar: 8 documents relevant to the topic (all unique to this search)

In total, 48 documents were downloaded for further review. This review confirmed that none of the articles described original research directly addressing the topic of interest. Therefore, hand-searching of the reference lists of the articles was also undertaken. A further 110 articles were identified that were relevant to the research question.

Of the total 158 articles accessed and reviewed, only two were found to have direct relevance to the research question, with one describing original research exploring the topic. These two articles will be discussed in detail below. In addition, 16 opinion/discussion/advice pieces were located which provide direction for healthcare providers in their documentation practices. To be included in this discussion, each piece of literature needed to provide advice, or evidence, for what should be included in the content of documentation. Articles describing audits of health records were excluded from the discussion because none of these clarified how they had arrived at their expectations for appropriate content of documentation.

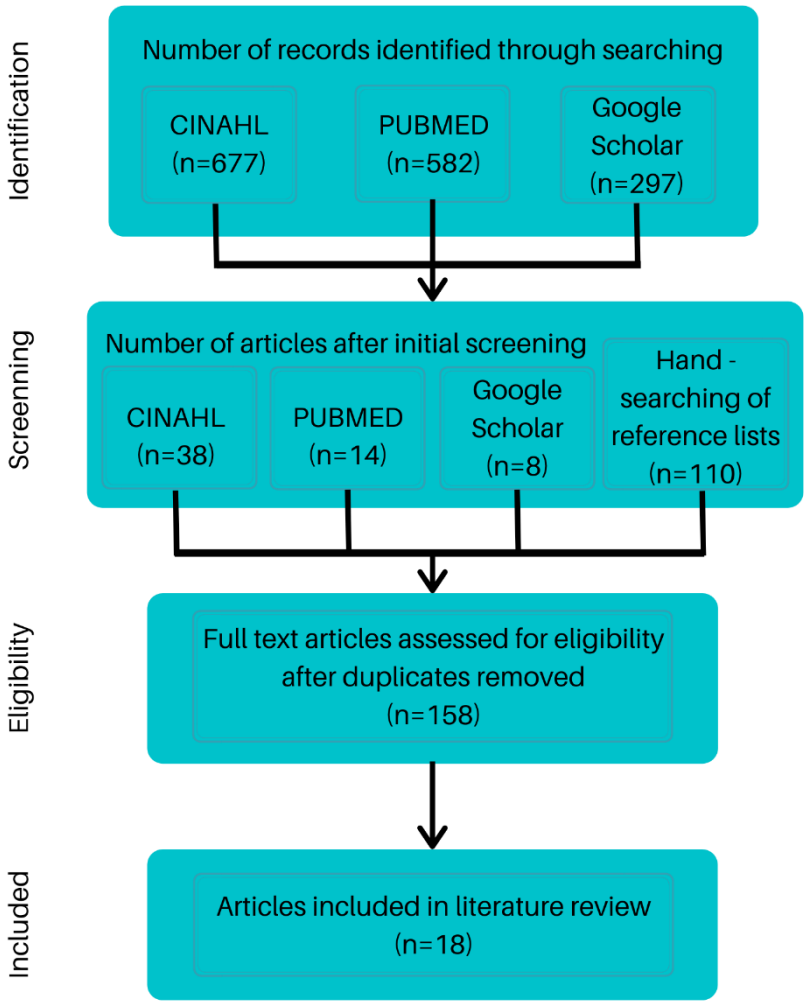

Figure 1: PRISMA representation of the literature review process

Most of the literature accessed, and summarised below, does not directly address evidence for appropriate midwifery documentation practice. It also does not address the content of the midwifery record. However, this literature has the potential to enhance our understanding of the context of midwifery record keeping and, therefore, the possible contextual influences on this research project, and the participant contributions. The themes which emerge identify considerations of interest as we explore how midwives can best document to effectively represent their practice. Opinions which influence professional perspectives about the documentation of care are evident. As documentation literature from other health fields is more extensive, it can be

used to broaden our perspective, while we recognise that the unique nature of midwifery may translate to fundamental differences in the way documentation of midwifery care is optimally constructed (Fleming, 1998; Guilliland & Pairman, 2010).

Professional and legal advice for documentation

As previously discussed, professional and legal opinion often forms the basis of the advice and instruction offered to healthcare providers in relation to ideal record keeping practices. While considering practice advice which is based on opinion rather than a foundation of evidence, it is important to acknowledge the possible limitations of this guidance, including potential author bias or agenda (Van Wagner, 2014). Without clear evidence underpinning the opinion that is offered, it may be difficult to understand the origin of the evidence, and it may not be appropriate to generalise the guidance to practice outside of the author's immediate context.

Advice arising from professional organisations

Opinion-based guidance often derives from the recommendation of local, regional, or national professional organisations. For example, in this literature review, documentation of nursing care is discussed in relation to the Nursing and Midwifery Council (NMC) guidelines in the United Kingdom (Andrews & St Aubyn, 2015; Ashurst & Taylor, 2010; Creed, 2017; McGeehan, 2007; Pirie, 2011; Wood, 2010). The visibility of record keeping within these guidelines, and the importance of prioritising documentation as a key component of nursing practice, is emphasised.

There is general agreement that effective record keeping is integral to communication between healthcare providers, and that this contributes to improved patient safety (Andrews & St Aubyn, 2015; Ashurst & Taylor, 2010;

Creed, 2017; McGeehan, 2007; Pirie, 2011; Wood, 2010). However, the discussion of this component of health professional communication generally does not provide extensive advice about the best approach to documentation. Rather, authors often reference, and summarise, the advice provided by the NMC (Ashurst & Taylor, 2010; McGeehan, 2007; Wood, 2010). For example, Ashurst & Taylor (2010) present the NMC "Principles of Good Record Keeping" and discuss the importance of taking a risk assessment and management approach to nursing documentation. They refer to the document: *"Record keeping: Guidance for nurses and midwives"* (Nursing and Midwifery Council, 2009) which was last published in 2009 and was not reissued when the NMC updated *"The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates"* in 2015 and 2018 (Nursing and Midwifery Council, 2018).

These later versions of "The Code" (Nursing and Midwifery Council, 2018) include more generic guidance in relation to documentation. This is referenced by Andrews & St Aubyn (2015) as they encourage nurses to document their interactions with their patients as effectively as they verbally report them. The authors recommend that nurses address each professional standard of the NMC in their documentation and provide examples of how to achieve this. Thus, the need to take "a systematic, accurate and succinct approach to record-keeping" (p. 22) is emphasised.

The advice offered by authors is sometimes discussed in relation to specific disciplines of nursing. For example, Pirie (2011) describes the legal implications of record keeping, the advice of the Nursing and Midwifery Council (2009) and common errors in perioperative practice documentation. Other authors provide advice for more general practice environments, although they may include quite specific recommendations for record keeping (Creed, 2017; Frank-Stromborg et al., 2001; Prideaux, 2011; Reamer, 2005). In an opinion piece titled "Medical records for general practice nurses", Creed (2017) discusses the

definition of a medical record, the benefits of keeping thorough healthcare documentation and what constitutes a "good clinical record". A concise list of documentation features is provided for the reader, along with a risk management focus, and an explanation of nursing professional responsibilities in relation to record keeping.

Medico-legal considerations

Internationally, legal parameters are also a common focus to guide health professionals in relation to the recording of their care provision (Campos, 2010; Dimond, 2005; Griffith, 2004, 2016). Authors may offer very specific advice regarding medico-legal considerations (Dimond, 2005) or may take a broader, more generalised approach, integrated with examples of specific documentation practices (Campos, 2010; Griffith, 2004, 2016). Campos (2010) discusses legal requirements for nursing documentation as defined by federal and state laws in the United States and addresses the potential for litigation. Further, Campos encourages health professionals to consider the possible "audiences" they are writing for. In particular, the following potential readers are identified:

- The healthcare team
- The scribe
- Lawyers and experts
- The judge and jury

Of interest, this list of potential observers of the nursing record does not include the recipient of care. It is possible that their inclusion might influence the advice for the content of documentation. As it is, examples of optimal documentation approaches are identified by Campos, with emphasis on completeness and accuracy.

General advice for record keeping

Some authors provide generalised advice for record keeping. This is often formulated with a brief overview of the purpose of documentation and the importance of keeping accurate records, alongside some basic examples of priorities for achieving this. Common themes identified are the need for records to be accurate, clear (Forrester, 2011; Griffith, 2004), consistent, and accessible (Pirie, 2011); legible and unambiguous (Dimond, 2005; Griffith, 2004); contemporaneous and factual (Forrester, 2011; Griffith, 2016). Whilst also providing broad advice, Doncliff (2015) offers the only article by a New Zealand author, explaining the need for nursing notes to be legible, understandable, applicable and reliable.

The support of students to develop appropriate documentation practices is addressed by Price (2006) who emphasises accuracy, clarity, accessibility and consistency in record keeping. He suggests students ask themselves three questions to help focus their approach to a documentation entry:

1. "What is the purpose of my record?"
2. "Who will read this record?"
3. "How will others judge the merit of this record?" (p. 2)

These suggestions for those recording clinical practice, while useful, tend to focus on self-protection strategies. Whilst some are directive and concise, they generally do not offer an original perspective on the topic. Additionally, the advice provided varies widely. Authors rarely address the same requirements and advice, and usually do not identify evidence for the perspective they present. Therefore, the reader is left to interpret the detail and relevance of the advice, and the optimal approach to documentation, for themselves.

Documentation as evidence of quality midwifery care

Devane et al. (2019) do not directly address documentation in their Delphi exploration of priority midwifery care metrics. Their focus, instead, is on the definition of metrics representing quality midwifery care. However, the way in which they analyse the extent to which these metrics are present in midwifery care, is via midwifery documentation. Therefore, it might be argued that they have identified what needs to be visible in midwifery documentation, to effectively represent the quality of the care provided. Indeed, they state "To determine…the quality of midwifery care, and in particular midwives' contribution to the safety of women and their infants, requires midwives to be able to clearly articulate…what it is that they do" (p. 2).

This four-phase study was conducted in Ireland, commencing with a systematic review of relevant literature which revealed 22 midwifery care metrics and 124 associated indicators. The metrics were then prioritised by participants in the second phase of the project, a two-round Delphi process. This same process was undertaken with the indicators in the third phase of the study. The fourth phase of the process involved "a face-to-face meeting with key stakeholders (midwives)" (p. 6) and the outcome of the staged research process was the identification of 18 midwifery care metrics and 93 associated care indicators. An example of the quality care metrics identified is "Intrapartum fetal wellbeing" and a related indicator is "When using intermittent auscultation, the fetal heart rate is recorded at least every 15 min in the 1st stage of labour and at least every 5 min in the 2nd stage of labour" (p. 7). The focus on midwifery documentation of the care provided is evident throughout. The authors conclude: "Knowing what midwives do, and how they do it, is a fundamental component to achieving high quality maternity care" (p. 9).

In constructing their research project, Devane et al. (2019) accessed a large number of midwife participants from a range of practice settings across Ireland,

and with varied midwifery roles, with the express purpose of effectively representing the profession. The research process appears to have been thorough and rigorous. However, there is no overt acknowledgment that relying on documentation to establish the quality of care may be problematic. There is the potential that the care documented may not have been delivered, and also that the care delivered may not have been documented (Adamsen & Tewes, 2000; De Marinis et al., 2010; Jefferies et al., 2011).

The essential qualities of documentation

The sole research article with an explicit aim of studying essential considerations for healthcare records, identified in this literature search, was authored by Jefferies et al. (2010). This project was part of a research series with a focus on midwifery and nursing documentation in the Australian context. It provided a meta-synthesis of the literature relating to nursing documentation, addressing the research question: "What are the main aspects (principles) of quality (accurate, concise, relevant) nursing documentation of patient care?" (p. 114). The authors relate the relevance of this exploration to the importance of documentation as a component of nursing care. They emphasise the need to define quality record keeping practices as preparation for the widespread use of electronic health records. The power of written communication as a permanent record of nursing knowledge is also acknowledged and discussed.

The initial literature search undertaken in the study of Jefferies et al. (2010) exposed diversity of opinion about the essential aspects of documentation. The authors concluded that institutional policies to guide practice were primarily focussed on legal considerations in record keeping and did not offer nurses guidance in relation to appropriate documentation content. This focus on medico-legal concerns, and lack of direction for practice, prompted Jefferies et al. to raise the concern that nurses may come to view documentation as a legal

defence exercise rather than a relevant record of patient care (Jefferies et al., 2010).

The literature selected for the meta-synthesis consisted of 28 studies, from which arose seven themes, representing the essential aspects of nursing documentation:

- Theme 1: Nursing documentation should be patient centred
- Theme 2: Nursing documentation must contain the actual work of nurses including education and psychosocial support
- Theme 3: Nursing documentation is written to reflect the objective clinical judgement of the nurse
- Theme 4: Nursing documentation must be presented in a logical and sequential manner
- Theme 5: Nursing documentation should be written as events occur
- Theme 6: Nursing documentation should record variances in care
- Theme 7: Nursing documentation should fulfil legal requirements

This study by Jefferies et al. (2010) offers an interesting perspective on documentation, using a consensus-seeking approach. However, there are a number of considerations when considering the results. The process by which the key findings were synthesised, and the review team reached consensus, was not detailed in the published description of the research method. Additionally, this study relied on the inclusion of retrospective audits of documentation. These have been excluded from the current literature review because the process by which retrospective audits define quality documentation, is often not clarified.

Conclusion

In summary, the literature addressing appropriate content of midwifery documentation proves to be limited. However, the themes discussed, with the support of literature from other health fields, can extend our understanding of the context of midwifery record keeping and relevant considerations which relate to, and may impact, midwifery documentation. The dearth of specifically relevant literature lends weight to the need to develop a body of midwifery knowledge about the most effective approach to documentation of midwifery practice, and "What content should be included in midwifery documentation in order to effectively represent the care provided."

Chapter Three: Theoretical framework, methodology and method

Chapters One and Two have provided the background and context for this project and led to development of the research question *"What content should be included in midwifery documentation to effectively represent the care provided?"*.

The preceding literature review has identified the scarcity of evidence for the appropriate documentation of midwifery practice. This study is, therefore, undertaken in the hope of contributing to a foundation for practice in this area. The absence of literature to guide the direction and development of the project necessitates a research approach which will explore the topic at a fundamental level.

This third chapter will address the research design by discussing and describing the philosophical considerations, methodological framework, and the detail of the research method employed.

Philosophical considerations and theoretical framework

The exploration of a practice area which currently has little evidence as a foundation, lends itself well to a qualitative research design (Smith et al., 2011). It is difficult to propose, and test, a specific hypothesis about a phenomenon when there is little literature to guide the development of that hypothesis. In this situation, a researcher may choose to propose a broad question of interest for inductive inquiry, rather than beginning with a hypothesis for testing (Whitley & Crawford, 2005).

Having identified a qualitative approach as appropriate for the research question of focus, it is necessary to decide what type of qualitative study to undertake and what an appropriate theoretical perspective might be. This may be determined by the research priorities and philosophical perspective of the researcher (Anfara, 2008), or these decisions may be complex, as there are such

diverse approaches to qualitative research. Even the extent to which a theoretical framework is required for a qualitative study is the subject of significant debate (Collins & Stockton, 2018; Smith et al., 2011).

A specific theoretical perspective can be used to focus the research process, and the data analysis and description (Anfara, 2008). It may assist to articulate the values, assumptions, and priorities of the researcher (Collins & Stockton, 2018). In qualitative healthcare research, the alignment with philosophical and theoretical traditions of other disciplines may provide a useful framework within which to design and explore the topic. Historically, this alignment may also have helped legitimise the move away from a quantitative approach and clarified the difference between qualitative inquiry and quantitative description (Thorne et al., 1997).

Some authors argue that the absence of a solid theoretical basis to a qualitative study will undermine the robustness of the methodological process and potentially impact the validity of the research (Smith et al., 2011). Others assert that inductive research may specifically aim to move from data to theory (Whitley & Crawford, 2005), taking a truly exploratory approach (Collins & Stockton, 2018), and therefore a generic descriptive study design unencumbered by the constraints of pre-determined philosophy and theory is legitimate for qualitative research in some situations (Carter & Little, 2007; Kim et al., 2018). Indeed, Smith et al. (2011) caution that domination of focus in qualitative inquiry by epistemological and ontological perspectives may detract from the research discussion centring on the research question, the data, and the transparency of the data analysis.

Anfara (2008) also discusses the potential for previously developed and defined ideology to dominate the emerging data. Application of a specific theoretical framework may disguise aspects of the phenomenon of interest as it potentially acts as a data filter and may diminish the complexity of the topic (Anfara, 2008). Researchers may also find themselves with an ill-fitting relationship between

their data and the theory they have chosen to inform, focus, and structure their research (Smith et al., 2011). This has the potential to result in what Sandelowski & Barroso (2002, p. 218) refer to as "Conceptual confusion and drift".

Descriptive qualitative studies may be less subject to these complexities as they are considered less theoretical than other qualitative research designs (Neergaard et al., 2009). A generic descriptive approach is based in the general principles of naturalistic inquiry (Kim et al., 2018; Neergaard et al., 2009; Sandelowski, 2000) and Sandelowski (2000, p. 337) tells us "that researchers conducting such studies are the least encumbered by pre-existing theoretical and philosophical commitments". However, no research project will be entirely atheoretical (Collins & Stockton, 2018; Sandelowski, 2010). The very process of conducting inquiry necessitates that interpretation of the data is undertaken in order to describe it. This includes the author's choice to select the aspects of the data which are included in the analysis and the presentation of results. "Descriptions always depend on the perceptions, inclinations, sensitivities and sensibilities of the describer" (Sandelowski, 2000, p. 335).

In a qualitative descriptive study, the researcher stays close to the surface of the data, rather than delving deeply into interpretation of it. That is, they take a low-inference approach and the data is presented in a similar way to that in which the participants shared their knowledge (Neergaard et al., 2009). 'Thick description' and transformation of the data is not undertaken (Sandelowski, 2010) and the participants own language is considered informative in, and of, itself. Thus, the knowledge gained can form a foundation for more interpretive research (Sandelowski, 2000).

Where previous investigation of a healthcare topic is lacking, there is opportunity to use qualitative description of existing practice experience and knowledge to inform development of evidence to support and advance practice. Indeed, Thorne et al. (1997, p. 173) argue that it is important to

acknowledge the existing "body of clinical knowledge that may have equal value" to that of formal study and investigation. Leeman & Sandelowski (2012) discuss the value of developing what is known as practice-based evidence. They emphasise the effectiveness of qualitative inquiry into the clinical knowledge, experience, and practice of healthcare professionals for development of context-appropriate knowledge and practice advancements.

A Delphi research process

A Delphi methodology provides an effective vehicle to explore expert opinion, knowledge and experience of a practice area of interest. A Delphi process uses an iterative surveying of this expert opinion to achieve consensus (or identify lack of consensus) about a topic (Walker et al., 2015). This approach is often used where there is a minimal body of evidence to support understanding of a particular subject of interest (Christie & Barela, 2005; Iqbal & Pipon-Young, 2009; Pollard et al., 2013). The theory is that expert opinion can inform a foundation of understanding about the topic, and that this may be used to develop a model for practice, or support the direction of future research (Kennedy, 2004).

In ancient Greece it was considered that the centre of the world was located in Delphi, where the oracle Pythia spoke the word of Apollo and foretold the future (Theodoropoulou & Karagianni, 2013). In reference to this ability to predict future events, the RAND Corporation called their 1950s research, exploring the use of expert opinion to forecast the likelihood of particular military outcomes, "Project DELPHI". The RAND Corporation is a United States federally funded, not-for-profit organisation which undertakes research and analysis with a focus on improving policy and decision making (RAND Corporation, n.d.). Dalkey & Helmer (1963) explain that the original purpose of the Delphi methodological approach was "to obtain the most reliable consensus

of opinion of a group of experts… by a series of intensive questionnaires interspersed with controlled opinion feedback" (p. 458).

Over the years the Delphi methodology has become a popular technique for the exploration of practice, and the development of consensus statements, in many healthcare fields, including midwifery (Kennedy, 2004; Pincombe et al., 2007; Pollard et al., 2013). Using an anonymous, iterative process, the opinions of the participants are sought until consensus is evident, or new data is no longer emerging (Kennedy et al., 2015; Wu et al., 2012). One of the recognised advantages of this approach is the contribution of a range of individuals, without the potential for a specific participant (or specific participants) to assert a dominating presence in the development of consensus (Keeney et al., 2006; Kennedy, 1999). Participants can feel confident in their anonymity within the group and are free to contribute honestly and openly (Kennedy, 1999; Pincombe et al., 2007), reducing the potential impact of group process on consensus creation (Birko et al., 2015; Hsu & Sandford, 2007). They also have the opportunity to develop and adapt their opinions about the topic during the iterative rounds of questioning (Kennedy, 2004). Physical location does not hinder the ability of participants to contribute and, therefore, there is potential for wide representation of the profession and a more robust outcome (Pollard et al., 2013).

In a traditional Delphi study, the participants are presented with one, or several, broad open-ended questions which they answer, either as a survey or as a focus group. The responses are then analysed, and a series of statements arising from the participant contributions are identified. These form the basis of the next round of questions which are presented to the participants, usually in survey form. The respondents then indicate whether they agree with these statements, and iterative surveying continues until the participants reach the level of consensus pre-determined by the researcher/s or there is stability of response.

At each round of questioning, in this classic Delphi approach, the participants are reminded of their previous responses, and the responses of the entire group are also identified, to support movement towards consensus. However, literature discussing the Delphi methodology, does not define the level of agreement required to constitute consensus (Pincombe et al., 2007) and a number of authors suggest this may undermine the rigour of the methodology (Diamond et al., 2014; Powell, 2003). Predetermination of the appropriate level of consensus required for completion of the study is considered to strengthen the design of a Delphi project (Keeney et al., 2006; Pincombe et al., 2007).

Many modern Delphi studies diverge from the traditional approach in some way and are, therefore, known as modified Delphi research (Hasson et al., 2000). Whilst these modified approaches vary considerably, the common characteristic remains the use of survey of expert opinion to explore the research question. This flexibility in methodology is seen as a potential advantage of Delphi research. However, departure from the traditional Delphi approach has been criticised by some authors, as there is no strict format as to how a researcher might proceed with the methodological modification (Beech, 2001; Hasson & Keeney, 2011; Keeney et al., 2006). Variations in Delphi studies make it difficult to generalise a description of the standard Delphi approach, and lead to discussion about the classification of the methodology as qualitative or quantitative (Hasson & Keeney, 2011; Sekayi & Kennedy, 2017). In some arenas it is considered a mixed methods approach (Bourgeois et al., 2006; Fletcher & Marchildon, 2014).

Generally, the qualitative or quantitative nature of a Delphi study will be determined by the way in which the data is gathered, analysed, and presented (Sekayi & Kennedy, 2017), and this will vary depending on the context and aim of the research, and the resulting modifications to the methodology.

Method

In this study, a modified Delphi methodology was the over-arching framework informing the data collection process, complemented by a qualitative descriptive approach contributing to data analysis and presentation.

Cultural considerations

Research undertaken in Aotearoa New Zealand must always be designed with consideration for the potential impact of the study for our tangata whenua and the way in which the research process or outcome might be of interest to Māori (Hudson et al., 2010). Aotearoa New Zealand is founded upon the principles of Te Tiriti o Waitangi (the Treaty of Waitangi), which directs our understanding of our individual and societal responsibility to Māori as tangata whenua (Came, 2013). The principles of Te Tiriti address the rights of Māori to be self-determining and to be supported to achieve equity in all aspects of life. Through a process of careful consultation, researchers can ensure their proposed exploration will reflect the principles of Te Tiriti (Hudson & Russell, 2009), and be guided to an appropriate research approach which will address potential issues of inequity.

In this project, the primary consideration relating to tangata whenua was the importance of ensuring Māori midwife representation within the participant pool. The essence of this consideration was to ensure the Māori voice was heard and that priorities of Māori would be represented within the data.

Ethical considerations

Aotearoa New Zealand has a population of approximately 3000 practising midwives (Midwifery Council of New Zealand, 2019) and, therefore, the small pool of potential participants was the primary ethical consideration identified in the ethics application. The possibility of power imbalance in the

researcher/participant relationship, given this reasonably small midwifery workforce, and the fact that the identity of the participants was known to the researcher, was acknowledged. The potential impact of this was addressed by the methodological modifications made to the study design, which departed from the traditional Delphi approach in order that participants could be reassured that their individual responses to the surveys were not able to be identified. Responses to the survey could not be traced to individual participants as a generic survey link was provided. In this way participant anonymity was assured. This said, the content shared by the respondents within the surveys was not likely to be of a sensitive nature and was unlikely to create distress for the participants. The process of obtaining consent is described below.

Participants and recruitment

In order to undertake Delphi research, it is necessary to initially provide a definition of "expert" so that appropriate participants can be recruited. Hasson et al. (2000) tell us that "Controversial debate rages over the use of the term `expert' and how to identify adequately a professional as an expert." (p1010). There appears to be general agreement, however, that this definition will vary depending on the context of the study (Day & Bobeva, 2005; Keeney et al., 2006; Kennedy, 1999, 2004). Kennedy (2004) asserts that "the key is to describe the panellists fully so that judgment can be made about their credibility" (p. 505).

For the purpose of this inquiry, an expert was defined as a midwife who holds a current annual practising certificate and has a minimum of 10 years post-registration midwifery practice experience.

The ethics application for this research was submitted to the Otago Polytechnic Ethics Committee, with approval and support from the Kaitohutohu (Māori advisory) office. Communication with the Kaitohutohu office is included as

Appendix One. Support for the project was provided with no revisions to the initial proposal necessary.

Once ethics approval was granted (see Appendix Two), a research assistant was employed to act as an intermediary for the recruitment of participants. The intermediary signed a confidentiality agreement and then, using purposive and snowball sampling, she identified midwives who might meet the project definition of expert. These potential participants were given the study information sheet (provided as Appendix Three), which included details of how to contact the researcher, if they agreed to participate. The midwives approached were encouraged to share the study details with colleagues. Recruitment took place during March and April 2018 and a total of 34 participants who met the study definition of "expert" agreed to participate.

Each participant was provided with a consent form (see Appendix Four) which detailed the right to discontinue participation at any time and clarified the anonymity of the data collection process. Participants were made aware that data could not be withdrawn once it had been collected, because of the anonymous data collection process. The consent forms were stored securely by the researcher, each one individually password protected, and saved in a password protected computer file.

While there is no clear guidance for researchers regarding the ideal number of experts to be included as participants in a Delphi study (Hsu & Sandford, 2007; Jorm, 2015) this decision is often based on logistical considerations and the accessibility of participants (Keeney et al., 2006; Powell, 2003). Further, Hsu & Sandford (2007) discuss the relevant number of participants for a Delphi process and suggest that this is related to the homogeneity of the population of interest. Too many participants may create procedural issues (low response rates etc) and too few may not be representative of the population of interest. While Delphi studies have been reported using as few as 7 experts and as many

as a 1000, Iqbal & Pipon-Young (2009)suggest a reasonable number of participants is between 10 and 50.

Data collection

Each survey iteration was pre-tested by two volunteers who were midwives but did not meet the definition of expert and were unable to participate in the study. These midwives provided feedback about the structure of the survey and the comprehensibility of the questions.

The initial survey distributed to participants consisted of a series of demographic questions and then a single, broad, open-ended research question, based on the identified topic of interest. Participants were asked:

With a focus on the content (rather than the legal aspects) of midwifery documentation, please carefully consider and answer the following question: *What do you think should be included in your midwifery documentation to effectively represent the care you have provided?*

On review of the responses to this initial survey, the researcher determined that she had not received sufficiently detailed information to provide a platform for thematic analysis. Therefore, some specific questions and some broad, open ended questions were asked in the second survey (included as Appendix Five). Once responses to the second survey were received, thematic analysis was undertaken (as described below). The resulting statements were then incorporated into a third survey (see Appendix Six).

Due to the use of a modified Delphi approach, with the purpose of preserving the anonymity of the participants, the respondents could not receive feedback on their previous survey responses. This removed the "controlled feedback" component of the classic Delphi approach in which each participant has the opportunity to review their previous responses and compare these to the responses of the entire participant group. Therefore, in Surveys Two and Three,

the participant responses reflected their current opinion about the questions asked of them, or the statements presented to them.

Survey construction

In Surveys Two and Three Likert scales were used for participants to rate their agreement (or not) with a series of statements derived from the previous iteration/s of the survey.

The Likert scale design used was reasonably traditional in structure, including the following scale points:

- Agree
- Somewhat agree
- Neither agree nor disagree
- Somewhat disagree
- Disagree

The ideal number of scale points, and the use of a neutral middle point, are aspects of Likert scale construction that are debated in the literature (Joshi et al., 2015; Nadler et al., 2015). Some authors advocate for as few scale points as possible to reduce the potential for confusion of respondents. Others state that this limits the option for participants to demonstrate subtlety of opinion (Decastellarnau, 2018). There is evidence that 5-scale point surveys result in better consistency of response than surveys with more points (Revilla et al., 2014; Weijters et al., 2010), and this evidence prompted the use of 5-point scales in the current project.

The inclusion of a neutral mid-point might be seen to allow respondents to offer what they believe is a socially desirable answer, or to be effected by central tendency bias (Douven, 2018; Nadler et al., 2015). However, it has been suggested that the neutral option avoids a "forced" response which might not

represent a true opinion. When participants without a strong opinion are required to commit to a positive or negative response, they are more likely to select the negative option (Weijters et al., 2010). For this reason, a neutral mid-point was included.

Survey Two also included a series of open-ended questions to strengthen the pool of data collected in Survey One. The responses to these open-ended questions from both surveys were then used for thematic analysis in the development of the consensus-seeking statements in Survey Three, as described below.

Data analysis

Thematic analysis of the participant responses to the second survey, combined with responses to the first survey, led to the development of a series of statements which were presented to participants in the third survey. The survey questions included in Survey Two and the consensus-seeking statements presented in Survey Three, can be found as Appendices Four and Five.

The thematic analysis was undertaken using the method described by Virginia Braun and Victoria Clarke (Braun & Clarke, 2006; Clarke & Braun, 2013). The researcher immerses themself in the data, becoming deeply familiar with it and then each line of data is explored, and coded. The coded data is then compared and contrasted to identify commonalities – known as "themes". Themes were derived from the dataset where two separate participants had identified a particular concept as relevant, in either Survey One or Survey Two. As responses to the surveys were anonymously submitted, it was not possible to know whether the same participant had identified a topic in both surveys. Therefore, if the concept was discussed by two respondents within a survey it was considered to be a theme.

Themes were reviewed by the researcher's supervisors to enhance reliability and consistency of the analysis. Where opinions initially differed about the categorisation of the themes, further discussion took place until consensus was achieved.

For the purpose of this study, these themes formed the basis of the consensus-seeking statements presented to participants in Survey Three. The themes fell into three identifiable categories – the procedural aspects of documentation, the style of documentation and the content of documentation. The original purpose of the study was to explore the content of documentation, but the participants clearly identified in their responses that these other considerations were extremely important, and perhaps could not be separated from the presentation of the content of the documentation. Therefore, it was deemed important to continue to include them. It also seemed logical to provide some structural advice to midwives about their documentation.

As previously discussed, there is no agreed level of consensus prescribed for researchers undertaking Delphi research (Powell, 2003; Walker et al., 2015). The researcher can decide the degree of consensus they believe is appropriate. Predetermining this consensus level, prior to analysing results, is considered to strengthen the methodology (Keeney et al., 2006). Diamond et al. (2014) found that 75% was the median percentage agreement required in the studies they reviewed, and Keeney et al. (2006) provide a convincing argument that 75% should be the minimum level accepted. These authors do acknowledge, however, that "there is no obvious scientific rationale for this" (p. 210).

Having reviewed the diverse literature addressing appropriate consensus levels in Delphi research, it was decided that the predetermined level of consensus in this study would be 80%. If 80% of participants agreed with a statement (choosing "agree" or "somewhat agree" on the rating scale), consensus was seen to have been reached. Once this level of consensus was reached for more

than 80% of the individual statements, no further iterations of the survey were required.

Following the data collection of the third iteration of the survey, thematic analysis was also employed to identify themes in the participant commentary. The purpose of this process was to represent participant opinion without transforming the data. This low-inference descriptive approach is used to present the perspective of the experts with minimal interpretation (Vaismoradi et al., 2013).

Conclusion

This chapter has explored philosophical considerations impacting the choice of methodological framework for this study. The specific research design has been detailed, along with methodological considerations which have influenced this design. A descriptive qualitative approach has been discussed as an appropriate method for representing the data elicited by the modified Delphi methodology. The process of survey development and thematic analysis of the data has been presented.

The next chapter will explore the findings arising from this modified Delphi exploration of expert opinion regarding the effective representation of midwifery care in documentation.

Chapter Four: Findings

The data resulting from the generous contributions of the survey participants, and the themes and sub-themes arising from the thematic analysis applied to it, will be presented in this chapter. A summary of the findings from the surveys is provided, along with selected quotes from the participant responses, which expand our understanding of the data. This commentary is presented faithfully to represent the opinions of the participants and to highlight the considerations they identified as priorities in relation to midwifery documentation. These priorities clarify the complex myriad of factors which impact on the documentation of midwifery practice and which need to be considered in relation to the effective representation of midwifery care in the maternity record.

Survey One

The initial survey in this project comprised of 2 sections. The first section addressed the demographic characteristics of the participants and the second section asked the participants to respond to the research question.

Section 1: Demographics

Self-identified ethnicity

The respondents self-categorised their ethnicity. Twenty (approximately 58%) of the participants identified as "NZ European/Pakeha" and three (9%) as "NZ European/Maori". One (3%) responded "American", one (3%) responded "Chinese", and two (6%) responded "European" with no further explanation. One participant (3%) identified as each of the following categories: "NZ Euro British", "NZ European Irish", "Kiwi/Scot" and "New Zealander/English". One respondent (3%) also self-identified as "British", one (3%) as "All" and another (3%) listed a range of ethnicities (10+, including Māori and Pacific Island).

Years of experience

The number of years of midwifery experience that the participants identified, at the time of the first survey, ranged from 10-43 years, with a median of 22.5 and an interquartile range of 13.5 years.

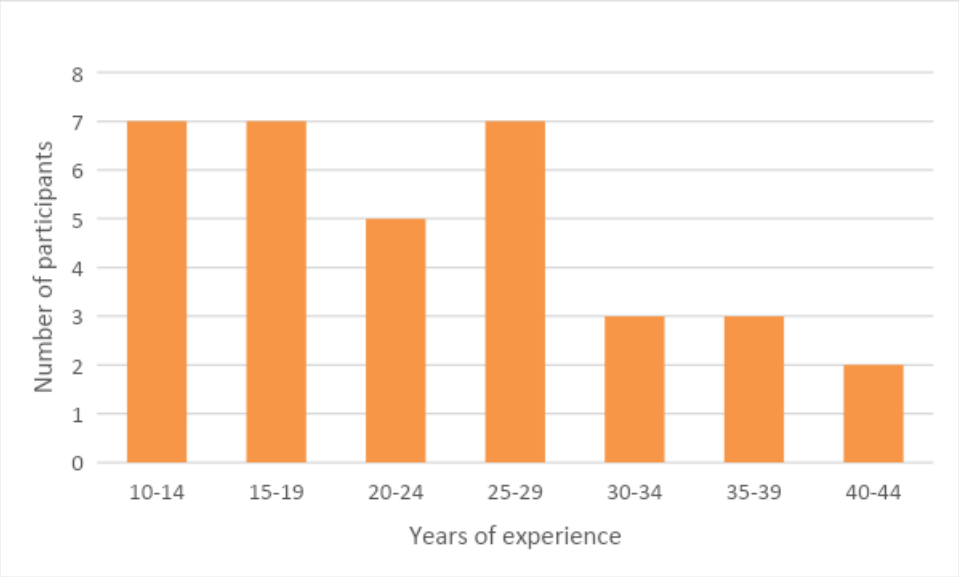

Figure 2: Participant's years of midwifery practice experience

Current role in midwifery

The participants self-identified their role in midwifery with eleven (32%) of them identifying they had more than one midwifery role. The majority were core (hospital employed, shift-working) midwives, and eleven (32%) (including clinical coordinators) identified this as their only work role classification. Of the participants who had multiple roles, six (approximately 18% of total participants) of these also listed some work as a core midwife. Eleven (32%) midwives reported work as a community (or LMC) midwife, but only four (12% of the total respondents) identified this as their only midwifery role. There were eleven (32%) responses from midwifery educators, and only four (12% of the total respondents) of these did not include reference to other roles.

Location

Participants were located in both the North and South Islands, with the majority based in the North Island. Sixteen (47%) identified their location as

Wellington (Capital Coast DHB) or the Hutt Valley, one (3%) lived in the Nelson Marlborough catchment area and one (3%) in the Waikato. Two participants (6%) identified their location as each of the following areas: Hawke's Bay, Otago, Taranaki, the Wairarapa, Auckland and Mid Central. Two participants (6%) identified that they practised in more than one region and the domicile of two could not be identified due to the description provided by the participant.

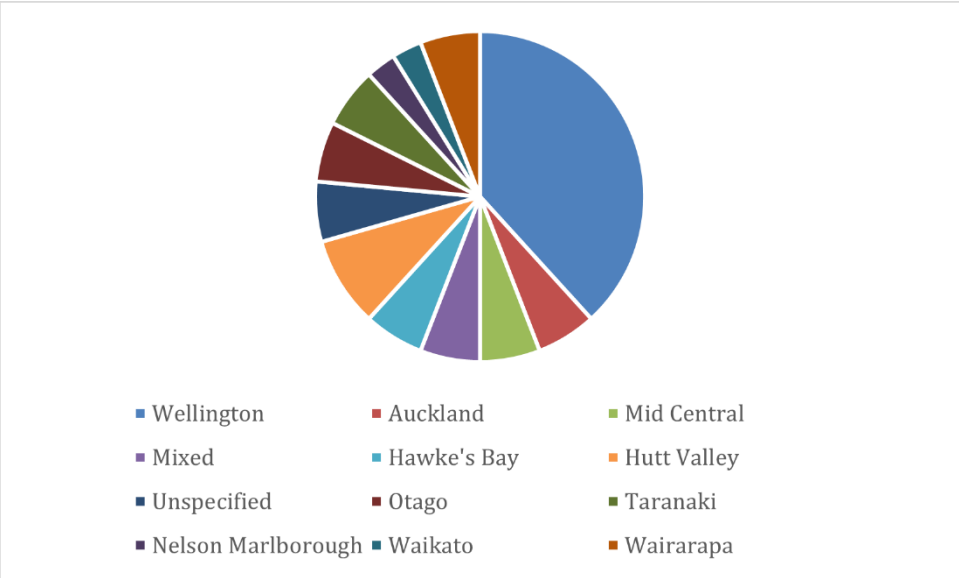

Figure 3: Location of participants

Section 2: Responses to the open-ended research question

Of the 34 participants who completed the survey, 32 answered the single open-ended research question: "With a focus on the content (rather than the legal aspects) of midwifery documentation, please carefully consider and answer the following question: *What do you think should be included in your midwifery documentation to effectively represent the care you have provided?"*

The length of the participant responses varied from 13 to 1188 words. Many participants provided brief responses, which did not allow for detailed thematic analysis to be undertaken. More specific questions were developed from these

responses and these formed the basis of the second survey (as described in Chapter Three).

The rich commentary provided by the participants is included below in the presentation of quotes from the responses to all three surveys. Quotes from Survey One are labelled "S1".

Survey Two

Survey Two questions are provided as Appendix Five.

Thematic analysis

Once the second survey was completed, thematic analysis of the responses to both Surveys One and Two was undertaken (see Chapter Three) and the resulting themes formed the basis of the Survey Three consensus-seeking statements.

While the original open-ended research question requested the participants to focus on the content of their documentation, it became clear during the thematic analysis that other considerations were deemed pertinent by the respondents. Thus, the concepts identified could be grouped into three themes:

- Procedural aspects of documentation
- Stylistic aspects of documentation and
- Content considerations in documentation

The initial coding of concepts within the participant responses revealed varied levels of detail. Some aspects of documentation identified as relevant by the participants were very specific, particularly those relating to procedural and stylistic aspects of documentation; while others were broader, particularly those relating to the content of the documentation. The broad concepts were, therefore, identified as sub-themes, while the specific concepts were identified

as documentation characteristics. Each consideration (sub-theme or characteristic) was maintained as it had been identified in the thematic analysis. This approach was intended to preserve the consistency of the data reporting and to accurately honour the data as presented by the participants. A total of 55 characteristics and subthemes emerged:

Table 1: Sub-themes and documentation characteristics arising from thematic analysis of the data

Theme 1: Procedural aspects of midwifery documentation	
Sub-themes:	
1	Documentation of every interaction (also represented in content question section)
2	Those present (separated into health professionals and support people)
3	Woman should hold and/or contribute to notes
4	Management of sensitive information
5	Temporary recording
6	Retrospective notes (also represented in style and content question sections)
7	Frequency of documentation
Documentation characteristics:	
8	Legibility
9	Page numbering
10	Signature and printed name
11	Designation of writer
12	Role of the writer in the woman's care
13	Woman co-signs documentation
14	Date and time of episode of care

15	Location of care
16	Gestation or number of days postpartum
17	Identifier on each page

Theme 2: Style of midwifery documentation

Sub-themes:	
18	Clarity and conciseness
19	Conversational style
20	Use of assessment summary records
21	Written differently for different locations (electronic record for example)
22	Written for anyone who may access it, including the woman
23	Individually personalised
24	Avoidance of duplication of information documented

Documentation characteristics:	
25	Use of abbreviations
26	Use of bullet points
27	Use of tick or check lists
28	Use of tools such as stickers

Theme 3: Content of midwifery documentation

Sub-themes:	
29	Context of care environment
30	Decisions made by the woman
31	The woman's perception/perspective/priorities

32	The woman’s understanding
33	Holistic nature of midwifery assessments
34	Midwife's interpretation of events
35	Woman's broader context (relevant information and recent pregnancy events included)
36	General wellbeing of the woman
37	Plan of care
38	Support offered to the woman
39	Information sharing (woman and midwife) and discussion
40	Rationale
41	Resources provided
42	Advice given/recommendations made
43	Full clinical assessment of mother and fetus (if applicable) or baby
44	Follow up
45	Communication with other health professionals
46	Findings of clinical assessment
47	Woman visible
48	Interventions/treatments offered
49	Actions arising from the assessment

Documentation characteristics:	
50	Reason for the episode of care
51	Appointment scheduling
52	Referrals
53	Consent

54	Prescriptions
55	How/when to make contact and who to contact

In the construction of Survey Three, at least one question was asked about each of the characteristics and subthemes to adequately explore participant opinion. This resulted in a total of 81 individual consensus-seeking statements, and six questions which had a number of consensus-seeking options associated with them.

Participants also contributed commentary about midwifery documentation practices, in their responses to Survey Two. These insights are included below in the presentation of quotes from the responses to all three surveys. Quotes from Survey Two are labelled "S2".

Survey Three

Survey Three questions are provided as Appendix Six.

Participant responses to each consensus-seeking question in Survey Three are presented below, categorised by the three themes arising from the thematic analysis of data from Surveys One and Two. The entire list of statements for which consensus was achieved are presented as Appendix Seven.

The commentary provided by the participants in all three surveys further clarified their perspectives about relevant considerations for midwifery record keeping. Their responses resulted in 666 individual units of text and, ultimately, elicited 70 statements of consensus in relation to the recording of midwifery care. The participant opinions verify that there is much to consider in midwifery documentation when determining what, and how, midwives should represent their care in a written format. The rich description was not able to be captured solely through the statements of consensus; thus, a summary of the

commentary is presented below. This is broadly aligned with the themes arising from the thematic analysis of the participant responses to Surveys One and Two. However, the quotes have been grouped according to relevant content rather than specifically related to the procedural or stylistic aspects, or the content, of documentation. Examples of the comments associated with each consideration are provided, rather than a list of every relevant quote. Please also note that the participant responses were collected anonymously and, therefore, it is not possible to conclude whether statements derived from different surveys were made by the same participants.

Procedural aspects of midwifery documentation

Participant contributions reached the pre-determined level of consensus on the following statements:

Table 2: Statements relating to the procedural aspects of midwifery documentation, which reached participant consensus

Procedural aspects of midwifery documentation	
1	Documentation must be legible to all readers
2	Each page of midwifery documentation should be numbered
3	Midwives should sign each entry of documentation
4	Midwives should record their designation on each page of documentation
5	The date should be recorded at the top of each page of midwifery documentation
6	The date should be recorded again if it changes during the sequence of documentation entries (i.e. if midnight passes, or a new midwifery contact is recorded for a different date, but on the same page as a previous contact)
7	The time of writing should be documented at each entry of documentation of ongoing midwifery contact
8	The time of the midwifery contact should be documented for a "routine" episode of antenatal or postnatal care
9	Midwives should document the date and time of their phone conversations with clients

10	The location of care should be recorded for each discrete episode of care
11	The location of care should be recorded for each new location that midwifery contact occurs in continuing documentation of an episode of care (i.e. location does not need to be recorded for an entry if the woman's location has not changed since the last entry during one episode of care)
12	The presence of other health professionals should be recorded, if they are contributing to the decision-making associated with the woman's care, but someone bringing the woman a cup of tea, or changing bed linen (for example) does not need to be recorded
13	Documentation of the presence of whānau/support people is essential when their presence is impacting the care provided or decisions made, but optional otherwise
14	The gestation of the pregnancy should be recorded for each antenatal visit
15	The age of the baby, or the number of days postpartum, should be recorded for each postnatal visit
16	Every woman should be offered a copy of her maternity record (including the antenatal, labour and birth and postnatal records)
17	Each page of midwifery documentation should identify the woman and/or baby about which it is written, by including: The full name of the woman and/or baby
18	Each page of midwifery documentation should identify the woman and/or baby about which it is written, by including: The NHI number of the woman and/or baby

A record shared by the woman or childbearing person and the midwife: Partnership

> **"The notes are about her experience, so belong to her, essentially"**

Different opinions about the extent to which women or childbearing people should participate in, and contribute to, the documentation process were evident in participant responses. One opinion holds that the sharing of the midwifery record enhances the partnership relationship: "*Shared documentation is key to the partnership between midwife and the woman,* [it] *enables her to engage in*

her own care" (Survey Three [S3]). The partnership relationship could be reflected in documentation, making it more visible to the reader: *"Documentation should provide space for women to write in their own records - whether it's just questions to ask the midwife next time, or an opportunity to include her thoughts and ideas and plans into the overall record. It also reflects the nature of her relationship with her midwife by displaying partnership" (S1).*

The role of the midwife might also be more apparent to the woman or childbearing person in a record constructed with, and for, her or them: *"I think all notes should be written with an expectation that the woman will be reading what has been written, so should be respectfully written and include any knowledge she brings about herself. She will have been invited to contribute to her notes also. Social information about her other children's responses to the new baby, and her own emotional well-being etc are important to include so that the woman understands that holistic assessments are being made" (Survey Two [S2]).* Indeed, some participants identified specifically that the ownership of the record lies with the woman or childbearing person: *"The notes are about her experience, so belong to her, essentially" (S3).*

However, the potential for record keeping to undermine partnership was also acknowledged: *"To record all conversations would be physically impossible,* [and would] *negatively affect the relationship with the woman as the conversation would be stilted and awkward" (S2).* One participant emphasised that they did not want record keeping practices to negatively affect the relationship with the woman or childbearing person: *"I want her to feel I have paid her attention, not just writing all the time" (S2).*

In addition, participants identified the concern that: *"…these are professional notes kept by the midwife" (S3)* and *"There may be issues of "concern".* [If written for the woman or childbearing person] *the records can then become a record that is sanitised and not reflective of genuine concerns, this can be detrimental to the care - thinking of neglect, violence, risk of flight, and mental health drug and addiction type*

concerns" (S3). Privacy concerns in the sharing of the maternity record were also raised: *"Sometimes very sensitive information is put into notes and while the woman has reasonable rights to know what we write, sometimes she should not know, i.e., when there is a place of concern over her and the baby. And where family/domestic violence has been disclosed. Much as the women have rights, copies of notes are easily lost and may get into hands that have no business knowing a woman's private details" (S3).*

Logistical considerations were acknowledged by the participants. In response to Survey Three, statement 5b "Every woman should be offered the opportunity to contribute to her maternity record by writing in the record herself", one midwife said: *"in the hospital setting, I cannot see how this would happen, or why it would be of any advantage in the woman's care or experience" (S3).* The potential for the workload of midwives to be affected when women or childbearing people contribute to documentation was identified: *"Women signing each entry will make additional work and may deter staff from making additional entries when working under pressure" (S3).*

The complexity of representing the unique role of the midwife in record keeping was articulated: *"Midwives work with women in a complex way, they spend a lot of time communicating and talking and forming and maintaining relationships. Whilst this is very important to the partnership and the provision of care it is not realistic to expect a midwife to document these" (S2).*

Electronic vs handwritten notes

> **"The way of the future"**

Electronic health records were frequently referred to in participant responses and the possibility that an electronic record might change the relationship between midwives and women or childbearing people and might

affect a woman or childbearing person's involvement in their own care was acknowledged: *"I currently work in an environment in which the notes are electronic, and there is no effort made to involve the woman in her documentation journey. I feel this is a big loss to midwifery partnership and women's ownership of their care" (S3).*

Respondents also identified the difference electronic records made to interaction with women or childbearing people in relation to their maternity records. In reference to whether women or childbearing people should be asked to sign their maternity record, one midwife queried if it *"may be a tad hard with paperless systems?" (S3).*

Advantages of an electronic record were discussed, however. When the record is electronic, one midwife said: *"All parties involved in the women's care are constantly up to date with care, including the women. Far safer. Especially for our non-attenders" (S3).* Additionally, electronic health records were seen by some to create opportunities to represent maternity care in a more timely fashion: *"With maternity records being available by phone now… it is difficult to see how a midwife wouldn't be able to access and record" (S3).*

Participants stipulated that electronic health records are an appropriate future focus with a number of comments identifying these midwives were keen for a national electronic health record to be available as soon as possible: *"I am hoping that we will commence MCIS* [the planned national electronic maternity health record] *in the near future. This is the way of the future and will ensure that documentation is thorough and complete before allowing you to move onto another section. Easy to read and easy to document, especially if there is a system where voice can be recorded and kept" (S2).* Another respondent said that documentation should occur: *"On a national online system that relevant people have access to including the woman. Paper needs to go" (S2).*

“Depending on the setting my documentation varies”

The context of the situation in which the midwife is documenting, as a determinant of appropriate approaches to documentation practice, was the subject of significant commentary. Priorities for record keeping may vary depending on the clinical situation: *“Working in Primary Care I tend to write a story, particularly if* [it is] *a homebirth.* [My documentation will be] *concise & factual if it is an acute situation” (S3).* This was relevant for structural aspects of the record too, and it was interesting how the midwives differentiated requirements in different environments: *“Although I agree with the concept I have to admit that* [while] *the page may be named and numbered; the NHI, DOB may not be detailed, especially at a homebirth. In a hospital situation the necessity for this is very obvious” (S2).*

The respondents identified further how the care location might impact their documentation practices: *“Depending on the setting my documentation varies. In the tertiary unit where I work, all documentation is online, and the women never see their notes. My documentation tends to be bullet points, impersonal, includes lots of the abbreviations that are accepted in my workplace, and reflects a set pattern of tasks completed and plan going forward. When working as a locum* [postnatal midwife] *my documentation is either online or in women held notes, tends to be narrative style and in words that lay-people can understand. It tends to include more discussion of information shared and the women’s voices come through more strongly with choices and opinions documented in the notes” (S1).*

This assumption that women or childbearing people will not be party to online records was repeated elsewhere, with acknowledgment that the format might

affect the woman or childbearing person's experience of the records: *"In woman-held/paper notes I am very careful to use accurate but accessible language/laypersons terms. Clinical notes are in narrative form and labour notes contribute to the woman's own construction of her birth story. In online documentation this is completely lost, my documentation is only viewed by other clinicians. It is full of accepted abbreviations and jargon, usually in bullet points" (S2).*

Documentation of the immediate physical context of care provision was also recognised as being potentially relevant: *"At times location may not be mentioned, but may be relevant if the location is impacting on the logistics of care. Managing a shoulder dystocia in a narrow toilet cubicle will have a different impact than in a spacious room." (S2).* Additionally, broader considerations in the practice environment were referenced. One example was a participant identifying that they would include commentary about: *"Context that may affect care e.g. short staffing, scanning appointment delays" (S1).*

The importance of the autonomy of midwives in relation to midwifery documentation practices, was referred to by a number of participants. In answering the question "When a midwife receives information that may compromise the safety or privacy of the woman, or the safety of the midwife, she should…", one respondent said: *"This presents a complex and challenging situation. Midwives may select the best option for them based on individual circumstances or their assessment at the time" (S3).*

Certainly, the woman or childbearing person's individual personal context was considered relevant for decisions about the appropriate construction of the maternity record: *"occasionally I will keep a separate set of notes e.g., when major mental health or family violence are issues, or when baby is to be uplifted at birth and the woman is not aware of these discussions" (S2).*

Stylistic aspects of midwifery documentation

Participant contributions reached the pre-determined level of consensus on the following statements:

Table 3: Statements relating to the stylistic aspects of midwifery documentation, which reached participant consensus

The style of midwifery documentation	
1	Midwifery documentation should be as clear and concise as possible
2	It is acceptable for midwives to use bullet points to detail information in the maternity record
3	It is acceptable for midwives to use tools such as stickers (for the documentation of CTGs, VEs for example)
4	It is acceptable for midwives to use assessment summary records (e.g. partograms, MEWS charts)
5	For every woman, the maternity record should be written in a way, and using language, that can be understood by all interested parties (including the woman)
6	The retrospective recording of "routine" antenatal and postnatal events should follow the same style as the retrospective recording of acute antenatal and postnatal events and labour and birth events (i.e. the retrospective nature of the record should be identified in the same way for these "routine" episodes of care)
7	It is not necessary for a midwife to document information in more than one location (e.g., in the body of the notes and also on the partogram) unless the result is abnormal and follow up is required

Is documentation by midwives different than that of other health professionals?

"Doctors or other medical health workers would never have this expected [of them]"

Some respondent commentary suggested that midwifery documentation might be viewed or constructed in quite a different way from that of other health

professionals. One participant shared: *"Offering the woman the opportunity to sign her notes is something I believe midwives would encourage. However, I can't see other members of the health care team using this approach, unless it was to waiver liability" (S3).* And another stated *"It would be time consuming to explain the medical language you are asking* [the] *woman to sign. This does not happen in other health encounters that they sign unless* [the document is a] *consent form" (S3).*

Expectations for midwifery documentation were compared to expectations of the documentation completed by other health professionals. Some participants reflected on the concept of having the recipient of care sign each entry made by the midwife. One participant wrote: "*Often my notes contain information that is not for the women to read, but* [for] *colleagues. For example: 'I am concerned about her state of mind',* [or I will describe her] *reaction to a situation etc or my thought processes. Doctors or other medical health workers would never have this expected* [of them]*" (S3).*

These differences were related to the socio-political reality of midwifery practice by one midwife: *"maybe midwives should access devices or have transcribers as the doctors do in surgery to document. This is another example of how midwives are not particularly valued. Doctors would be provided with these services, right?" (S2).*

The timing of midwifery documentation

> **"Technically, every bit of documentation is retrospective!"**

Differences of opinion emerged in relation to the appropriate frequency of documentation, particularly in a shift-work context. Some respondents felt it was important that regular updates were documented, regardless of the situation. In response to the question "During an antenatal or postnatal admission, when the woman and/or baby are stable, it is acceptable for the

midwife to document once per shift, unless there is a change in the woman or baby's wellbeing", one participant said: *"Documentation should not be once a shift but as per care, e.g. pain relief, feeding assistance etc... at the time it happens" (S3).* Whereas others felt that, under some circumstances, less frequent record keeping was reasonable: *"I consider one entry per 4 hours acceptable if all is stable ie x2 entries per 8 hour shift or x2 entries per 12 hour shift" (S3).* Some commentary reinforced a contextual approach: *"Depending on the acuity and how quickly the situation is changing then the documentation can be spaced out" (S2).*

One respondent explored these options in more detail: *"When a woman and baby's care is 'routine' it may seem pointless to document more than once. However, writing more frequently proves contact and there are nuances of care that may retrospectively be important. I don't feel that every contact needs to be recorded if their condition remains stable" (S3).*

When answering the question "How frequently do you recommend a midwife documents the care she is providing in a developing scenario (e.g., labour, an acute antenatal event, or postnatally)?" one respondent replied: *"I don't think you can prescribe a documentation regiment, there is no timeline for events that a woman with her unique physiology will adhere to. Each point of care should ideally be captured as it occurs" (S2).* This perspective was reinforced by another participant, with reference, again, to the autonomy of midwives in their decision-making about appropriate documentation practice: *"I believe that the answer is when the midwife believes it should be done. I do not believe that we should or could put an actual time frame around this. We need to allow midwives to make decisions on an individual basis. Ideally as often as possible without negatively affecting the care and the woman's experience" (S2).*

Participants were asked to give their opinion about retrospective documentation, and the timeframe that might define this. Again, opinion varied widely, but a common theme was the perspective that: *"Technically, every bit of documentation is retrospective!" (S2).* One midwife explained this further:

"Interesting point - how do we define 'retrospectively'? Most documentation of course is retrospective as we do not instantaneously provide care and document. I understand that if there were acute events that delayed the documentation then this would be retrospective, but I believe it is less clear at other times what is retrospective and what is not" (S2).

Time to reflect on events before recording them was not necessarily seen as inappropriate by some participants, as there might be: *"situations where the reflection on a critical event requires time, for maybe support or consultation around the care to assist reflection. Tiredness, stress and access to notes, can at time of event effect the quality of the documentation" (S2).* Perhaps, this time to reflect might even enhance the recording process: *"Writing in retrospect is a way to perhaps add in more information that you had not considered at the time of the initial documentation. So in retrospect* [a midwife] *could cover the aspects that you did not consider were pertinent at the time but now since an event has occurred, they become pertinent so you write these down" (S2).* However, the alternate view expressed was that: *"anything after 15 mins is retrospective. After that you are no longer 'in the moment' so your recall is going to be different to if it is happening as you are documenting" (S2).*

Again, the importance of the individual clinical context was identified in relation to retrospective documentation *"It is impossible to give a time frame, as it is context dependent. What is more important, rather than a time frame, is the reason. For example, 'written in retrospect 30 minutes later because of an emergency and this is what happened'" (S2).*

The need to prioritise the provision of care was emphasised. When asked for a definition of retrospective documentation, one participant said: *"Approximately one hour or at a point when the midwife is able to begin writing the notes following an episode of care when she has been unable to document e.g. the woman birthing or an emergency…the woman's care must take precedence" (S2).* However, another respondent made the point that a lack of documentation might impact the

appropriate provision of care: *"If the woman or baby's condition could be at risk, then* [the midwife should document] *ASAP" (S2).*

Documentation as a communication strategy between health professionals

"promote trust in other health professionals"

Record keeping as a strategy to enhance interprofessional communication, and to protect the woman or childbearing person's experience of their care, was identified as relevant: *"Documentation between* [health professionals] *e.g., referral letters, needs to give the other person a clear picture of why you are referring, what you are seeking a response to, and a good description of the woman's clinical picture. I think this assists with focussing the visit, and hopefully avoids the other practitioner going off on other pathways about the woman's care" (S1).*

It was obvious participants felt a well-constructed record could improve understanding of the woman or childbearing person's individual circumstances, making their priorities visible, and might potentially strengthen the relationship with allied colleagues: *"Plunket nurses* [well child practitioners, providing care for infants after midwifery care has been completed] *should be alerted to special considerations so the transitions of care can keep the woman and baby at the centre of the care, and help to promote trust in other health professionals" (S2).* Likewise, well composed referral communications might facilitate the woman or childbearing person's transition to another service: *"Important background information should be added including some personal information allowing easy beginnings of conversations" (S2).*

Within the midwifery community, clear documentation can enhance the understanding of the woman or childbearing person's needs and promote the

woman or childbearing person's and the midwife's experience of care: *"I work in the DHB and I would like all women to have entries from their midwives in the notes with an updated care plan at point of transfer, as we can't offer continuity of carer but to offer continuity of care it's nice to understand something of the woman, her family and her needs" (S2).*

A focus on collegial communication might support the midwife to structure and compose the documentation appropriately. One midwife shared: *"Best to be comprehensive and accurate but brief - so other* [health professionals] *can find what they need to know" (S2).* And another stated: *"I should be able to tell the story of what happened when reading another midwife's notes" (S2).*

Autonomy of women and childbearing people

> **"The woman should always be in control of her own records"**

The dynamic, responsive nature of the midwifery relationship was identified by participants in relation to record keeping, with reference to the visibility of women and childbearing people's decision-making: *"I think it is so important for the decision of the woman to be documented, and then the midwife's care in relation to this, as it is the woman's decision making that will dictate the care the midwife provides" (S3).*

By focussing documentation on the woman or childbearing person, participants identified, it is possible to: *"reflect the woman's active involvement in decision-making" (S2).* Some respondents felt this was a priority: *"The woman should be highly visible in the narrative so it's not just a series of tests, assessments etc documented without her being visible" (S2).*

One participant shared that they encouraged women and childbearing people to *"document when they have texted or sought clarification/information in regards their*

care. Date/time included" (S2) when they made contact for information or support between midwifery visits. This midwife emphasised the usefulness of woman- or childbearing person-held written records for this purpose. Another comment identified that this approach had the potential to enhance the woman or childbearing person's agency in their care, because it is possible for women and childbearing people to *"take responsibility if they have requested advice, and… document* [the contact] *in their midwifery file" (S2).*

The woman or childbearing person's ownership of the maternity record was identified as a priority by some participants: *"the woman should always be in control of her own records. She should give consent for information shared. Documentation should be transparent, and the woman should carry or at least have a copy of her records" (S2).* Another comment was that: *"Midwifery notes are essentially the woman's notes, these would be shared only with the woman's consent" (S2).*

A number of respondents provided commentary similar to the following: *"*[The] *Woman only needs to sign when there is disagreement" (S3).* This may indicate that the practice of having the woman or childbearing person sign the notes was seen as a defensive strategy, rather than a strategy of collaboration. However, one midwife did demonstrate a different perspective on this, saying *"Midwives should ask or encourage women to sign their documentation to reflect the woman's voice as part of informed consent processes" (S3).* Another midwife also said "*I would do this to ensure that she was aware of the importance of her decision in her and her baby's wellbeing, and to give her the chance to read what I have documented regarding our discussion, and to invite her to participate in my own professional safety if I'm supporting her in an unusual birth choice" (S3).*

The purpose of the midwifery record

> **first and foremost it is a record of the story of this baby's birth**

The purpose of the maternity record was a consideration for participants in their discussion of what is relevant for midwives to include in their documentation: *"Personally, I think when writing this narrative midwives should write it bearing in mind the purposes to which it might be put. By which I mean, first and foremost it is a record of the story of this baby's birth, so for the woman and her family it needs to be worded with encouraging and kind comments, for the potential reviewers it needs to reflect the midwife's decision-making process in concert with the woman (making the woman visible in the decision-making), and reflect why the midwife has chosen to do what she is doing, or why she isn't doing something that may have been recommended" (S1). A*nother comment also specified the possible immediate and future audience as a consideration: *"The whānau/family, partner and baby (when literate) are likely to read this. They are all part of the woman's journey; her social context impacts her care" (S2).*

The accessibility of the content of the documentation for these parties who might read it was identified as a consideration: *"I feel the style of writing is an individual practice decision, but it should be accessible to lay people and health professionals in other disciplines" (S3).* However, the importance of a professional approach to documentation was emphasised by some: *"Documentation should be professional. A conversational style while fashionable tends to lose its professionalism. Reviewing this type of documentation is challenging. In the event of a poor outcome it could be seen as being less than professional" (S3).* And another consideration was: *"If your style is too conversational it can become too long to read" (S3).*

In contrast, the potential for personalisation of the documentation, and the possible approaches to this was acknowledged. One midwife indicated they would include: *"Thoughts and dreams about how things are going and how they might be - Words or things that* [the] *woman and her whānau say about the pregnancy, and the baby. Also, the midwife's response to these. Telling the story of this baby... Painting a picture of how the journey of the baby's life starts and progresses" (S1).*

This story-telling approach was identified as relevant in the long-term also, with one participant writing: *"I think it's good if the postnatal story contains some narrative about how the baby is being integrated into the family, how family members e.g. siblings are responding etc as I think this creates a great overall story for that family way down the track" (S1).* And this approach had clinical relevance too, with one midwife explaining how it might impact the woman or childbearing person's future experiences: *"I often suggest when women have their next baby that they drag out their old notes, and remind themselves about what babies can be like during those early days and weeks in terms of sleeping patterns (i.e. maybe not much sometimes!) feeding patterns (all the time sometimes!) output etc. I think it helps mums to put themselves 'back there' and temper expectation, obviously acknowledging that every baby is different, and that her mothering skills have developed more from her previous experience" (S1).*

The content of midwifery documentation

Participant contributions reached the pre-determined level of consensus on the following statements:

Table 4: Statements relating to the content of midwifery documentation, which reached participant consensus

The content of midwifery documentation	
1	When recording retrospectively, the midwife should document the reason for the retrospective entry

2	A midwife should record any contextual issues which impact her ability to document or the frequency of her documentation
3	Midwives should document the content of their phone conversations with clients
4	The woman's maternity record should clarify for the woman when she should be concerned about herself, or her baby, and make contact with a health professional
5	The woman's maternity record should clarify for the woman who she should make contact with if she is concerned about herself or her baby
6	The woman's maternity record should clarify for the woman how she should make contact with the appropriate health professional if she is concerned about herself or her baby
7	The midwifery record should make visible the woman's active involvement in decision making relating to her care
8	The maternity record should represent the context, perspectives priorities, actions, decisions and plans of the woman, and her whānau/support people where appropriate
9	The midwifery record should represent the woman's understanding of the events which have occurred
10	Midwifery documentation should make the holistic nature of midwifery assessments visible
11	The midwifery record should represent the midwife's impression/interpretation of the events which have occurred/are occurring
12	In her documentation, it is important for a midwife to incorporate a summary of the purpose of the episode of care at the beginning of the documentation entry. E.g. "Antenatal visit as planned" or "Assessment in birthing suite for reduced fetal movements"
13	During an acute assessment, or labour and birth, a brief summary of vital information about the woman and/or baby should be provided at the beginning of the documentation entry. E.g. blood group or any significant history
14	In her documentation, it is important for a midwife to incorporate the general wellbeing of the mother and/or baby and updates about this as the episode of care continues
15	In her documentation, it is important for a midwife to incorporate a summary of recent pregnancy or postnatal events (e.g., onset of fetal movements, cessation of nausea)

16	In her documentation, it is important for a midwife to incorporate relevant personal commentary (e.g., family or work issue of importance to the woman
17	In her documentation, it is important for a midwife to incorporate midwifery plan arising from the assessment/contact (e.g., to re-check BP in 2 days)
18	In her documentation, it is important for a midwife to incorporate support offered to the woman by the midwife
19	In her documentation, it is important for a midwife to incorporate prescriptions provided
20	In her documentation, it is important for a midwife to incorporate a brief summary of the information shared and options discussed
21	In her documentation, it is important for a midwife to incorporate the reason/rationale for sharing this information/having this discussion
22	In her documentation, it is important for a midwife to incorporate a brief summary of any midwifery recommendations made
23	In her documentation, it is important for a midwife to incorporate a brief summary of resources provided (brochures, articles etc)
24	In her documentation, it is important for a midwife to incorporate relevant questions asked by the woman during the discussion
25	In her documentation, it is important for a midwife to incorporate decisions made by the woman as a result of the information shared
26	In her documentation, it is important for a midwife to incorporate information that the woman may choose to refer back to (e.g., breastfeeding advice)
27	In her documentation, it is important for a midwife to incorporate the reason/rationale for the test, investigation or assessment being offered/ordered
28	In her documentation, it is important for a midwife to incorporate information shared about the test, investigation or assessment being offered/ordered
29	In her documentation, it is important for a midwife to incorporate the woman's consent (if given) to the test, investigation or assessment
30	In her documentation, it is important for a midwife to incorporate the reason the woman has declined (if relevant) the test, investigation or assessment

31	In her documentation, it is important for a midwife to incorporate the result of the test, investigation or assessment (once available)
32	In her documentation, it is important for a midwife to incorporate that the woman has been informed of the result
33	In her documentation, it is important for a midwife to incorporate ongoing plans or decisions the woman has made as an outcome of the result of the test, investigation or assessment
34	In her documentation, it is important for a midwife to incorporate ongoing plans or decisions the midwife has made, or actions she has taken as an outcome of the result of the test, investigation or assessment (e.g., offer of further testing, provision of prescription, consultation etc)
35	In her documentation, it is important for a midwife to incorporate the reason for the communication/referral/consultation
36	In her documentation, it is important for a midwife to incorporate consent from the woman for the referral or consultation
37	In her documentation, it is important for a midwife to incorporate time and date of the communication
38	In her documentation, it is important for a midwife to incorporate type of communication – phone, referral, face-to-face
39	In her documentation, it is important for a midwife to incorporate name of the person communicated with
40	In her documentation, it is important for a midwife to incorporate designation of the person communicated with
41	In her documentation, it is important for a midwife to incorporate information provided to the health or allied professional
42	In her documentation, it is important for a midwife to incorporate recommendation or response from the health or allied professional
43	In her documentation, it is important for a midwife to incorporate that the woman has been informed of the conversation and recommendation or response arising from it
44	In her documentation, it is important for a midwife to incorporate decisions the woman has made as a result of the communication with the health or allied professional
45	In her documentation, it is important for a midwife to incorporate ongoing plan/actions taken by the midwife as a result of the communication with the health or allied professional

“Obviously ensuring the safety of the woman and baby supersedes the documentation”

Many participants commented on the impact of practice realities on midwifery record keeping practice. One midwife said *“Contemporaneous documentation during labour should ideally not interfere with either providing close support to the woman nor focused assessment of unfolding events. So hopefully whatever consensus is reached* [about retrospective recording] *honours this aspect of the provision of effective midwifery care - 'being with' prioritised over writing it down, which can occur retrospectively after the birth as necessary - sensible flexibility of expectations should occur around emergency care documentation” (S3).*

This focus on the woman or childbearing person’s experience in relation to documentation priorities was reinforced by another comment: *“Most frequently it* [retrospective documentation] *occurs in the labour and birth process when writing may be an interruption for the woman in her process or physically difficult to do in the situation” (S2).* The need to be realistic in the balancing of care provision with documentation was clarified. One midwife shared: *“It is hard to transcribe what is occurring and provide care at the same time” (S2).*

Consideration of the impact of expectations for documentation on midwifery workload was evident: *“we have to fill in this form and that form and another form; it all gets too much. Research and reviews are important and I am not saying we should get rid of them, but there needs to be an acknowledgement of the amount of bureaucracy and extra requirements that are being placed on midwives' time” (S2).* One midwife identified using a documentation strategy to articulate workload issues in the practice environment: *“I personally would only use in retrospect when the acuity of*

the event led to the delay. As a staff midwife previously, I would write however 'in retrospect' if my workload prevented me from providing care in a timely manner to almost justify why something wasn't completed" (S2).

A clear commitment to clinical safety was voiced: *"Obviously ensuring the safety of the woman and baby supersedes the documentation" (S2).* And this was related to the prioritisation of clinical care practices over documentation: *"It is more important to give care when it is needed than try and do two things at once. Sometimes for safety the summary is the best you can do. I'm not going to write at the expense of a woman and baby's outcome just so I can prove what I did" (S3).*

One midwife summarised these considerations: *"Sometimes during a developing scenario this is the hardest time to document things as they occur. You are actually too busy doing the care provision to capture it in the record. You may be holding up a presenting part during a cord prolapse, you are physically unable to write up what you are doing. The woman and baby come first and you cannot allow secondary considerations to compromise their outcome because you live in fear of the hindsight microscope where your practice will be unpicked and in this instance the lack of documentation should be defensible if we don't expect midwives to be super women! This is the litigious pressure we are under. A good practitioner is seen as recording her actions, but a good practitioner takes care of her woman and that may mean a retrospective entry is the most appropriate course of action in the given circumstance" (S2).*

Safety was relevant in more than one way: *"The midwife must make sure that she is not documenting any information about the woman that may endanger the woman in any way. The midwife must consider her own safety and make sure she documents adequate information about the care she is providing to ensure that she is protected in the case of an adverse outcome" (S2).*

The need for midwives to respond to individual circumstances and identify the most appropriate approach to their documentation process was again evident:

"The dilemma we face, I believe, is that it may not be apparent until later which aspects of the interaction may have been (in hindsight) useful to document. However, a midwife makes that judgement and decision at the time. It is important that consumers of the documentation are aware of the nature of the relationship between a midwife and a woman in order to appreciate that the documentation covers the assessments and aspects of the provision of care to women" (S2).

Choices in documentation practice were also related to philosophical considerations: *"The need to record absolutely everything is excessive - this is a normal health event; I think too much written is defensive and medicalised" (S1).*

Strategies for midwifery documentation

"Tick boxes are lazy!"

The midwives shared strategies for documentation and gave their opinion about a variety of techniques which were the subject of survey questions. One respondent specifically identified the challenge associated with meeting documentation expectations while working as a core midwife: *"There is an awful lot of unnecessary waffle written in maternity notes. The poor core midwives have a huge challenge in caring effectively and also having to write up notes."* A potential solution was offered: *"I would suggest a standardised tick box in the notes for each shift to encourage minimal waffle and to encourage concise record keeping" (S3).*

Other strategies suggested were:

- *"a checklist to make sure I have covered all information necessary and use the same format as much as possible to help myself remember what to record" (S2).*
- *"Recording information in structured, uniform ways is helpful. If information is recorded this way other providers can access the information they require to guide decision making" (S2).*

- *"I only document once - I don't have time to duplicate information. They can talk to me if they need information" (S2).*
- *"I write in the woman held notes for home and primary births, when transfer occurs I write a precis in the DHB notes with times and progress and reason for transfer. Then the woman held notes are kept separate. I do this because when things become medical, I want to make it safe for the woman eg the medical staff are not familiar with woman held notes to find info and where to write so the DHB ones mean we are working more as a unit" (S2).*
- *"provide background information so that the other health professionals can assess the situation from their professional viewpoint" (S2).*

There was significant commentary indicating concern about the use of some strategies that were suggested in the consensus-seeking statements:

- *"My experience of stickers* [used to summarise assessment findings, usually for vaginal examinations or cardiotocograph summaries], *checklists are that they are ticked but there is no critical thinking that is applied. So while the midwife can use the sticker she may not think about what she has written. I have read many where the findings just don't make sense" (S3).*
- *"Tick boxes are lazy!" (S3).*
- *"I think it is acceptable to use stickers, but we need to know how to document without them too" (S3).*
- *"Check lists do not give the detail of exactly what has been 'checked'. Using stickers for basic midwifery competencies such as VEs and CTGs risks midwives losing skills and the detail being lost" (S3).*
- *"I personally prefer to use the tick box for the neonatal birth examination but qualify longhand on each tickbox. Anybody can tick a box and not do a thorough check" (S3).*

However, some midwives made the point: *"there is so much to document we HAVE to use these tools" (S3)* and strategies for documentation were related to more efficient and effective care: "*Yes to anything which helps midwives to record care in a concise way that makes the most effective use of their time.... more time caring for and talking and listening to women less on writing a load of waffle in notes" (S3).*

In a comprehensive summary, one participant shared: "*It is interesting about summary records - we use them in conjunction with written notes, but I often wonder if this is not required. There might be a lot of doubling up. Bullet points to summarise a 'stocktake' during labour, or to describe the information pamphlets given at an antenatal visit for example are okay. Checklists that have space for comments are ok, but not just for 'ticks' that don't tell you anything useful. Stickers can be useful in a shared care situation where several people are involved in care, but they can deter critical thinking if they are just a circle and tick exercise. Assessment summary documents can be useful for the same reason, communication of information in a standard format where several people are involved in care. These can also deter from critical thinking and judgement is required for interpretation. Personally, I find the word 'acceptable' tricky - it is better to use these than to write nothing, but they are not ideal. In that sense they are 'acceptable'. My own preference is narrative for most things, but this is coloured by my usual practice setting (home) - I can see that they are all useful tools in other settings, and that midwives are expected to comply with using them" (S3).*

Who is the record for?

> **midwifery notes are a treasure**

Some comments indicate the participants preference for a consistent approach to documentation regardless of the location of recording and the format of the record. A common theme was that documentation should be recorded in the

same way regardless of the intended audience: *"I think the notes are a record of her pregnancy journey and the format that is legally and clinically necessary is an accurate record for the woman" (S2).* The question "Is there anyone else you think a midwife should consider, when recording the details of the care she has provided?" elicited the following response from one participant: *"The woman, as this is her record. This needs to be written and interpreted, so to be fully understood by a non-healthcare professional, but not to lose the essence of professional documentation" (S2).*

Writing in a clinical way did not necessarily lead to the conclusion that the record would be inaccessible to women and childbearing people: *"*[the] *Woman can have the medical terminology explained to them. It is reasonable to use terminology for ease of professionals being communicated with via the documentation" (S3).* Indeed, some comments clarified that the universality of the record might be considered important: *"I don't* [document specifically as a record for the woman or childbearing person in the maternity notes] *as the record must encompass all potential users. This needs to be an accurate picture of the care that women are offered, receive, discussions that are had. While they are the woman's notes they are also the legal record…" (S2).*

Consideration of other potential purposes of the record was also identified as relevant: *"The midwife should get into the habit of recording as though her documentation will be read by another professional body eg HDC, ACC. This will not happen very often but the midwife never knows when it may occur so treat every set of notes as though her care may be looked at" (S2).*

Workload implications for midwives were also acknowledged: *"I do not think there needs to be a special way to document for the women as time does not allow for a second set of specific documentation. I think going through the notes postnatally with the women, gives them time to ask specific questions or to answer queries about documentation or to explain what words mean. This also is a time for the woman to have a 'debrief' for want of a better word" (S2).*

Other responses suggest that it may be more appropriate for documents to be written specifically for different audiences. For example, one participant shared: *"Midwifery notes are a treasure that the woman may keep to help remind her and her baby of their birth story. It is important that it is written in a way that the woman can understand, as it is her record of the pregnancy, labour and birth and postnatal period" (S3).* Taking a different perspective, another respondent indicated they would document differently depending on the record being contributed to: *"This is a more clinically based record with just the facts and not the "warm fluffy" stuff that I might include in the woman's notes. I tend to document in a direct way and ensure I include a "plan" at the end of my documentation" (S2).*

Certainly, a conversational style was identified as being reader friendly: *"I find that when writing in the woman's own notes especially in the postnatal period I adopt a more conversational style. This is because I often use these notes to pass on advice and plans so feel it needs to be readable for the woman" (S3).*

The potential for midwifery documentation to contribute to women and childbearing people's experiences in an inimitable way, and to represent the uniqueness of midwifery practice was shared by some participants: *"In some ways it is all for the women, but.... there may be aspects that we document for ourselves and our professional agenda. The woman should have a record however and what she sees is important is important. We can't really judge or tell what that might be. Each woman would be different. Perhaps we should ask women. Some of my colleagues used to document very airy fairy entries about how brave and strong the woman was and how her roars in labour were signs of her strength etc. I didn't like it and it didn't fit with me, but I can see that they were making a point that we have the opportunity to empower women through our documentation. We should keep this in mind… perhaps we need to have something unique for midwifery as so many of our examples come from medicine which has a different set of standards and a different philosophy" (S2).*

This concept was captured by one participant, with a focus on fundamental philosophical considerations in midwifery practice: *"We need to be realistic that*

whilst documentation is completely and utterly an important part of care provision, being a midwife is about being with women. We find ways to work with women where our documentation doesn't appear to be the main focus. The way one documents could be seen as quite a medicalised approach and we all can associate medical care with hierarchy and documenting. Midwifery documenting is unique" (S2).

Statements that did not reach consensus

Participant contributions did not reach the pre-determined level of consensus on the following statements:

Table 5: Statements that did not reach participant consensus

1	Midwives should record their role in the woman or baby's care (e.g., back-up midwife, LMC, postnatal shift midwife) on each page of documentation
2	Midwives should ask women to sign the documentation associated with each episode of care
3	Every woman should be offered the opportunity to contribute to her maternity record by writing in the record herself
4	The timeframe for retrospective recording of "routine" antenatal and postnatal events should be the same as for the retrospective recording of acute antenatal and postnatal events and labour and birth events
5	During an antenatal or postnatal admission, when the woman and/or baby are stable, it is acceptable for the midwife to document once per shift, unless there is a change in the woman or baby's wellbeing
6	When a midwife receives information that may compromise the safety or privacy of the woman, or the safety of the midwife, she should: Record this information in a separate record (not held by the woman)
7	When a midwife receives information that may compromise the safety or privacy of the woman, or the safety of the midwife, she should: Record this information in the notes held by the woman
8	When a midwife receives information that may compromise the safety or privacy of the woman, or the safety of the midwife, she should: Not record this information at all, in order to avoid the information being accessed by others

9	When a midwife has clinical contact with the woman, in person or on the phone, without the maternity record being available, the midwife should: Wait until she has the record and document in it
10	When a midwife has clinical contact with the woman, in person or on the phone, without the maternity record being available, the midwife should: Document the clinical contact in another location
11	When a midwife has clinical contact with the woman, in person or on the phone, without the maternity record being available, the midwife should: Not document the contact
12	Notes can be considered retrospective if they are written more than this period of time after events have occurred: (did not reach consensus)
13	A midwife should document care during "active" labour at least: (did not reach consensus)
14	A midwife should document care when a woman is pushing at least: (did not reach consensus)
15	Midwives should avoid the use of abbreviations in their documentation
16	Midwifery documentation should incorporate a conversational style
17	It is acceptable for midwives to use tick or check lists (e.g. for newborn examinations)
18	Midwifery narrative documentation should be written in the same way regardless of the location of the record (i.e. hospital notes, electronic record, woman-held notes)
19	Midwifery documentation is an important record for the woman and should be individually personalised
20	It is not necessary for a midwife to document changes to scheduled appointments (e.g., time and location) unless there is a clinical implication associated with the change
21	Midwives should document the content of social or informal interactions with women (i.e. bumping into a current client in the supermarket)
22	Midwives should document brief non-clinical interactions such as passing on a phone message, or serving the woman a cup of tea
23	Each page of midwifery documentation should identify the woman and/or baby about which it is written, by including: The date of birth of the woman and/or baby

Conclusion

The complexities of writing midwifery documentation are evident in the commentary of the expert midwife participants in this Delphi research. However, despite these complexities, and the impact of contextual influences on documentation practice, the midwife participants have reached consensus on 70 of the 93 individual consensus-seeking statements. In addition, the results present the broad perspectives of the participants on the most important considerations for effective documentation of midwifery care and how midwives might best represent their practice in the maternity record.

Chapter Five: Discussion and Conclusion

This research project has identified a broad range of considerations which are relevant for the effective documentation of midwifery care. In this chapter the interpretation of the results in relation to the objectives of the research will be discussed. Application of the results to the current practice environment will be explored, along with comparison to the existing pool of literature. Strengths and limitations of the research will also be considered, and recommendations for future research presented.

The midwife participants in this study have shared perspectives about the most appropriate way to document midwifery practice and the content that midwives should include in the maternity record. In addition, they have identified priorities for how midwifery documentation might optimally be constructed, along with contextual realities and influences on this component of practice. Some of these considerations are articulated in the statements of consensus, which form a body of knowledge describing appropriate foci for, and potential approaches to, the recording of midwifery care. Other knowledge has been shared via the participant's generous commentary which has clarified documentation practice priorities and provided context. Integration of the results identifies a variety of factors to consider when deliberating the most appropriate documentation processes in any given situation.

Fundamental principles

Factors which might be considered fundamentally important for midwifery record keeping were revealed by the statements of consensus, and by some of the participant comments contextualising these. These fundamental principles are those which are always relevant for record keeping and do not change no matter the circumstance of care. An example is the statement: "Midwives should sign each entry of documentation". The time and date of the record

entry, the name and designation of the writer and identifying features of the recipient of care are other fundamental principles. These considerations were not the subject of significant debate by the participants and did not elicit substantial commentary, other than some explanatory contributions. They are aspects of documentation which are likely to be automated in an electronic health record.

The fundamental principles for midwifery documentation reflect many of the considerations identified as appropriate record keeping priorities in the opinion-based literature sourced in the literature review for this study (Ashurst & Taylor, 2010; Forrester, 2011; Frank-Stromborg et al., 2001; Griffith, 2004; Pirie, 2011). These articles largely addressed medico-legal concerns for documentation, and the fundamental principles identified here might be considered to represent medico-legal practicalities. In addition, many of these factors align with the findings of Devane et al. (2019), particularly in relation to the construction of the midwifery record. These authors listed required indicators of midwifery metrics of care within the maternity record including: identification of the woman on each page/screen of documentation, recording of date and time of record entries, legibility of records, and the signature of the writer.

Safety and priority aspects of care

A focus on the safety of the mother, childbearing person and baby was evident throughout the participant's commentary and was identified as relevant in a number of different ways in documentation practice. In particular this included, but was not restricted to:

- The safety of the woman, childbearing person and baby, and documentation practices and decisions to keep them safe

- The clinical safety of the woman, childbearing person and baby, and choosing to document (or prioritise the clinical care over documentation), in order to keep them safe
- The safety of the midwife and self-preservation, in terms of medico-legal protection

The safety of the recipient of care

Patient safety is an area of global focus in health (World Health Organisation, 2019) and documentation errors are a recognised contributor to patient safety events (So et al., 2010; Stevenson & Nilsson, 2012). The significant clinical implications of inadequate representation of care in health records are thoroughly discussed in international literature. Poor record keeping has the potential to contribute to errors in care provision, and poor outcomes for patients (Instefjord et al., 2014; Johnson et al., 2010; Kerr et al., 2016; Okaisu et al., 2014). This topic was specifically explored in relation to the provision of maternity care, and adverse foetal and neonatal outcomes, by Rowe et al. (2001), who concluded that inadequate record keeping may contribute to neonatal deaths and stillbirths.

Prioritising the safe provision of care

Effective documentation of care in an acute situation may be critical to the communication of that care, and the safety of the person being cared for. In the current study respondents related this specifically to timely documentation when the mother, childbearing person or baby might be at risk. However, the participants also addressed the need to prioritise the clinical safety of the person receiving care over the documentation of the care being provided. Their commentary strongly emphasised that the act of documenting should not compromise the safety of the recipient of care by interfering with hands-on care provision. In particular, the comments of these expert midwives supported the

acceptability of retrospective documentation when the care of the woman, childbearing person or baby requires urgent attention.

The logistical challenge of providing care while writing it was also clarified by the participants, and they acknowledged the pressure of these competing priorities. This concern is not limited to midwifery practice. Nurses have also reported that achieving balance between timely documentation and the provision of hands-on care is difficult, and that this is particularly true when caring for patients of high acuity (Grainger, 2007). Healthcare professionals may choose to prioritise hands-on care over the documentation of that care (Broderick & Coffey, 2013; De Marinis et al., 2010; Hyde et al., 2005). De Marinis et al. (2010) found that nursing documentation represented actual nursing activities only 40% of the time in a study combining observation of nursing care, structured interviews with nurses and retrospective auditing of clinical records. Likewise, Adamsen and Tewes (2000) explored discrepancies between patient experiences and nursing documentation and found that the nurses' knowledge of the patient's individual circumstances was much more extensive in interview than in their written records.

Some authors are critical of findings that indicate care is not fully represented in clinical notes (Bergen-Jackson et al., 2009), and query whether the practitioners concerned value documentation and the contribution of the health record to the care being provided (Adamsen & Tewes, 2000; Brooks, 1998; Taylor, 2003). Others relate the quality of record keeping practices directly to the quality of care. So et al. (2010), for example, concluded that patient outcomes were poorer when the documentation of their care was retrospectively rated as suboptimal. However, it is important to acknowledge potential influences on documentation practice, which may arise from the context within which care is occurring, or the individual clinical circumstances. So et al. (2010) may have identified an association, rather than a causative relationship, with both care and documentation suboptimal because of other factors in the care

environment. Additionally, a lack of evidence for effective documentation practice may make exploration of the appropriateness of health records challenging. When researchers conclude that care is not effectively represented in documentation, this may reflect inadequate evaluation processes.

Given the strength of professional recommendations to document carefully and thoroughly, and emphasis on the value of documentation to support practice in healthcare literature, it seems likely health professionals will be motivated to effectively record their practice wherever possible. A lack of engagement with documentation might not, in reality, represent a lack of willingness to record the care provided. It is likely that resourcing and workload considerations will also influence the ability of health professionals to document. Prioritisation of documentation requires appropriate resourcing, including the presence of enough staff that hands-on care and adequate record keeping can both be effectively achieved. The results of the current study demonstrate that concern for the safety of the recipient of care may cause a midwife to deprioritise documentation.

If documentation is not completed appropriately, the potential reasons for this should be considered. In nursing practice, some authors discuss whether requirements for nursing documentation, which have largely been defined by medicine, allow for appropriate representation of nursing activities. They question whether nurses might feel less inclined to engage in these documentation processes because the records don't represent nursing priorities in providing care (Brooks, 1998; Grainger, 2007; Heartfield, 1996; Taylor, 2003). Heartfield (1996) proposes that nurses are resistant to record keeping practices which may be seen to undermine the intuitive, holistic nature of nursing.

Grainger (2007) conducted interviews of emergency department nurses in Aotearoa New Zealand to explore influences on their documentation practices, and found her participants felt their documentation was not valued by other health professionals. It may be difficult for healthcare providers to appreciate

the importance of their own documentation if they feel it is not valuable to others. In the current study, respondents identified that there may be different expectations for midwifery documentation, than there is for the record keeping of other health professionals. They felt, for example, that asking a recipient of care to sign the clinical record (with the exception of consent forms) was not something that other healthcare providers would be asked to do.

The safety of the person providing the care

Inadequate documentation can compromise the clinical safety of the person receiving care but may also impact the professional safety of the health practitioner responsible for that care. As discussed previously, medico-legal considerations related to record keeping form a significant theme in the international healthcare documentation literature (Austin, 2010; Stevens & Pickering, 2010). For example, Wood (2010) states that "one of the most common causes of a legal claim arises because of a breakdown in communication between health professionals. This is often directly related to incomplete and/or inadequate medical records…" (p. 20). This perspective is common, with many authors discussing a potential link between legal claims and patient complaints, and inadequate communication between health professionals involved in a patient's care (Andrews & St Aubyn, 2015; Austin, 2010; Creed, 2017; Grainger, 2007).

The relevance of the use of documentation as a self-protection strategy was identified by some participants in the current study. The need for a midwife to ensure adequate recording of the care provided, in order to protect themself in case of later clinical review, was discussed. There is no doubt that effective documentation is useful for this purpose (Pezaro & Lilley, 2015; Scott, 2017). However, the overwhelming message from participants, again, was that the safety of the mother, childbearing person and baby must take precedence over other considerations in acute clinical situations. One midwife respondent

discussed the "hindsight microscope" and the importance of not allowing the fear of critical review of practice to force prioritisation of documentation when clinical, hands-on care is required. Furthermore, some participant commentary made it clear that the experience of the person being cared for was also important, and that this might be negatively affected by attention to record keeping, rather than the provision of supportive care. Therefore, documentation strategies, such as retrospective documentation, to support a woman or childbearing person's experience of their care were recognised as reasonable.

Functionally useful considerations

Considerations which might enhance the structure, content or accessibility of the documentation were identified by the participants in the current study.

These include, but are not limited to:

- Timing of documentation
- Frequency of documentation
- Women and childbearing people holding their own records

Participants did not reach consensus about the appropriate frequency of documentation, or the definition of a retrospective record. In fact, they seemed to hold quite different perspectives about the optimal timing of documentation. Several respondents also overtly stated that they did not know how retrospective documentation should be defined. Murray et al. (2001) found that more nurses considered an entry to be retrospective if it was written any time after the care had been provided, or if the documentation entry was out of sequential order, rather than this "late" documentation being specified by a particular timeframe.

Strict requirements for the frequency of documentation were not considered ideal by participants in the current research project. They concluded that it is

important to allow midwives autonomy in deciding how often, and when, record entries should be written. Whilst autonomy in documentation is not overtly discussed in the literature accessed in support of this research project, autonomy in midwifery practice is related to the professional confidence and capacity of midwives. It supports their ability to effectively advocate for their clients, and tailor care appropriately for them (Zolkefli et al., 2020). The International Confederation of Midwives tells us "Autonomous midwifery practice enables midwives to fulfil their contract with society by providing up-to-date, evidence-based, high quality and ethical care for childbearing women and their families" (Fullerton et al., 2011, p. 1). Professional autonomy will, therefore, support a midwife to practice as effectively as possible, and it has been shown to be protective for midwives against the risk of occupational burnout (Dixon et al., 2017).

Strategies to support the efficiency and effectiveness of midwifery documentation were generally considered reasonable by participants in this study. A number of strategies were discussed, including the use of tick boxes, templates and stickers for summarising care. The concern was also raised, however, that the use of such approaches for the purpose of streamlining documentation may impact the critical thinking of the documenting midwife or may reduce opportunities to demonstrate that critical thinking. In an opinion piece titled "A healthy ticker… or a good heart?" (Anon, 2014) one midwife discusses the frustration associated with a tick box approach to documentation. This author expresses concern that this approach has the potential to undermine the quality of documentation, change care provision and have a significant impact on the recipient of care, explaining, "we seem to have lost the ability to quantify care in words" (p. 2). If this is accurate, the impact of such strategies has implications for the effective expression of care in the maternity record.

The visibility of healthcare practice in healthcare records is widely discussed in international literature (Brooks, 1998; Butler et al., 2006; Chiejina, 2019). According to Pearson (2003) complex requirements for documentation diminish opportunities for nurses to make their real work visible in their clinical records. Bergen-Jackson et al. (2009) also tell us: "nursing practice remains largely invisible, partially due to inadequate documentation systems. Documentation of nursing practices is essential for knowledge development of nursing contributions to quality, patient safety, and patient outcomes" (p. 335). The importance of a permanent record of nursing practice, and knowledge to make the work of nurses accessible to others, and also to nurses themselves, is widely acknowledged (Heartfield, 1996; Karkkainen & Eriksson, 2003; Prideaux, 2011; Taylor, 2003).

The potential for the visibility of midwifery practice to be enhanced through midwifery documentation was also evident in the expert midwife commentary in the current study. The participants included reference to the importance of the visibility of the nature of the relationship between the midwife and the woman or childbearing person, the holistic assessments made, the decision-making of the woman or childbearing person and the unique nature of midwifery care. Fleming (1998) cautions, however, that it may be difficult to capture the reality of midwifery practice in midwifery documentation, because the nature of what midwives do does not lend itself easily to being written.

A client-held maternity record is one approach to improving efficiency of documentation and communication which was identified as useful by respondents in the current study. Woman- and patient-held records have been shown to enhance the care recipients' experience of their care, and their communication with caregivers (Hart et al., 2003; Hawley et al., 2014; McMath & Harvey, 2004; Rowe et al., 2002). Additionally this type of record has the potential to improve communication between health professionals and the availability of records during acute presentations (Brown et al., 2015; Homer et

al., 2010). Nonetheless, woman- and patient-held documentation does not appear to affect clinical outcomes (Brown et al., 2015; Hart et al., 2003; Rowe et al., 2002).

Care enhancing considerations

Not all components of, or approaches to, documentation will be relevant in all circumstances, or to all women, childbearing people, families, midwives, allied health professionals or other interested parties. There are some aspects of documentation that might be considered "optimal" but not always achievable, or they may be desirable under some circumstances, or to some people. As an example, these might be the documentation components which articulate the partnership relationship and make the woman or childbearing person's decision-making highly visible in the record. Some midwives will consider these factors fundamental to midwifery documentation, and the argument is not that they are not important, but rather that they constitute something beyond the basic construction of the record and communication of clinical details. For some, they may represent a philosophical approach to the provision of care.

The participants in this study did not agree about the extent to which women and childbearing people should, or could, contribute to their midwifery record by documenting in it. The statement *"Every woman should be offered the opportunity to contribute to her maternity record by writing in the record herself"* did not reach participant consensus. However, the co-creation of midwifery documentation, and the potential for this to contribute positively to the partnership relationship, was identified as important by some participants. Shared documentation is not addressed widely in international literature, even when patient- or woman-held health records are explored. It should be noted that women and childbearing people holding their own maternity record does not necessarily mean they will document in it (Hart et al., 2003).

In some areas of healthcare practice, it is only recently that discussion has addressed whether patients should even be allowed to see their clinical notes (Bell et al., 2017). Furthermore, some authors debate whether records shared with patients should be selectively redacted in order to protect the experience of patients and their relationship with their physician (McCarthy et al., 2018). This might not seem optimal, relevant or desirable within the context of a maternity service founded upon partnership relationships. However, the participants in the current study did identify that there are times where the woman or childbearing person holding their own maternity record might compromise their safety, or that of the midwife. In particular, situations of intimate partner violence were mentioned. The participants suggested that the midwife should address each situation individually to decide what is relevant and safe to document, and how and where the midwife should do so, to support their client's circumstances and experience.

While shared documentation might not be the focus of significant discussion in health literature, shared care planning and decision-making is addressed. Shared decision-making may lead to the woman or childbearing person's perspective being represented clearly in documentation. Interestingly, there is some evidence that the development of care planning with patients can support nurses to hold a less negative attitude to documentation (Karkkainen & Eriksson, 2005). In Aotearoa New Zealand maternity care planning is undertaken with the woman or childbearing person, reflecting the partnership model approach to care. The Midwifery Council of New Zealand Competencies for Entry to the Register of Midwives state that the midwife "formulates and documents the care plan in partnership with the woman/wahine" (Midwifery Council of New Zealand, n.d.) and Standard Five of the Standards of Practice holds that "Midwifery care is planned with the woman" (New Zealand College of Midwives, 2015).

The unique nature of the midwifery partnership model, and the shared planning of care, may affect the way in which maternity care is documented. Participant commentary in this research project incorporated reference to partnership and how this might impact, or be impacted by, record keeping practices. In particular, attention was drawn to the potential for documentation to detract from personal interaction between the woman and the midwife. There were also mixed participant opinions about the extent to which the midwifery record should be written with the partnership relationship in mind. Some respondents overtly addressed the importance of the visibility of the relationship between the woman or childbearing person and the midwife in documentation. Others strongly emphasised that the midwifery notes are a professional document and seemed to prefer a functional approach to the maternity record, rather than a personalised one.

While the statement: *"Midwifery documentation is an important record for the woman and should be individually personalised"* did not reach participant consensus, the visibility of the woman or childbearing person in the record was also important to some participants. This focus is echoed in literature concerning patient or person-centred care. Indeed, Jefferies et al. (2010) argue that positioning the patient at the centre of documentation is a core component of quality in nursing record keeping. Awareness of the condition of the recipient of care, and documentation of clinical actions and response to the patient's experience, may be seen to provide evidence of effective nursing care (Buus and Hamilton, 2016). It is important to recognise, however, that a lack of patient focused documentation might not translate to a lack of patient focused care (Adamsen & Tewes, 2000; Asamani et al., 2014; Brooks, 1998; De Marinis et al., 2010).

Context of the care provided

The influence of the context in which care is provided on appropriate documentation practice, was a focus of significant participant commentary in this research. The need for midwives to be autonomous in the construction of their documentation, in response to contextual influences, was clearly articulated. Expectations for documentation which are relevant and reasonable in some situations may not be relevant or reasonable in others. Often the context of care provision dictates the appropriate path for documentation above and beyond the fundamental principles for record keeping.

Expectations for documentation, workload and other resourcing issues

Participants in the current study addressed the ways in which documentation might impact the workload of midwives, and how the provision of care might impede their ability to document. Workload is a significant issue for healthcare professionals when they are attempting to find time for documentation. Additionally, record keeping might require a significant time commitment from care providers (Björvel et al., 2003; Gomes et al., 2016; Taylor, 2003). This workload may restrict the ability of midwives to spend time with the person to whom they are providing care. In relation to nursing practice, Cheevakasemsook et al. (2006) tell us "many nurses judge care plans as an unnecessary burden, separate from and additional to providing ongoing nursing care" (p. 368). These authors also identify that 70% of the work of nurses is not direct nursing care, and that documentation is a significant component of this.

Indeed, Melberg et al. (2018) found that birth care workers spent at least the same amount of time on their documentation of care as they spent on the provision of care itself, and this reduced the time available for hands-on healthcare tasks. These health workers felt the expectations for record keeping

imposed on them were not achievable and realistic. Some authors argue that the documentation required by the clinical setting may serve the purpose of the organisation more than it does that of the person receiving care, or that of the person providing care (Cline, 2020; Karkkainen & Eriksson, 2005; O'Connell et al., 2000; Prideaux, 2011). Institutional regulations and organisational requirements may restrict the preferred writing style and approach of individual health professionals (Kärkkäinen et al., 2005; Taylor, 2003) and may negatively impact professional autonomy (Buus & Hamilton, 2016; Hamilton & Manias, 2006).

The tension between the realities of practice, and professional and philosophical preferences in relation to documentation, were expressed by the midwife participants in the current study. The need to document, rather than attending to hands-on clinical work, has the potential to cause healthcare providers significant professional discomfort (Michel et al., 2017; Prideaux, 2011). Heartfield (1996) tells us that "Attempts to meet ethical, legal, medical and institutional guidelines have influenced nursing records to the point whereby the records are often [so sanitised that they barely] represent what has actually been done for the person" (p. 99).

The respondents in the current research project identified that working in partnership with women and childbearing people, and the provision of midwifery care in a responsive, individualised way, takes time. Women and childbearing people, and midwives, need the opportunity to develop, consolidate and maintain their relationships. The midwifery record can capture these partnership processes in action, and make them visible, but only if appropriate time and resources are available to do so. As an example, some of the expert midwife participants indicated that the woman or childbearing person signing the maternity record might be an opportunity to demonstrate a partnership/shared decision-making arrangement. However, other participant commentary acknowledged the potential workload associated with this.

The way in which documentation has been constructed by other health professionals, including midwives, is also relevant to consider. Participants cautioned about the potential to create unnecessary work for colleagues when documenting. Both the inadequate, and the excessive, documentation of others might contribute to the workload of midwives. The former requires interpretation, investigation and information-gathering, and the latter requires time to "sift" through the documentation to find the relevant content for care planning and provision.

While acuity of workload, or inadequate resourcing, may influence the ability of midwives to document the care they provide (Bailey et al., 2015; Grainger, 2007; Owen, 2005), participants indicated that their documentation might also provide an opportunity to highlight the impact of these contextual issues. This included documentation of the reason a record was being written retrospectively. Explanation of the context of care in clinical notes will make the contextual influences on midwifery practice visible to the reader. This has the potential to support the ongoing development of the service and is significant for care planning. Highlighting contextual considerations in the practice environment will also support the individual midwife should the need to review care provided arise later. Factors that might have influenced the outcome of a particular care scenario, may be identified.

The context of the location of care

The location of care may be relevant for documentation practice in a number of ways (Lövestam et al., 2015). The expert midwives in the current study acknowledged that their documentation would vary depending on the setting in which they were caring for the woman, childbearing person or baby. For example, some participants referred to their tendency to write more of a story when providing care in the client's home. This approach may be easier to achieve where there are fewer institutional documentation requirements for a midwife to address. Hendry (2008) identifies that midwives experience

frustration with diverse hospital systems and organisational expectations relating to record keeping. For instance, the sheer quantity of documentation required may not necessarily relate to maternity assessments. Lövestam et al. (2015) found that the documentation recorded by dieticians in primary care settings was more effective than that recorded in the hospital setting. They queried whether this was due to the time resourcing available for documentation in the primary care environment, which might also be related to the acuity of the patients being seen in hospital.

Community documentation was also seen to be written to reflect the woman or childbearing person's decision-making and make them more visible in the record by participants in this research project. Some of the expert midwife respondents identified that they felt a single version of the maternity record should be considered for all environments, to accommodate all potential audiences. However, the statement *"Midwifery narrative documentation should be written in the same way regardless of the location of the record (i.e. hospital notes, electronic record, woman-held notes"* did not reach participant consensus.

The context of the format of the record

The location of care may also provide a platform for documentation which changes the approach to the construction and maintenance of the record. The structure of a paper-based record might necessitate a particular approach to documentation, as will an electronic health record (EHR) system.

The participants in the current study generally seemed to view EHRs favourably. This is not consistent with the majority of health professional perspectives represented in international literature (Brooke-Read et al., 2012; Gomes et al., 2016; Stevenson & Nilsson, 2012). Cline (2020) conducted a literature review exploring patient-centred care in nursing and the use of electronic health records, and found much of the nursing literature conveyed negative perspectives on the implementation and use of EHRs. Stevenson & Nilsson (2012) report that nurses are generally dissatisfied with EHRs. The

concerns expressed by nurses are that EHRs take longer to complete and they can make it challenging to find relevant information to inform care decisions. Patient safety could, therefore, be threatened. There is also the possibility that the structure of the electronic record will not support the visibility of the holistic nature of the care provided (Kärkkäinen et al., 2005) or the individual circumstances of the person receiving care (Lee et al., 2019). However, communication between health professionals, and the immediacy of documentation, were seen to be supported by the use of an EHR, in the current study. The expert midwives equated this with enhanced effectiveness of the provision of care, and improved safety for the woman, childbearing person, and baby.

These different perspectives might reflect different types of EHRs used internationally, or different approaches to the use of the record. Nursing processes for the implementation and use of the EHR might also be different to that of midwifery. Additionally, because EHRs are not yet routinely used throughout Aotearoa New Zealand, the positive perspective of the participants in the current study might arise from a lack of exposure to EHRs. International literature indicates that the reality of EHRs may not reflect the theoretical advantages of them (Fawdry, 2007; Fawdry et al., 2011; Stevenson & Nilsson, 2012).

An interesting theme of discussion by participants, in the current research project was the assumption that women and childbearing people would not be party to electronically recorded documentation. This perspective may then result in an assumption, by the writer, that the record is being written for an audience other than the recipient of care. Whilst in an immediate sense it is true that the woman or childbearing person is unlikely to instantly access the majority of electronic health records, in reality an EHR can be accessed by the recipient of care in the same way as any other clinical record.

The potential for a change in documentation content, or approach, as a result of an EHR is widely discussed in the nursing literature addressing this subject (Kaakinen & Torppa, 2009; Karkkainen & Eriksson, 2003). There is an associated concern that "patients" might feel their healthcare record is being constructed for some purpose other than their own well-being (Cline, 2020). Some authors express caution that EHRs may result in a lack of holistic expression of the patient or the care provided (Cline, 2020; Laitinen et al., 2010; Tornvall et al., 2004). Brooke-Read, Baillie, Mann, & Chadwick (2012), for instance, found their participants questioned how this style of documentation aligns with the nature of midwifery care. This perspective was not reflected in the responses of the participants in the current study, however. These expert midwives seemed to hold the view that EHRs are a natural evolution of, and for, documentation practice and will improve the experience of midwives and those they are caring for.

Strengths and limitations of the research

In order to protect anonymity of the participants, in this Delphi research project, the survey data was collected without identifiable participant features. This approach was designed to encourage the expert midwife respondents to share their opinions openly and honestly. While this represents a significant strength of the research, it does mean there was no way to clarify the meaning of the participant responses. Analysis of any ambiguous comments was, therefore, reliant on the interpretation of the researcher. However, minimal transformation of the data was undertaken, given the qualitative descriptive presentation of the participant commentary. This has allowed authentic representation of the expert midwives' perspectives and opinions, and provides the reader the opportunity to explore these findings and reach an understanding of the meaning offered.

One limitation, not of the study findings but of the data reporting, was the presentation of the demographic data. The data gathering approach allowed participants to self-nominate their ethnicity, current midwifery role and location of practice. The varied responses do not allow for easy translation into tabular or graphical representation.

Analysis to separate comments according to ethnicity was not able to be undertaken, due to the anonymous survey contributions of the participants. Twelve percent of the participating expert midwives identified themselves as Māori. This is less than the general population of Māori in Aotearoa New Zealand (16.5%) (Stats NZ, 2019), but is higher than the percentage of midwives who identify as Māori (6.11%) (Midwifery Council of New Zealand, 2019). The comments of these participants are woven throughout the discussion.

Whilst not necessarily a strength, or limitation, of this research project, it is important to remain mindful of the context within which the study was conducted. Aotearoa New Zealand is a reasonably well-resourced country, with a relatively unique, fully-funded continuity of care maternity service and health legislation which reinforces the requirement for informed choice. This system of care has a midwife-client partnership focus, and women and childbearing people are able to receive individualised care in most circumstances.

Implications for practice

This exploration of expert opinion about the effective representation of midwifery care in documentation, has provided a new source of knowledge for midwifery record keeping practice. Midwives might use the statements of consensus to guide their assessment of their own documentation or as a prompt to inform their choice of approach to record keeping.

The importance of the context of care provision on record keeping cannot be underestimated. Expectations for documentation priorities must adapt to allow

for contextual influences, according to the expert midwife participants in this study. In addition, adequate resourcing is critical for the appropriate development of the midwifery record. In order to document effectively, midwives require time, support and appropriate workload management. Assessment of the adequacy of documentation should be undertaken with appropriate evidence for optimal record-keeping practice and should take into consideration these contextual influences.

Documentation priorities in a community, or continuity of care, context might be different from those within the hospital care setting. Participants in this study identified clearly that their documentation practices would vary in different locations, and in different record formats. The results of this research project indicate that the ability to take a flexible approach is crucial, with participants emphasising the importance of the safety of the recipient of care. The autonomy of midwives to determine the most appropriate approach to record keeping in each situation, in order to provide individualised, person-centred care, is the critical consideration.

The safe provision of care is of primary importance. Prioritisation of documentation processes to support the safety of mother, childbearing person and baby will also require flexibility and autonomous decision-making by midwives. In order to achieve an appropriate focus on the experience of the care recipient, and ensure safe care provision, retrospective documentation is a reasonable practice approach.

Qualitative descriptive presentation of the participant commentary in this study has allowed the voices of the midwives to 'tell the story' of their perspectives about effective documentation of midwifery care. The reader is able, therefore, to develop their own interpretation of the messages of relevance. The research results, summarised and discussed in this chapter, have stimulated the development of a conceptual representation of considerations for midwifery documentation practice:

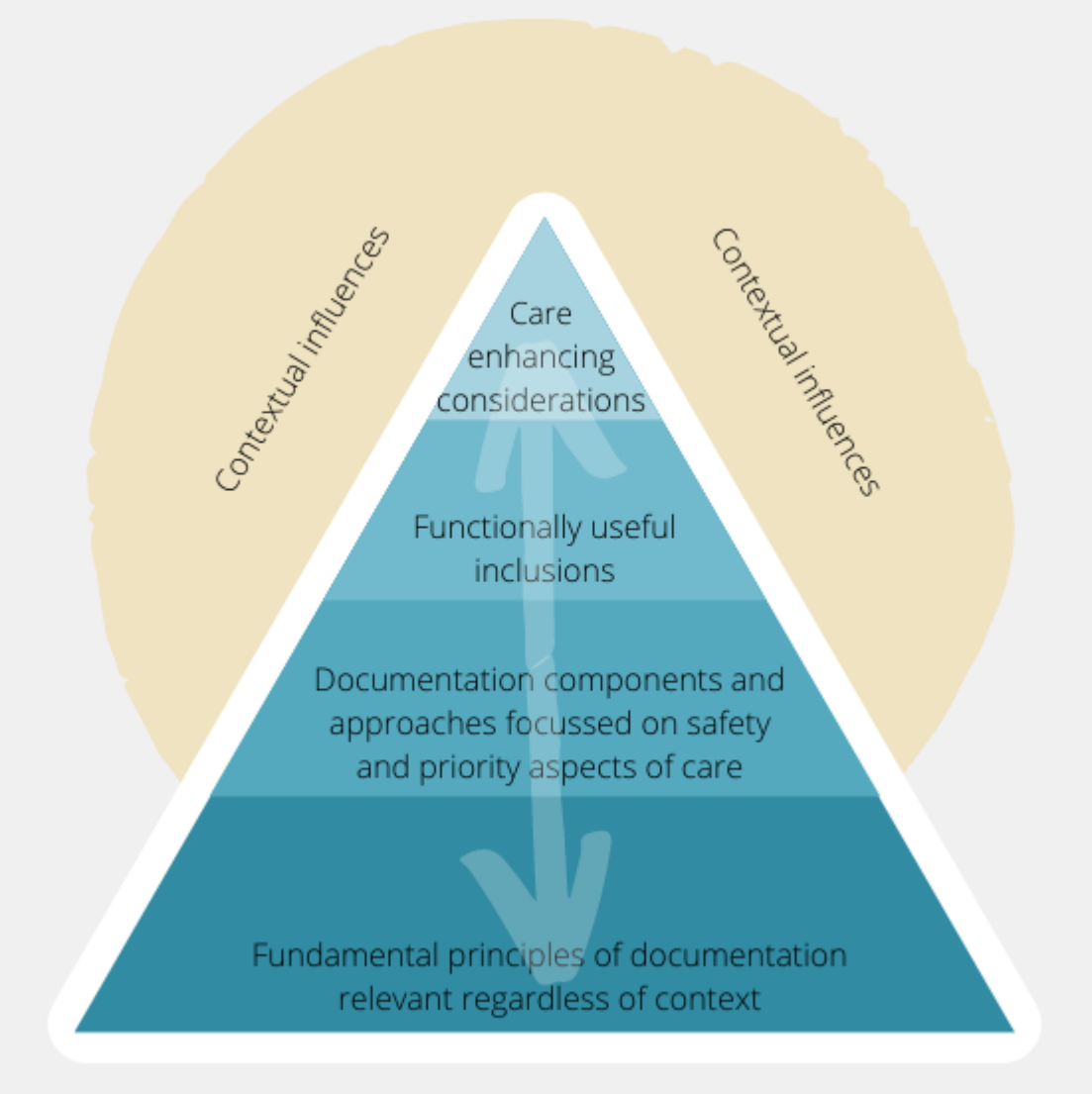

Figure 4: Conceptual representation of considerations for midwifery documentation practice

In this graphic, the fundamental principles are shown as foundational, because they remain consistent, regardless of the context of the woman, childbearing person or baby, the clinical situation, the care environment and the documentation format. None of the "layers" within the pyramid, above the fundamental principles, are necessarily less important than any of the others. However, the ability of the midwife to record the components within each layer, and the prioritisation of these, may vary depending on the individual circumstance. The "care enhancing considerations" at the top of the pyramid represent what is possible when resources are optimal, and these considerations

are relevant and desirable to include. The arrows demonstrate that there is potential for interpretation of which components of documentation practice belong in each section, and this may vary depending on the context too. For example, some considerations will be functional under some circumstances but will become safety issues under others.

Recommendations for future research

There are any number of opportunities for future research arising from this Delphi study. It would be interesting to explore the experiences of women and childbearing people, of their midwifery record, and identify their priorities and preferences for their own care documentation. Additionally, it might be useful to investigate whether core and community midwifery documentation vary from each other in content and/or structure. There is also potential to attempt to identify whether midwifery documentation is unique in nature, by specifically comparing it to nursing record keeping.

Conclusion

The data arising from this Delphi study has provided a rich source of evidence for understanding the complexity of the relevant considerations for midwifery documentation practice. These considerations, and the optimal approach to documentation, will vary considerably depending on the context of the care provided. This research has demonstrated that midwives are dedicated to providing individualised, attentive care regardless of the woman, childbearing person or baby's circumstances and that this focus may translate to their documentation practices. Individualised, person-centred care will be relevant in any situation, and can be represented in the maternity record, but it may be reasonable for documentation to be delayed as the midwife prioritises the clinical care provision.

The effective representation of midwifery care in the maternity record is about more than just the content that is documented, and it is influenced by many contextual factors. The expert midwife respondents in this study also identified that the timing and purpose of the documentation are important for understanding the care that is provided, and may reflect the context of the care provision. The maternity record has the potential to represent the unique nature of midwifery relationships and the depth of care that midwives offer women.

The high level of consensus evident in participant responses to the consensus-seeking statements provides a platform of evidence for the midwifery profession to consider in relation to documentation practice. The supporting commentary of the participants clarifies that midwives should be autonomous in their decision-making about their approach to record keeping. Requirements and expectations for documentation will need to accommodate contextual realities, and appropriate resourcing of midwifery care must be prioritised to safeguard the recipient of care and optimise documentation practice.

At a fundamental level there are documentation parameters which a midwife will include regardless of the context of the care provision. Beyond these foundational principles, however, contextual influences will impact the development of the record, and which components of documentation are relevant to prioritise. The provision of safe care of the woman, childbearing person and baby was identified as a significant priority by the participants in this research. After the fundamental and safety considerations, parameters which make the record more accessible and functional may be prioritised along with those that enhance the experience of the care recipient, dependent on the context and the individual approach of the midwife. Addressing these principles in record keeping may articulate the midwife's philosophy and make visible the priorities, preferences and experiences of the woman or childbearing person, and the midwife. Midwifery documentation will, therefore, clarify the role of the midwife to the reader, and has the potential to meaningfully represent the partnership relationship.

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Appendix One: Consultation with Kaitohutohu office

Effective and appropriate care of women within the maternity services of Aotearoa/New Zealand relies on the clear communication of the needs, care and well-being of mother, childbearing person and baby between health professionals, and between women and midwives. Midwifery clinical documentation serves a number of important purposes, however there is little evidence currently for what constitutes adequate content of the midwifery record.

The aim of this research is to contribute to professional guidance for midwives in achieving optimal documentation practices in their care of women and babies. The need for evidence to support midwifery practice in this area having been identified, the specific question being posed is: "What should midwives write to provide evidence of the care they have provided, and to effectively support the maternity care experience of women and babies?"

In order to explore the most effective approach for midwives to adequately document the care they provide to women, a modified Delphi method will be used to draw consensus about the topic from a group of experienced practitioners in the field.

- **Will the research involve Māori?**

  I hope to recruit some Māori midwife "experts" into the participant pool, to contribute to the consensus forming process.

- **Is the research being conducted by Māori?**

  I am not of Māori descent myself.

- **Are the results likely to be of specific interest or relevance to Māori?**

Again, I hope so. The recording of the midwifery care provided to women is extremely important in that it can contribute to a positive and safe experience for the wāhine and her whānau. Additionally, accurate recording of care enhances accurate collection of data and statistics which can be used to support the provision of services for Māori accessing maternity care.

- **Could the research potentially benefit Māori?**

  As described above, it is my hope that improved guidance and information to support midwifery documentation will improve the ability of midwives to identify and articulate the needs and priorities of the women they are providing care to. If midwives understand how best to document and what to record, they can enhance their service provision, and the accuracy of the information available to support the maternity experiences of wāhine and their families will be improved. I think this is particularly important for Māori women who are over-represented in our more concerning maternity statistics.

Appendix Two: Ethics approval

19 February 2018

Bridget Kerkin

Dear Bridget

Re: Application for Ethics Consent

Reference Number: 754
Application Title: *The documentation of midwifery care: What serves as appropriate evidence of care?*

The review panel has considered your revised application including responses to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm ethical approval for the project.

We wish you well with your work and remind you that at the conclusion of your research to send a brief report with findings and/or conclusions to the Ethics Committee.

All correspondence regarding this application should include the reference number assigned to it.

Regards

Liz Ditzel (PhD)

Co-Chair, Otago Polytechnic Ethics Committee

Otago Polytechnic Forth Street Freephone 0800 762 786 Email: info@op.ac.nz Private Bag 1910
Phone +64 3 477 3014 www.op.ac.nz Dunedin 9054

Appendix Three: Study information sheet

Information Sheet

Project title The documentation of midwifery care: What serves as appropriate evidence of care?

General Introduction

As a midwife, and midwifery educator, my interest is in the process and practice of midwifery documentation. I am undertaking this research study in partial fulfilment of the requirements for a Master of Midwifery degree at Otago Polytechnic.

Effective and appropriate care of women within the maternity services of Aotearoa/New Zealand relies on the clear communication of the needs, care and well-being of mother and baby between health professionals, and between women and midwives. Midwives have a professional, legal and ethical responsibility to thoroughly and accurately record the care provided to their clients, the information shared between woman and midwife, and the decisions made within the midwifery partnership. While midwifery clinical documentation serves a number of important purposes there is currently little evidence for what constitutes appropriate content of the midwifery record. The development of a body of knowledge to support midwifery practice is, therefore, important.

What is the aim of the project?

The aim of this research is to canvas the opinions of a range of experienced midwives about what constitutes optimal documentation of

the care of women and babies, to answer the research question: "What should midwives write to provide evidence of the care they have provided?"

How will potential participants be identified and accessed?

You may be approached by my intermediary or find details about the study in the NZCOM newsletter. Midwives interested in participating are invited to contact me. My contact details are:

bridget.kerkin@op.ac.nz or 027 248 4382

What types of participants are being sought?

Participants must hold a current Annual Practicing Certificate and have a minimum of 10 years post-registration midwifery practice experience.

What will my participation involve?

Should you agree to take part in this project you will be initially invited to answer an open ended question about midwifery documentation. Responses to this question will be amalgamated and questions based upon the initial responses will be developed into a questionnaire. This survey will be distributed to participants, and the responses will again be collated and amalgamated into the next iteration of the questionnaire. This process will be repeated a third time and possibly a fourth time until consensus is reached or no new data emerges. The distribution of the questionnaires is expected to occur over a 6-8 month time period.

The surveys will be formatted electronically, using "Survey Monkey"; however, any participant who prefers a paper copy of the questionnaires can request this at any time. The link to the survey or a word document version of the questionnaire will be emailed to you. Alternatively, a printed version of the survey can be posted to you.

How will confidentiality and/or anonymity be protected?

Responses to the questions will be received directly by the researcher and the data will be de-identified on receipt. The individual responses will be entered into a database with no features identifying which participant has provided each response.

What data or information will be collected and how will it be used?

Results of this project may be published in midwifery related journals, and presented at midwifery related conferences. Each participant will be offered a copy of the results of the project once it is completed, and a link to the completed thesis.

Data Storage

Data will be securely stored electronically for a period of five years, after which it will be destroyed. Only the researcher will have access to the data.

Can participants change their minds and withdraw from the project?

You can decline to participate without any disadvantage to yourself. If you choose to participate, you may withdraw from the study at any time, without giving reasons for your withdrawal. You can also withdraw your responses up until the time they have been amalgamated into the next iteration of questionnaire.

What if participants have any questions?

If you have any questions about the project please contact:

Bridget Kerkin BSc BHSc PGDip, RM (Researcher)

Bridget.kerkin@op.ac.nz

Or

Assoc. Prof. Jean Patterson PhD, RM (Supervisor)

Jean.patterson@op.ac.nz

Or

Professor Vicki van Wagner PhD, RM
(Supervisor) vvanwagn@ryerson.ca

Appendix Four: Study consent form

Consent Form

Project title:

The documentation of midwifery care: What serves as appropriate evidence of care?

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage. I know that:

- my participation in the project is entirely voluntary and I am free to refuse to answer any particular question
- I am free to stop participating at any time without giving reasons and without any disadvantage
- I cannot withdraw any information I have supplied after the data is amalgamated into the next iteration of the questionnaire
- My data will be de-identifed at the point of receipt, and any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.
- the results of the project may be published in a peer reviewed journal and presented at an academic conference but my confidentiality will be preserved
- I will receive a summary of the research findings and a link to the completed thesis

I agree to take part in this research study

…… (signature of participant)

…… (date)

…… (signature of researcher)

…… (date)

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee (Ethics approval #754)

Appendix Five: Survey Two questions

Documentation research - survey two

Documentation research - survey two

The contributions to the first survey in this project identified broad themes which I would like to ask you to explore further in this second survey. You will find this survey structured as "Part A" and "Part B".

Part A addresses a number of "procedural" aspects of midwifery documentation which emerged in the first survey. There are twelve questions in this section of the survey.

Part B presents you with broad themes relating to the content of midwifery documentation, and invites further commentary. Because every context in which a midwife might document is relevant to the considerations of this project, please answer in as much detail as possible. There are seven questions in this section of the survey.

The survey is not complete until you click "next" after the seventh question in Part B. You will be able to exit and re-enter the survey until then.

Any comment boxes will expand to fit your entire commentary. Please feel free to respond in as much detail as you prefer.

Thank you again for your contribution.

Part A: The procedural aspects of midwifery documentation

Every individual entry:

Please indicate whether you agree that the following parameters are relevant for each and every episode of midwifery documentation.

Q1 Date and time of the entry

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q2 Location of the episode of care

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q3 People present during the episode of care (including whānau/support people)

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q4 Clear identification when an entry is being recorded retrospectively

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q5 The signature of the writer

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q6 Are there other similar "procedural" parameters which you believe should be included in each and every episode of midwifery documentation?

_____

_____

_____

The "procedural" aspects of midwifery documentation - every page of the record:

Please indicate whether you agree that the following parameters should be present on each page of the woman/baby's record.

Q7 The printed name and designation of the writer

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q8 A series of unique identifiers which identify the woman/baby to whom the record belongs (e.g., name, NHI, DOB)

- ○ agree (1)
- ○ disagree (2)
- ○ other (please comment) (3) _____

Q9 Are there other similar "procedural" parameters which you believe should be included on each page of the woman/baby's record?

_____

_____

_____

To further clarify some of the parameters of the "procedural" aspects of midwifery documentation identified in the first survey round, please provide your opinion below.

Q10 Do you believe there are any interactions with a woman where it is not necessary for a midwife to document? Please explain your response.

_____

_____

_____

Q11 How long after an episode of care has occurred do you think an entry in the woman's notes should be considered retrospective? Please suggest a time frame and explain when there might be an exception to this.

_____

_____

_____

Q12 How frequently do you recommend a midwife documents the care she is providing in a developing scenario (e.g., labour, an acute antenatal event, or postnatally)?

_____

_____

_____

Part B: The content of midwifery documentation

Please answer each question in as much detail as possible.
When you click the "next" arrow at the bottom of the page, your survey responses will be recorded.

Q1 In your midwifery documentation how do you record your discussion and the information sharing aspects of your interaction with a woman?

_____

_____

_____

Q2 In your midwifery documentation how do you represent the clinical information (i.e. tests, investigations and midwifery assessments) sought and responded to (by yourself and others)?

_____

_____

_____

Q3 In your midwifery documentation how do you represent your communication with other health professionals?

_____

_____

_____

Q4 In what ways, if any, would you recommend events be documented specifically as a record for the woman in her maternity notes?

_____

_____

_____

Q5 In what ways, if any, would you recommend midwifery documentation be recorded for healthcare facilities (including the woman's DHB), researchers, potential reviewers and data collectors?

_____

_____

_____

Q6 In what ways, if any, would you recommend midwifery documentation be recorded for other healthcare professionals involved in the woman's care?

_____

_____

_____

Q7 Is there anyone else you think a midwife should consider, when recording the details of the care she has provided?

_____

_____

When you click the "next" arrow below you will have completed the survey and your answers will be recorded.

Appendix Six: Survey Three questions

Documentation research - survey three

Documentation research - survey three

Your responses to the first and second surveys in this project have identified a number of important themes about the documentation of midwifery care. I would now like to clarify your opinion about these themes. You will find this survey structured as "Part A", "Part B" and "Part C".

Part A addresses the "procedural" aspects of midwifery documentation. This refers to the way the documentation is structured. There are twelve questions in this section of the survey.

Part B addresses the "style" of midwifery documentation. This relates to the way the documentation is written. There are four questions in this section of the survey.

Part C addresses the "content" of midwifery documentation. This refers to the content which is included in the record. There are nine questions in this section of the survey.

Some questions have multiple parts to them.
In each section please express your opinion for each question and then provide a comment, if you would like to.

Key:

I have used "episode of care" to describe each discrete episode of midwifery care.

I have used "documentation entry" to describe each individual time the midwife documents during that episode of care. For instance, midwifery care during labour might constitute one "episode of care" with multiple "documentation entries" associated with it. A planned antenatal visit would constitute one “episode of care” and might have one “documentation entry” associated with it.

I have used maternity record, midwifery record, notes and documentation interchangeably.

The survey is not complete until you click "next" after the final question in Part C. You will be able to exit and re-enter the survey until then.

Any comment boxes will expand to fit your entire commentary. Please feel free to respond in as much detail as you prefer.

Thank you again for your contribution.

Part A: The procedural aspects of midwifery documentation

The "procedural aspects" of midwifery documentation refers to the way the documentation is structured. There are twelve questions in this section of the survey.

Q1 Please indicate the extent to which you agree (or not) with the following statements:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. Documentation must be legible to all readers (1)	○	○	○	○	○
b. Each page of midwifery documentation should be numbered (2)	○	○	○	○	○
c. Midwives should sign each entry of documentation (3)	○	○	○	○	○
d. Midwives should record their designation on each page of documentation (4)	○	○	○	○	○
e. Midwives should record their role in the woman or baby's care (e.g., back-up midwife, LMC, postnatal shift midwife) on each page of documentation (5)	○	○	○	○	○
f. Midwives should ask women to sign the documentation associated with each episode of care (6)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 1 or have other thoughts to share (the text box will expand to fit your response):

_____

Q2 Please indicate the extent to which you agree (or not) with the following statements:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The date should be recorded at the top of each page of midwifery documentation (1)	○	○	○	○	○
b. The date should be recorded again if it changes during the sequence of documentation entries (i.e. if midnight passes, or a new midwifery contact is recorded for a different date, but on the same page as a previous contact) (2)	○	○	○	○	○
c. The time of writing should be documented at each entry of documentation of ongoing midwifery contact (3)	○	○	○	○	○
d. The time of the midwifery contact should be documented for a "routine" episode of antenatal or postnatal care (4)	○	○	○	○	○
e. Midwives should document the date and time of their phone conversations with clients (5)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 2 or have other thoughts to share (the text box will expand to fit your response):

_____

Q3 Please indicate the extent to which you agree (or not) with the following statements:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The location of care should be recorded for each discrete episode of care (1)	○	○	○	○	○
b. The location of care should be recorded for each new location that midwifery contact occurs in continuing documentation of an episode of care (i.e. location does not need to be recorded for an entry if the woman's location has not changed since the last entry during one episode of care) (2)	○	○	○	○	○
c. The presence of other health professionals should be recorded, if they are contributing to the decision-making associated with the woman's care, but someone bringing the woman a cup of tea, or changing bed linen (for example) does not need to be recorded (3)	○	○	○	○	○
d. Documentation of the presence of whānau/support people is essential when their presence is impacting the care provided or decisions made, but optional otherwise (4)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 3 or have other thoughts to share (the text box will expand to fit your response):

_____

Q4 Please indicate the extent to which you agree (or not) with the following statements:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The gestation of the pregnancy should be recorded for each antenatal visit (1)	○	○	○	○	○
b. The age of the baby, or the number of days postpartum, should be recorded for each postnatal visit (2)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 4 or have other thoughts to share (the text box will expand to fit your response):

_____

Q5 Please indicate the extent to which you agree (or not) with the following statements:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. Every woman should be offered a copy of her maternity record (including the antenatal, labour and birth and postnatal records) (1)	○	○	○	○	○
b. Every woman should be offered the opportunity to contribute to her maternity record by writing in the record herself (2)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 5 or have other thoughts to share (the text box will expand to fit your response):

_____

Q6 Please select as many choices as appropriate in response to the following question.

Each page of midwifery documentation should identify the woman and/or baby about which it is written, by including:

- ☐ The full name of the woman and/or baby (1)
- ☐ The NHI number of the woman and/or baby (2)
- ☐ The date of birth of the woman and/or baby (3)
- ☐ Other (please specify) (4) _____

Q7 Please select the answer which best represents your opinion.

When a midwife receives information that may compromise the safety or privacy of the woman, or the safety of the midwife, she should:

- ○ Record this information in the notes held by the woman (1)
- ○ Record this information in a separate record (not held by the woman) (2)
- ○ Not record this information at all, in order to avoid the information being accessed by others (3)
- ○ Other (please specify) (4) _____

Q8 Please select the answer which best represents your opinion.

When a midwife has clinical contact with the woman, in person or on the phone, without the maternity record being available, the midwife should:

- ○ Wait until she has the record and document in it (1)
- ○ Document the clinical contact in another location (2)
- ○ Not document the contact (3)
- ○ Other (please specify) (4) _____

Q9 Please select the answer which best represents your opinion.

Notes can be considered retrospective if they are written more than this period of time after events have occurred:

- ○ fifteen minutes (1)
- ○ thirty minutes (2)
- ○ One hour (3)
- ○ two hours (4)
- ○ four hours (5)
- ○ six hours (6)
- ○ twenty four hours (7)
- ○ forty eight hours (8)
- ○ one week (9)
- ○ Other (please specify) (10) _____

Q10 Please select the answer which best represents your opinion.

A midwife should document care during "active" labour at least:

- ○ every fifteen minutes or when a new event occurs (1)
- ○ every thirty minutes or when a new event occurs (2)
- ○ every hour or when a new event occurs (3)
- ○ Other (please specify) (4) _____

Q11 Please select the answer which best represents your opinion.

A midwife should document care when a woman is pushing at least:

- ○ every five minutes or when a new event occurs (1)
- ○ every fifteen minutes or when a new event occurs (2)
- ○ Other (please specify) (3) _____

Optional: Feel free to comment if you would like to clarify your responses to Questions 6-11 or have other thoughts to share (the text box will expand to fit your response):

_____

Q12 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The timeframe for retrospective recording of "routine" antenatal and postnatal events should be the same as for the retrospective recording of acute antenatal and postnatal events and labour and birth events (1)	○	○	○	○	○
b. During an antenatal or postnatal admission, when the woman and/or baby are stable, it is acceptable for the midwife to document once per shift, unless there is a change in the woman or baby's wellbeing (2)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 12 or have other thoughts to share (the text box will expand to fit your response):

_____

Part B: The style of midwifery documentation

The "style" of midwifery documentation relates to the way the documentation is written. There are four questions in this section of the survey.

Q1 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. Midwives should avoid the use of abbreviations in their documentation (1)	○	○	○	○	○
b. Midwifery documentation should be as clear and concise as possible (2)	○	○	○	○	○
c. Midwifery documentation should incorporate a conversational style (3)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 1 or have other thoughts to share (the text box will expand to fit your response):

_____

Q2 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. It is acceptable for midwives to use bullet points to detail information in the maternity record (1)	○	○	○	○	○
b. It is acceptable for midwives to use tick or check lists (e.g. for newborn examinations) (2)	○	○	○	○	○
c. It is acceptable for midwives to use tools such as stickers (for the documentation of CTGs, VEs for example) (3)	○	○	○	○	○
d. It is acceptable for midwives to use assessment summary records (e.g. partograms, MEWS charts) (4)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 2 or have other thoughts to share (the text box will expand to fit your response):

_____

Q3 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. Midwifery narrative documentation should be written in the same way regardless of the location of the record (i.e. hospital notes, electronic record, woman-held notes) (1)	○	○	○	○	○
b. For every woman, the maternity record should be written in a way, and using language, that can be understood by all interested parties (including the woman) (2)	○	○	○	○	○
c. Midwifery documentation is an important record for the woman and should be individually personalised (3)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 3 or have other thoughts to share (the text box will expand to fit your response):

_____

Q4 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The retrospective recording of "routine" antenatal and postnatal events should follow the same style as the retrospective recording of acute antenatal and postnatal events and labour and birth events (i.e. the retrospective nature of the record should be identified in the same way for these "routine" epsiodes of care) (1)	○	○	○	○	○
b. It is not necessary for a midwife to document information in more than one location (e.g., in the body of the notes and also on the partogram) unless the result is abnormal and follow up is required (2)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 4 or have other thoughts to share (the text box will expand to fit your response):

_____

Part C: The content of midwifery documentation

The "content" of midwifery documentation refers to the content which is included in the record. There are nine questions in this section of the survey.

Q1 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. When recording retrospectively, the midwife should document the reason for the retrospective entry (1)	○	○	○	○	○
b. A midwife should record any contextual issues which impact her ability to document or the frequency of her documentation (2)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 1 or have other thoughts to share (the text box will expand to fit your response):

_____

Q2 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. It is not necessary for a midwife to document changes to scheduled appointments (e.g., time and location) unless there is a clinical implication associated with the change (1)	○	○	○	○	○
b. Midwives should document the content of social or informal interactions with women (i.e. bumping into a current client in the supermarket) (2)	○	○	○	○	○
c. Midwives should document brief non-clinical interactions such as passing on a phone message, or serving the woman a cup of tea (3)	○	○	○	○	○
d. Midwives should document the content of their phone conversations with clients (4)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 2 or have other thoughts to share (the text box will expand to fit your response):

_____

Q3 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The woman's maternity record should clarify for the woman when she should be concerned about herself, or her baby, and make contact with a health professional (1)	○	○	○	○	○
b. The woman's maternity record should clarify for the woman who she should make contact with if she is concerned about herself or her baby (2)	○	○	○	○	○
c. The woman's maternity record should clarify for the woman how she should make contact with the appropriate health professional if she is concerned about herself or her baby (3)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 3 or have other thoughts to share (the text box will expand to fit your response):

_____

Q4 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The midwifery record should make visible the woman's active involvement in decision making relating to her care (1)	○	○	○	○	○
b. The maternity record should represent the context, perspectives priorities, actions, decisions and plans of the woman, and her whānau/support people where appropriate (2)	○	○	○	○	○
c. The midwifery record should represent the woman's understanding of the events which have occurred (3)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 4 or have other thoughts to share (the text box will expand to fit your response):

_____

Q5 Please indicate the extent to which you agree (or not) that:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. Midwifery documentation should make the holistic nature of midwifery assessments visible (1)	○	○	○	○	○
b. The midwifery record should represent the midwife's impression/interpretation of the events which have occurred/are occurring (2)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 5 or have other thoughts to share (the text box will expand to fit your response):

_____

Q6 Considering the general information recorded about a midwife's interaction with a woman and/or baby, please indicate the extent to which you agree (or not) that each of the following are important for a midwife to incorporate in her documentation:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. A summary of the purpose of the episode of care at the beginning of the documentation entry. E.g. "Antenatal visit as planned" or "Assessment in birthing suite for reduced fetal movements" (1)	○	○	○	○	○
b. During an acute assessment, or labour and birth, a brief summary of vital information about the woman and/or baby should be provided at the beginning of the documentation entry. E.g. blood group or any significant history (2)	○	○	○	○	○
c. The general wellbeing of the mother and/or baby and updates about this as the episode of care continues (3)	○	○	○	○	○
d. A summary of recent pregnancy or postnatal events (e.g., onset of fetal movements, cessation of nausea) (4)	○	○	○	○	○
e. Relevant personal commentary (e.g., family or work issue of importance to the woman) (5)	○	○	○	○	○
f. Midwifery plan arising from the assessment/contact (e.g., to re-check BP in 2 days) (6)	○	○	○	○	○
g. Support offered to the woman by the midwife (7)	○	○	○	○	○
h. Prescriptions provided (8)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 6 or have other thoughts to share (the text box will expand to fit your response):

_____

Q7 Considering the discussion and information sharing aspects of a midwife's interaction with a woman, please indicate the extent to which you agree (or not) that each of the following are important for a midwife to incorporate in documentation:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. A brief summary of the information shared and options discussed (1)	○	○	○	○	○
b. The reason/rationale for sharing this information/having this discussion (2)	○	○	○	○	○
c. A brief summary of any midwifery recommendations made (3)	○	○	○	○	○
d. A brief summary of resources provided (brochures, articles etc) (4)	○	○	○	○	○
e. Relevant questions asked by the woman during the discussion (5)	○	○	○	○	○
f. Decisions made by the woman as a result of the information shared (6)	○	○	○	○	○
g. Information that the woman may choose to refer back to (e.g., breastfeeding advice) (7)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 7 or have other thoughts to share (the text box will expand to fit your response):

Q8 Considering the clinical information (e.g., tests, investigations and midwifery assessments) made, interpreted or shared by a midwife, please indicate the extent to which you agree (or not) that each of the following are important for a midwife to incorporate in documentation:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The reason/rationale for the test, investigation or assessment being offered/ordered (1)	○	○	○	○	○
b. Information shared about the test, investigation or assessment being offered/ordered (2)	○	○	○	○	○
c. The woman's consent (if given) to the test, investigation or assessment (3)	○	○	○	○	○
d. The reason the woman has declined (if relevant) the test, investigation or assessment (4)	○	○	○	○	○
e. The result of the test, investigation or assessment (once available) (5)	○	○	○	○	○
f. That the woman has been informed of the result (6)	○	○	○	○	○
g. Ongoing plans or decisions the woman has made as an outcome of the result of the test, investigation or assessment (7)	○	○	○	○	○
h. Ongoing plans or decisions the midwife has made, or actions she has taken as an outcome of the result of the test, investigation or assessment (e.g., offer of further testing, provision of prescription, consultation etc) (8)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 8 or have other thoughts to share (the text box will expand to fit your response):

_____

Q9 Considering communication with other health or allied professionals, please indicate the extent to which you agree (or not) that each of the following are important for a midwife to incorporate in documentation:

	Disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Agree (5)
a. The reason for the communication/referral/consultation (1)	○	○	○	○	○
b. Consent from the woman for the referral or consultation (2)	○	○	○	○	○
c. Time and date of the communication (3)	○	○	○	○	○
d. Type of communication – phone, referral, face-to-face (4)	○	○	○	○	○
e. Name of the person communicated with (5)	○	○	○	○	○
f. Designation of the person communicated with (6)	○	○	○	○	○
g. Information provided to the health or allied professional (7)	○	○	○	○	○
h. Recommendation or response from the health or allied professional (8)	○	○	○	○	○
i. That the woman has been informed of the conversation and recommendation or response arising from it (9)	○	○	○	○	○
j. Decisions the woman has made as a result of the communication with the health or allied professional (10)	○	○	○	○	○
k. Ongoing plan/actions taken by the midwife as a result of the communication with the health or allied professional (11)	○	○	○	○	○

Optional: Feel free to comment if you would like to clarify your responses to Question 9 or have other thoughts to share (the text box will expand to fit your response):

_____

Thank you!

When you click the "next" arrow below you will have completed the survey and your answers will be recorded.

Appendix Seven: Statements which achieved participant consensus

1	Documentation must be legible to all readers
2	Each page of midwifery documentation should be numbered
3	Midwives should sign each entry of documentation
4	Midwives should record their designation on each page of documentation
5	The date should be recorded at the top of each page of midwifery documentation
6	The date should be recorded again if it changes during the sequence of documentation entries (i.e. if midnight passes, or a new midwifery contact is recorded for a different date, but on the same page as a previous contact)
7	The time of writing should be documented at each entry of documentation of ongoing midwifery contact
8	The time of the midwifery contact should be documented for a "routine" episode of antenatal or postnatal care
9	Midwives should document the date and time of their phone conversations with clients
10	The location of care should be recorded for each discrete episode of care
11	The location of care should be recorded for each new location that midwifery contact occurs in continuing documentation of an episode of care (i.e. location does not need to be recorded for an entry if the woman's location has not changed since the last entry during one episode of care)
12	The presence of other health professionals should be recorded, if they are contributing to the decision-making associated with the woman's care, but someone bringing the woman a cup of tea, or changing bed linen (for example) does not need to be recorded
13	Documentation of the presence of whānau/support people is essential when their presence is impacting the care provided or decisions made, but optional otherwise
14	The gestation of the pregnancy should be recorded for each antenatal visit
15	The age of the baby, or the number of days postpartum, should be recorded for each postnatal visit
16	Every woman should be offered a copy of her maternity record (including the antenatal, labour and birth and postnatal records)

17	Each page of midwifery documentation should identify the woman and/or baby about which it is written, by including: The full name of the woman and/or baby
18	Each page of midwifery documentation should identify the woman and/or baby about which it is written, by including: The NHI number of the woman and/or baby
19	Midwifery documentation should be as clear and concise as possible
20	It is acceptable for midwives to use bullet points to detail information in the maternity record
21	It is acceptable for midwives to use tools such as stickers (for the documentation of CTGs, VEs for example)
21	It is acceptable for midwives to use assessment summary records (e.g. partograms, MEWS charts)
23	For every woman, the maternity record should be written in a way, and using language, that can be understood by all interested parties (including the woman)
24	The retrospective recording of “routine” antenatal and postnatal events should follow the same style as the retrospective recording of acute antenatal and postnatal events and labour and birth events (i.e. the retrospective nature of the record should be identified in the same way for these "routine" episodes of care)
25	It is not necessary for a midwife to document information in more than one location (e.g., in the body of the notes and also on the partogram) unless the result is abnormal and follow up is required
26	When recording retrospectively, the midwife should document the reason for the retrospective entry
27	A midwife should record any contextual issues which impact her ability to document or the frequency of her documentation
28	Midwives should document the content of their phone conversations with clients
29	The woman’s maternity record should clarify for the woman when she should be concerned about herself, or her baby, and make contact with a health professional
30	The woman’s maternity record should clarify for the woman who she should make contact with if she is concerned about herself or her baby
31	The woman’s maternity record should clarify for the woman how she should make contact with the appropriate health professional if she is concerned about herself or her baby

32	The midwifery record should make visible the woman's active involvement in decision making relating to her care
33	The maternity record should represent the context, perspectives priorities, actions, decisions and plans of the woman, and her whānau/support people where appropriate
34	The midwifery record should represent the woman's understanding of the events which have occurred
35	Midwifery documentation should make the holistic nature of midwifery assessments visible
36	The midwifery record should represent the midwife's impression/interpretation of the events which have occurred/are occurring
37	In her documentation, it is important for a midwife to incorporate a summary of the purpose of the episode of care at the beginning of the documentation entry. E.g. “Antenatal visit as planned” or “Assessment in birthing suite for reduced fetal movements”
38	During an acute assessment, or labour and birth, a brief summary of vital information about the woman and/or baby should be provided at the beginning of the documentation entry. E.g. blood group or any significant history
39	In her documentation, it is important for a midwife to incorporate the general wellbeing of the mother and/or baby and updates about this as the episode of care continues
40	In her documentation, it is important for a midwife to incorporate a summary of recent pregnancy or postnatal events (e.g., onset of fetal movements, cessation of nausea)
41	In her documentation, it is important for a midwife to incorporate relevant personal commentary (e.g., family or work issue of importance to the woman
42	In her documentation, it is important for a midwife to incorporate midwifery plan arising from the assessment/contact (e.g., to re-check BP in 2 days)
43	In her documentation, it is important for a midwife to incorporate support offered to the woman by the midwife
44	In her documentation, it is important for a midwife to incorporate prescriptions provided
45	In her documentation, it is important for a midwife to incorporate a brief summary of the information shared and options discussed
46	In her documentation, it is important for a midwife to incorporate the reason/rationale for sharing this information/having this discussion

47	In her documentation, it is important for a midwife to incorporate a brief summary of any midwifery recommendations made
48	In her documentation, it is important for a midwife to incorporate a brief summary of resources provided (brochures, articles etc)
49	In her documentation, it is important for a midwife to incorporate relevant questions asked by the woman during the discussion
50	In her documentation, it is important for a midwife to incorporate decisions made by the woman as a result of the information shared
51	In her documentation, it is important for a midwife to incorporate information that the woman may choose to refer back to (e.g., breastfeeding advice)
52	In her documentation, it is important for a midwife to incorporate the reason/rationale for the test, investigation or assessment being offered/ordered
53	In her documentation, it is important for a midwife to incorporate information shared about the test, investigation or assessment being offered/ordered
54	In her documentation, it is important for a midwife to incorporate the woman's consent (if given) to the test, investigation or assessment
55	In her documentation, it is important for a midwife to incorporate the reason the woman has declined (if relevant) the test, investigation or assessment
56	In her documentation, it is important for a midwife to incorporate the result of the test, investigation or assessment (once available)
57	In her documentation, it is important for a midwife to incorporate that the woman has been informed of the result
58	In her documentation, it is important for a midwife to incorporate ongoing plans or decisions the woman has made as an outcome of the result of the test, investigation or assessment
59	In her documentation, it is important for a midwife to incorporate ongoing plans or decisions the midwife has made, or actions she has taken as an outcome of the result of the test, investigation or assessment (e.g., offer of further testing, provision of prescription, consultation etc)
60	In her documentation, it is important for a midwife to incorporate the reason for the communication/referral/consultation
61	In her documentation, it is important for a midwife to incorporate consent from the woman for the referral or consultation
62	In her documentation, it is important for a midwife to incorporate time and date of the communication
63	In her documentation, it is important for a midwife to incorporate type of communication – phone, referral, face-to-face

64	In her documentation, it is important for a midwife to incorporate name of the person communicated with
65	In her documentation, it is important for a midwife to incorporate esignation of the person communicated with
66	In her documentation, it is important for a midwife to incorporate information provided to the health or allied professional
67	In her documentation, it is important for a midwife to incorporate recommendation or response from the health or allied professional
68	In her documentation, it is important for a midwife to incorporate that the woman has been informed of the conversation and recommendation or response arising from it
69	In her documentation, it is important for a midwife to incorporate decisions the woman has made as a result of the communication with the health or allied professional
70	In her documentation, it is important for a midwife to incorporate ongoing plan/actions taken by the midwife as a result of the communication with the health or allied professional