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Documentation, Reporting and Legal Aspects in Midwifery

Midwifery & Obstetrical Nursing

Maternal and newborn records, labour room documentation, birth registration, informed consent, confidentiality, professional accountability, obstetric emergencies reporting and medico-legal responsibilities.

For educational purposes only.

CHAPTER 26 / MIDWIFERY AND OBSTETRICAL NURSING 26. Documentation, Reporting and Legal Aspects in Midwifery

1. Purposes and principles

Maternity documentation supports continuity, early recognition, audit, legal accountability and service planning. Record accurate, timely, objective, dated/timed and attributable information; use approved abbreviations, correct errors according to policy and preserve confidentiality. Do not copy unverified observations or alter records to hide errors.

Record	Essential content
ANC/MCP card or electronic record	Registration, LMP/EDD, gravida/parity, history, vitals, tests, fetal assessment, supplements/vaccines, high-risk status and follow-up.
Labour record/LCG or partograph	Time, maternal observations, FHR, contractions, cervical findings, membrane status, supportive care, medications, escalation and consent.
Birth and newborn record	Birth date/time, mode, attendants, maternal blood loss, placenta/perineum, newborn identifiers, sex recorded for clinical/register purpose after birth, weight, Apgar, resuscitation, prophylaxis and feeding.
Postnatal record	Uterus, lochia, vitals, wound, pain, bladder/bowel, mental health, feeding, newborn findings, counselling and referrals.
Emergency/transfer report	Onset/condition, trends, interventions and times, medicines/fluids, team notified, destination, transport and response.
Incident/death reporting	Objective events, immediate care, authorized reporting and review including maternal/perinatal death surveillance as required.

2. Birth registration and legal context

Birth registration is governed in India by Registration of Births and Deaths Act and applicable rules/amendments. Health institution's designated informant/registering process reports births and deaths to civil registration authority according to timelines; commonly standard reporting within 21 days, verify local rules and duties. Clinical birth record is distinct from official civil birth certificate. For pregnancy termination use MTP Act and current rules, authorized provider and required consent/confidentiality; do not disclose prohibited information.

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PCPNDT law prohibits sex selection and disclosure of fetal sex for prohibited purposes; medically indicated ultrasound/diagnosis subject to requirements. Report child safeguarding or sexual offence concerns through applicable statutory/institutional pathways (including POCSO when relevant).

3. Consent, accountability and emergencies

Explain procedure, benefits, material risks, alternatives and option to refuse through responsible clinician; verify valid consent and decision-making support, document discussion/decision and emergency lawful basis if applicable. Obtain separate appropriate consent for student involvement. Preserve dignity and privacy even in emergencies, share information only as authorized. Practice within professional scope, follow authorized prescriptions, escalate deterioration and report clinical errors promptly. Keep samples, records and medico-legal evidence according to chain-of-custody policy when relevant.

4. Clinical handover and documentation example

SBAR: situation - postpartum woman with measured increasing blood loss and tachycardia; background - time/mode of birth and risk factors; assessment - current volume, vitals, uterine tone and treatment; recommendation - immediate PPH team review/transfer. Record exact time of call, advice, drugs and response. Review care and participate in improvement without fabricating records. Use current official laws/rules and facility protocols for definitive legal obligations.

5. Important Examination Questions

Long Answer Questions

1. 1. Explain obstetrical records, legal responsibilities and emergency reporting.

Short Answer Questions

1. 1. Describe birth registration
2. 2. explain informed consent and confidentiality
3. 3. state legal concerns in prenatal diagnosis.

Very Short Answer Questions (with answers)

1. 1. What does SBAR stand for? - Situation, background, assessment, recommendation.
2. 2. Is birth record always the civil birth certificate? - No.

6. Quick Revision

- Timely records support safety.
- Consent and legal obligations require verification.
- Escalate and document emergencies accurately.

7. Conclusion

Timely records support safety. Consent and legal obligations require verification. Escalate and document emergencies accurately.

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B.SC. NURSING / CHAPTER-WISE STUDY NOTES

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Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. Which documentation entry best supports clinical accountability?

A. Copied observations that were not verified

B. Undated notes without the examiner's identity

C. Accurate, objective findings that are dated, timed and attributable

D. Altered records that conceal an error

2. In SBAR handover, which element contains the request for immediate team review?

A. Situation

B. Background

C. Assessment

D. Recommendation

3. Which statement correctly distinguishes a clinical birth record from a civil birth certificate?

A. They are distinct records

B. Every clinical birth note is automatically the official civil certificate

C. The birth certificate replaces all clinical newborn documentation

D. Neither requires a record of the birth date

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Answer key and explanations

1. C - Accurate, objective findings that are dated, timed and attributable

Clinical records must be accurate, timely, objective and attributable.

2. D - Recommendation

Recommendation states the requested action or next step.

3. A - They are distinct records

The clinical record and the official civil birth certificate serve different functions.

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