

DEPARTMENT OF MIDWIFERY
Chart Audit SUMMARY Form

Attending RM _____

Date Chart Review begun _____

Chart	1	2	3	4	5
Initials of reviewer					
Initials of client					
Date of delivery event					

Date completed _____

No denotes situations where it is verified that standard care was not done and explanations for variations were not documented.

N/A denotes that the topic was not relevant, e.g. genetic screening if late to care, or care could not be verified, e.g. if Antenatals not complete.

YES	NO	N/A	PRENATAL CARE
ANTENATAL 1			
			1. Personal information
			2. Allergies ...Medications/herbals ...Beliefs & practices
			3. OB hx
			4. Dating hx
			5. Present pregnancy
			6. Family hx
			7. Medical hx
			8. Lifestyle & Social hx
			9. Physical exam (done by MW, or noted as done by MD)
			a. Pap smear and vaginal swabs
			11. Summary & signature
ANTENATAL 2			
			12. Planned place of birth documented on Antenatal 2
X	X	X	13. Testing/exams as required – f/u if necessary:
			a. Blood work
			b. WinRho given or documented as declined
			c. Urine: culture and sensitivity
			d. Ultrasound
			e. Other
X	X	X	16. Narrative notes:
			a. SFH appropriate – deviations & f/u testing accounted for
			b. SFH plotted on curve

			c. Number of AN visits meets standard of midwifery care (minimum q6 wks until 30 wks; q3 wks until 36 wks; q2 wks until delivery)
			d. ICD: Genetic testing (TMS, SIPS, IPS, CVS, Amnio) – f/u if necessary
			e. ICD: GDM Screen – f/u if necessary
			f. ICD: GBS – plan noted unless GBS negative
			g. ICD: Third stage management
			h. ICD: NB procedures
			i. ICD: Postdates care
			j. Declining of any standard testing documented
			Most recent antenatals in hospital chart
YES	NO	N/A	LABOUR AND BIRTH
X	X	X	Charting done in appropriate places:
			1. Physician Hx and Progress notes as required by hospital
			a. Clear plan documented
			b. EFM interpretation/comment as indicated (N/A if no EFM)
			c. GBS protocol followed or alternative approach documented (N/A if GBS neg)
			d. VE's documented thoroughly
			e. Informed refusal of any treatments documented
			f. Delivery note
			g. Transfer of care documented (N/A if not relevant)
			2. Partogram
			a. FHT assessed and charted appropriately
			3. Orders completed appropriately
YES	NO	N/A	POSTPARTUM
			PP visits daily while in hospital
YES	NO	N/A	NEWBORN
			Resuscitation charting completed on NB Record
			PP visits daily while in hospital
YES	NO	N/A	GENERAL
			Consultations obtained and documented as needed (N/A if not relevant)
			Complete & legible documentation
			Appropriate overall care
NOTES/COMMENTS			