Writing Maternity Notes in Family Clinic

- Clinical documentation is essential for communication between health care professional to ensure safe and effective care. It also forms the basis of evidence of care to be used for insurance purposes, legal analysis, quality improvement and research.
- Good notes need to be clear, concise and complete, but without duplicating information. They should be completed as soon as possible after an episode of care.
- Do not copy and paste
- Interns should consult for each case. Record who you consulted with and what was communicated

This document is to be used <u>alongside</u> the ROUTINE ANTENATAL CLINIC guideline

1. FIRST ANTENATAL APPOINTMENT IN FAMILY CLINIC

SUBJECTIVE:	
History of this pregnancy	• Age • Parity, gravidity, number of living children • LMP (is she sure?), GBD or GBU (gestation when US was done), **<u>AGREED</u>** EDD (communicate this to patient to avoid confusion of conflicting dates) • How she is feeling, fetal movements, any symptoms/problems/worries • Any key obstetric symptoms / red flags? (nausea/vomiting, PV bleeding or d/c, abdo pain, headache, visual disturbances, epigastric pain, swelling, pruritis, chest pain or SOB, fever) • Details of previous care in this pregnancy and/or antenatal profile • Mental health • If any significant symptoms then take a full history of that problem
Past Obs/Gyn history	Details of each pregnancy in **order by year**, delivery, post-partum period, complications and management Previous contraception Menstrual history Cervical screening details Any gynae conditions or surgery Breast problems STIs
PMSH	• Hx of chronic illnesses (especially diabetes, epilepsy, thyroid disorder, VTE, heart disease, HIV) • Hx of surgery • Any admissions • Hx of transfusions
Meds	• Include **generic** name of medication instead of brand, as well as doses, compliance, side effects • Encourage patient to bring all medication to every visit
Allergies	Medication and reaction
FSH	• Work, home, social support structures • GBV screening • NHIF or other insurance • FH of cardiovascular dx/cancer/autoimmune as pertinent • Alcohol, tobacco, drug use • **Spiritual history**

OBJECTIVE:

- **Appearance/general** – baseline BMI (if later presentation ask if patient knows her non-pregnant weight or check MUAC)
- **Vital signs** - Complete set. Any abnormal vitals make sure to comment in your assessment
- **General physical exam** – heart and lung examination and other systems according to history
- **Obstetric examination** – abdo (presentation, position), FHR and FH (more detail if late presentation as per ANC guideline. e.g. CEFW), speculum if indicated
- **Investigations:** Any from elsewhere. Document to show you have reviewed.

ASSESSMENT AND PLAN:

Summary of the case including age, parity, gestation and any risk factors or problems.
e.g. *"32y G4, P2+1, 2 living, 13 weeks GBD with history of primary PPH. Current symptoms of nausea but drinking well with no dehydration"*

- Plan for tests or interventions that day (if required)
- Report and review of any investigations done (indicate the **time that you review results** if later)
- **Plan of management** - for the pregnancy and for any particular issues, plan for delivery (discuss from early on)
  - be sure to include **follow-up plan, plan for tests** and **review of danger signs**
- ICD-10 diagnosis – ensure this is accurate, even if you have to change the diagnosis after results; give more than one diagnosis if relevant
- If you have consulted with someone more senior, **ALWAYS** document their name and what was said

2. FOLLOW UP ANTENATAL VISITS

SUBJECTIVE

Introductory statement	Age, parity, GBD or GBU (as per previously agreed EDD), number living children, **high risk or normal risk** pregnancy (and give reason)
History of this pregnancy	• How she is feeling, fetal movements, any symptoms/problems/worries • Interval history since last visit, how are the symptoms/illnesses progressing • Any key obstetric symptoms / red flags? (nausea/vomiting, PV bleeding or d/c, abdo pain, headache, visual disturbances, epigastric pain, swelling, pruritis, chest pain or SOB, fever) • If any new symptoms then take a full history of that problem • Mental health
Past Obs/Gyne/Medical/ Surgical history	Past history can be reviewed and verified from initial visit – record that this has been done, but no need to write everything out again if it is correct. *"Past obstetric and medical history reviewed, verified and noted"*
Updated medication list	• Include **generic** name of medication (not brand), as well as doses, compliance, side effects • Encourage patient to bring all medication to every visit

OBJECTIVE

- Appearance/general
- Vital signs - complete set. Any abnormal vitals make sure to comment in your assessment
- Weight - note weight gain
- Obstetric examination **– abdo** (presentation, position), **FHR and FH,** CEFW (3rd trimester), speculum if indicated
- Further examination as indicated by history
- Investigations: Any from elsewhere. Document to show you have reviewed.

ASSESSMENT & PLAN

Summary of the case including age, parity, gestation and any risk factors or problems
e.g.*"32y G4, P2+1, 2 living, 21 weeks GBD with history of primary PPH. No additional risk factors or problems currently identified"*

- Plan for tests or interventions (if required)
- Report and review of any investigations done (indicate the **time that you review results** if later)
- **Plan of management** - for the pregnancy and for any particular issues**, plan for delivery** (discuss from early on)
  - be sure to include **follow-up plan, plan for tests** and **review of danger signs**
- ICD-10 diagnosis – ensure this is accurate, even if you have to change the diagnosis after results; give more than one diagnosis if relevant
- If you have consulted with someone more senior, **ALWAYS** document their name and what was said