

**Scottish Woman Held Maternity Record (SWHMR) – Draft Version 5 - for Consultation**

**Consultation Feedback Form**

The consultation period for the Scottish Woman Held Maternity Record (SWHMR) – Draft Version 5 - for Consultation takes place between Monday 28 March – Friday 6 May 2011. Please download a copy of this from our website ([www.nhshealthquality.org](http://www.nhshealthquality.org)) and return completed forms to [swhmr.gis@nhs.net](mailto:swhmr.gis@nhs.net) no later than **Friday 6 May 2011**.

We would be grateful if you could take the time to complete this form as fully as possible; all comments will be considered and will help to shape version 6 of the SWHMR. All pages in the record are numbered for ease of reference.

**About you:**

<b>Job Title – must be completed</b>	Senior Policy and Parliamentary Officer
<b>NHS Board / Local Authority / Organisation - must be completed</b>	Children in Scotland

**COMBINED PREGNANCY AND POSTNATAL RECORD**

<b>Specific Questions</b>	<b>Your Comments</b>
The pregnancy and postnatal records have been combined to encourage information sharing across care episodes and to minimise clinical risk and child protection issues. Do you think this is helpful?	We think sharing of information, particularly between staff delivering pregnancy care and those providing post-natal support, can be a critical factor in promoting child-well being from the outset. Anything that facilitates this is welcome.

<p>Some information has been inserted into a table format (pages 8-9). Does this make the document easier to complete?</p>	
<p>Clinicians requested that the fundal height column (pages 14-19) is moved to the location it traditional sat in the shared care card. Is this helpful to clinical practice?</p>	
<p>Should reference be made to the newly released Scottish Nutrition &amp; Diet Resources Initiative (SNDRI)</p>	<p>Yes, although our general comment is that giving paper information needs to be supported by ensuring that the prospective mother and the prospective father/partner understands the material and how to act on its advice -- and by following up and reinforcing the messages. Information about alcohol use during pregnancy (and awareness raising about the risk of fetal alcohol harm) should be accorded the same prominence now given to smoking during pregnancy.</p>

<p>leaflets about healthy eating and managing weight gain during pregnancy on page 27?</p>	
<p>The “your progress” sections in the postnatal section of the records (pages 38-41) have been rotated from landscape to portrait layout is this preferred by clinicians?</p>	
<p>Gender based violence colleagues have requested that a box is visible to clinicians identifying if routine enquiry has been undertaken. This has</p>	<p>This information is of great importance in determining risk to mother and baby, and providing appropriate care, advice and support. We have concerns about it being contained in a document to which a violent partner, for example, could have access. Of course, we recognise that this is an attempt to convey the information to professionals in a discreet way. However, it is not possible to guarantee that the significance of this can be kept secret and indeed it would be legally questionable whether this information could be withheld if clarification was requested. We think that some other way of recording and sharing this data should be considered.</p>

<p>been inserted into the pregnancy record (page 18) and referred to as RE. Is this helpful to clinicians?</p>	
<p>The recent CEMACH report recommends the use of a national MEWS chart. Should this MEWS sit within the record?</p>	
<p><b>Please provide your comments on the following</b></p>	
<p>Outside cover</p>	
<p>Pages 2 - 3</p>	
<p>Pages 4 - 5</p>	<p>Sometimes the purpose of the questions is not clear (ie is a question for gathering genetic/medical information or social information or a combination?)</p> <p>Replace: “Is current pregnancy with a new partner” with “Have you previously become pregnant by, or had a baby with, this father? – as ‘new partner’ is too ambiguous – (you could become pregnant with one man but now be living with another (or with a woman). Perhaps there should be an additional question for those using donor sperm.</p> <p>Why is there not a question explicitly about previous terminations to pregnancy? Similarly, while the information might be embedded in answers about previous pregnancies, there is nothing explicitly asked about still births or other foetal deaths post-20</p>

	<p>weeks. Perhaps such questions should be asked.</p> <p>For previous pregnancies, the 'problems' queried are limited to the post-natal period (even if that baby is now a teenager or young adult). It would be a good opportunity to get information about previous problems (and therefore, potential risks) with child health – especially since a variety of significant problems (e.g. learning disabilities or degenerative conditions are not able to be diagnosed in the post-partum period. Adding a new category here about major health problems or chronic conditions seems like a good idea.</p>
Pages 6 - 7	<p>We were not sure about the ethnic origins questions. They seem too general for purposes such as determining the level of need for translation/interpretation or medical risks more prevalent in certain countries or among certain communities. On the other hand they seem over-specific for demographic monitoring.</p> <p>We are concerned about the use of the term 'female circumcision'. This should be referred to as Female Genital Cutting or Mutilation which is the standard language used internationally.</p>
Pages 8 - 9	<p>The point would be clearer – and the data more useful – if the question: “What do you know about drinking/smoking during pregnancy?” was changed to “What do you know about the risks to your baby from drinking/smoking during pregnancy?”</p> <p>Maternal alcohol consumption between conception and booking should be both explicitly asked about and recorded – both here in the child’s health record -- as this is directly relevant to the identification of fetal alcohol harm.</p> <p>Possibly the term 'street drugs' needs some elaboration. The question “Do you or have you ever attended an addiction service?” should explicitly include alcohol and tobacco – otherwise, it will be taken to refer only to street drugs.</p> <p>We believe that the information captured on these pages could be expanded to cover a number of other relevant social factors. The opportunity presented when gathering this information is unique in identifying the degree of risk to this mother/child, so getting as comprehensive a picture as possible would be invaluable. This is consistent with the aspiration to 'get it right for every child'. Some suggestions are listed below.</p> <ul style="list-style-type: none"> <li>• Pregnancy planned or not</li> <li>• Emotional response to pregnancy</li> <li>• Attendance at and response to ante-natal classes</li> <li>• Mental health questions should cover wider categories of mental well-being including 'softer' issues e.g. stress, low-level depression, anxiety etc.</li> <li>• Level of educational qualifications</li> <li>• Employment</li> <li>• Household composition and relationship to patient</li> </ul>

	<ul style="list-style-type: none"> <li>• Basic profile of household members</li> <li>• More detailed profile of partner, whether or not in household</li> <li>• Experience of caring for babies/young children</li> <li>• Own experience of being parented</li> <li>• Contact with immediate and extended family</li> <li>• Previous children – feeding, sleeping and weaning experience</li> <li>• Previous children – admissions to SCBU</li> </ul>
Pages 10 - 11	<p>It may be helpful if a reason for refusal was documented.</p> <p>It is not clear whether the boxes and list under screening for fetal abnormalities are just a bullet point list of examples or are a list of options to be ticked, although the former seems most likely. If a bullet point list, it should have a different visual, not a box.</p> <p>Perhaps this section should go after the second request for consent, rather than being sandwiched between two consent sections.</p> <p>Is Neural tube defects synonymous with Spina Bifida? This is unclear. On page 11 you can choose to be screened for Neural Tube Defects, but this is not mentioned on page 12, where Spina Bifida is included.</p>
Pages 12 - 13	<p>This needs to go beyond 'discussed' i.e. 'understood' and 'acted on'.</p> <p>'Rooming in' – does this mean the same as 'keeping baby near'? It is a phrase used later in the record and as it is not normal language it needs to be clear i.e. "Rooming in" means having your baby in the same room as you, or simply keeping baby near. Repeat this explanation later in the record.</p>
Pages 14 - 15	
Pages 16 - 17	
Pages 18 - 19	
Pages 20 - 21	

Pages 22 - 23	
Pages 24 - 25	
Pages 26 – 27	<p>Once again we believe that provision of written information needs to be followed up and reinforced.</p> <p>There is no reference here to the forthcoming NHS Parent Education Syllabus, but it should be referenced. Similarly, there are references to smoking cessation information and support, but nothing at all about dealing with alcohol-related concerns before, during and after pregnancy. That gap should be filled.</p>
Pages 28 – 29	
Pages 30 - 31	<p>The questions “Do I understand... etc seem a strange change of tone from ‘you’ questions to self-reflecting ‘I’ questions that sometimes seem a little forced. The question about the baby’s heartbeat monitoring perhaps should be more like the vaginal examination question – how do you feel about it? – rather than seeming to ask for specific medical instructions. If a woman has clear views they can be expressed here, but equally if a woman would like to emphasise freedom of movement, this can be included here. For example, a continuous electronic monitoring does not necessarily mean lying on your back.</p> <p>Comprehension and voicing opinions in this section is highly dependent on access to antenatal education/information. Again this section should highlight the NHS parent education syllabus and opportunities to learn/discuss these issues.</p>
Pages 32 - 33	
Pages 34 – 35	This is a very practical section that a woman might want to reference easily and quickly to check when an appointment is, but it is in the middle of the book and so requires a lot of leafing through pages. Might this not be better at the back or front?
Pages 36 – 37	<p>Midwives should not take a ‘deficit’ approach (third bullet point) – question would more appropriately be ‘What would positively promote this woman’s or baby’s wellbeing?’.</p> <p>Typo in second bullet point – ‘woman’s and family’s’ not ‘woman and families’.</p>
Pages 38 - 39	

Pages 40 - 41	
Pages 42 – 43	
Pages 44 – 45	
Pages 46 – 47	
Pages 48 – 49	
Pages 50 - 51	
Back cover	
Any other comments on combined pregnancy and postnatal record	<p>There is no reference to emotional attachment or bonding in the post-birth part of the form. Given the huge significance of this to later outcomes, it would be important to include this issue.</p> <p>A report by a Government-funded Expert Working Group on Infant Mental Health led by Dr Christine Puckering in 2007 made clear suggestions of ways midwives could support emotional attachment and parent-baby interaction. Specifically: “The Brazelton Neonatal Behavioural Assessment (7) should be demonstrated to all parents before discharge”.</p> <p>This should be recorded alongside the list of care that focuses on cleanliness and feeding.</p> <p>Further details are here:  <a href="http://www.playfieldinstitute.co.uk/information/pdfs/publications/Infant_Mental_Health/InfantMentalHealthGuideForPractitioners.pdf">http://www.playfieldinstitute.co.uk/information/pdfs/publications/Infant_Mental_Health/InfantMentalHealthGuideForPractitioners.pdf</a></p> <p>This record largely ignores the impact of fathers (biological or de facto) to the health and well-being of the mother and baby during and after pregnancy. The forthcoming DADs2b resources should be referenced and information incorporated throughout this Record that is inclusive of fathers/partners.</p>

## MATERNITY SUMMARY RECORD

Specific Question	Your Comments
A chronology of significant events has been included in the maternity summary (page 3). This is similar to the chronology used by public health nurses/health visitors. The aim of the chronology is to highlight strengths, assets and challenges. Will clinicians find this helpful/workable?	A chronology is helpful in understanding circumstances that may affect the outcomes for mother or child for good or ill. Some clear guidance needs to be provided on what is appropriately recorded here.
<b>Please provide your comments on the following</b>	
Page 1	
Pages 2 - 3	
Pages 4	
Any other comments on maternity summary record?	

## LABOUR AND BIRTH RECORD

Specific Questions	Your Comments
The labour and birth record has been increased to A4 size is this helpful?	
The layout of the labour and birth record has been altered with a stronger focus on normality, is this acceptable?	
The management of PPH (page 30) has been altered to reflect that taught by the SMMDP and contained in the green top guidelines, are any amendments required?	
Is the flow of the content logical?	
We are currently sourcing a partogram, should the partogram contain the 4 hour action line as recommended by WHO?	
<b>Please provide your comments on the following:</b>	
Outside cover	
Pages 2 - 3	
Pages 4 - 5	
Pages 6 - 7	
Pages 8 - 9	

Pages 10 - 11	
Pages 12 - 13	
Pages 14 - 15	
Pages 16 -17	
Pages 18 -19	
Pages 20 - 21	
Pages 22 -23	
Pages 24 -25	
Pages 26 – 27	
Pages 28 – 29	
Pages 30 -31	
Pages 32 -33	
Pages 34 – 35	

Pages 36 – 37	
Pages 38 -39	
Back cover	
Any other comments on the labour and birth record?	

## ELECTIVE LUSCS RECORD

Specific Question	Your Comments
Clinicians requested a separate booklet for women having an elective LUSCS; this booklet is very much in first draft format. Would this booklet be beneficial to your unit?	Use the acronym alongside more ordinary language if it is to be seen by women as well as staff.
Is anything missing from the pre-op checklist?	
The consent form is the one currently utilised by NHS GG&C. Is there a universal consent form that could be utilised for the national record?	
Is it beneficial to have the WHO surgical safety checklist for maternity cases included in this part of the SWHMR?	
The questions used in routine surveillance of infection have been included in page 6 is this appropriate/helpful?	
<b>Please provide your comments on the following</b>	
Pages 1 – 2	
Pages 3 – 4	
Pages 5 – 6	
Pages 7 – 8	
Any other comments on the elective LUSCS	

record?	
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**LABOUR AND BIRTH SUMMARY – MULTIPLE BIRTHS**

<b>Specific Question</b>	<b>Your Comments</b>
Clinicians asked for a better way to record multiple births, do you think this document is helpful?	
<b>Please provide your comments on the following</b>	
Pages 1 – 2	
Pages 3 – 4	
Any other comments on multiple births insert?	

## NEONATAL RECORD

Our Question	Your Comments
<b>Please provide your comments on the following</b>	
Pages 1 – 2	
Pages 3 – 4	
Any other comments on the neonatal record?	While social history is referred to on page 2, the examples appear to indicate that only 'high tariff' situations are appropriate to include. Our comments on the SWHMR suggest that a wider range of social factors should be included. We would like to see the neonatal record reflecting this wider range of social issues that may impact on the baby's wellbeing and development.

## BABY RECORD – MIDWIFERY CARE

Specific Question	Your Comments
The “your baby’s progress” sections the records have been rotated from landscape to portrait layout, is this preferred by clinicians?	
<b>Please provide your comments on the following:</b>	
Outside cover	
Pages 2 - 3	
Pages 4 - 5	
Pages 6 - 7	

Pages 8 - 9	
Pages 10 - 11	
Pages 12 - 13	
Pages 14 - 15	
Back cover	
Any other comments on the baby record – midwifery care?	Once again we are concerned that information known about the mother and documented in the SWHMR, even when directly relevant to the health and wellbeing of the baby, is not replicated or referred to in this document.

**OTHER – please add any other comments that you have on the SWHMR here**

1. Not only should there be a more comprehensive set of social information gathered on the SWHMR, there should be a clear and consistent national approach as to how issues that arise here are addressed. This is entirely in line with the principle of ‘Getting It Right For Every Child’.

2. Some information included in the SWHMR, even when directly relevant to the baby’s health, such as maternal alcohol consumption, is not routinely transferred to neonatal or baby records. Systems to ensure transmission of such information should be developed. This principle should also apply when the mother and baby transfer from maternity to community health services. It would be of particular value to Health Visitors if this information were routinely shared/accessible.

3. Although we are aware that there are at present no plans for a national electronic version of the SWHMR, such a development would facilitate accessibility of relevant data to the appropriate professional staff.

4. If and when an e-SWHMR is developed, we would urge that it is set up so that data fields can be aggregated and correlated.

5. There should be a greater recognition of fathers (biological or de facto) and partners throughout these documents – and they should become part of the movement to become more inclusive of prospective fathers in maternity and antenatal services.

6. There should be greater emphasis on raising awareness about the value of family planning and preconception health/care through these documents, given that for many women, this pregnancy will not be their last pregnancy.

7. The risks of fetal alcohol harm should be given equal attention and priority with the risks of smoking and street drugs,

8. While acronyms should be avoided and medical terminology explained in context, there should be a glossary to enable women to make the best use of the information they are carrying with them.

9. Women are encouraged to record their own view/thoughts etc in this document to aid discussions and influence care from medical practitioners. The more involvement women have with this record, from carrying it, to inputting information and reading it for an insight and understanding into the medical processes around their care, the more attached they become to it. However, when signed off by the midwife, the document is removed for medical filing with little thought to the woman’s wish to retain this information for reflection or personal reference for future pregnancies. This might be particularly important for women experiencing post-natal problems/depression etc or for women’s experience of care during subsequent pregnancies.

It seems overly authoritarian to talk about it being “property” of the NHS Board, while also encouraging women to ‘feel free to write in your record’. There seems to be a conflicting notion of ownership. Suggesting women contact the NHS Board data controller to gain a copy they have to pay for just conveys a message that you can have a copy but it will be made difficult for you. This attitude conveys a

feeling of an authoritarian NHS and a passive woman patient, rather than as is intended by policies such as KCND, a partnership of care whereby the best care is gained through a woman's active involvement and engagement with staff who are able to listen and be sensitive in their offering of care.

A copy of the report should be offered as standard. It could be a scanned pdf copy or photocopy, or even the original, if storage of the data is done digitally. Women need not accept the offer.

Please return completed forms to:

Dawn Robb  
Administrative Officer  
NHS Quality Improvement Scotland  
Elliott House  
8-10 Hillside Crescent  
Edinburgh, EH7 5EA

OR

[swhmr.qis@nhs.net](mailto:swhmr.qis@nhs.net)

For further information on the project please visit:

[www.nhshealthquality.org](http://www.nhshealthquality.org)