

Maternity record standard project – survey 1 findings (antenatal period)

This report presents a summary of the findings from an online survey consultation conducted as part of the maternity record standard project. The survey ran from 08 December 2017 until 22 January 2018. The purpose of the consultation was to capture the views of pregnant individuals and parents, carers, healthcare professionals, and clinical information system suppliers on draft national standards for the structure and content of a maternity record standard. The focus of this survey was the antenatal period, including booking and antenatal care. The draft standards consulted on via the survey were developed following an evidence review and informed by a consultation workshop held at the Royal College of Physicians on 9 November 2017.

Methods

An online survey using Survey Monkey software was developed to seek feedback on draft national standards for the structure and content of a maternity record, with a focus on antenatal care. A stakeholder mapping exercise was undertaken and the survey was communicated via a number of channels using social media, direct emails and newsletters.

The survey asked for feedback on five main areas, identified during the evidence gathering and consultation workshop phase as needing wider consultation. A copy of the survey can be found



Maternity survey 1
surveymonkey copy.pc

These areas included:

1. What types of investigation results would be expected to be recorded in a maternity record?
2. How should 'Family history' be recorded?
3. How should 'Clinical risk factors' be recorded?
4. What types of information should be recorded under 'Past obstetric history'?
5. Should a pregnancy that ends before 24 weeks be referred to as 'fetal loss' or 'fetal demise'?

Participants were given the opportunity to provide additional feedback under an 'any other comments' section.

Quantitative analysis of the survey responses was conducted to identify the preferred position of the survey respondents. In addition, a thematic analysis was conducted on the qualitative responses to identify common themes in the data. The findings can be found below. It is suggested that when the project team reviews the findings the following considerations are taken into account:

- a) a greater majority of respondents across all professional and patient cohorts demonstrate a preference for a position;
- b) a stronger rationale for an alternative minority position is demonstrated, eg patient safety;

c) a suggestion is not assessed as practical to implement at this time.

Findings

Participation

Eight hundred and fifteen people participated in the survey. A breakdown by respondent role is presented below:

<i>Role</i>	<i>No.</i>	<i>%</i>
Pregnant person or parent	115	13.81%
Allied health professional	9	1.08%
General practitioner	15	1.80%
Health visitor	11	1.32%
Health/care system vendor or developer	6	0.72%
Informatician	9	1.08%
Midwife	552	66.27%
NHS administration/ management	32	3.84%
Nurse	19	2.28%
Obstetrician	52	6.24%
Pharmacist	2	0.24%
Secondary care doctor (not obstetrician)	11	1.32%
Total	833*	100.00%

* some respondents chose to enter two roles, eg informatician and clinician

Respondents were asked to provide their speciality or discipline where Patient/carer and healthcare professional respondents had experience of at least one of the following specialties or service areas:

Ambulatory care	Information systems
Anaesthesia	Maternity
Antenatal care	Nursing
Clinical practice facilitator	Obstetrics
General practice	Paediatrics
General Practice	Patient safety
Gynaecology	Perinatal mental health
Home birth specialist	Pharmacy
Infectious diseases	
Pregnant persons and parent representation	Research
Provision to pregnant migrants	Risk and governance
Psychiatry	Safeguarding
Public health	Screening

The rest of this document presents the findings from the survey, question by question. The numbers correspond to the question numbers in the survey, eg question three in the survey asked which blood investigations are commonly recorded in a maternity record during pregnancy,

3. Would you expect to see results of the following BLOOD investigations commonly recorded in a maternity record during pregnancy?

<i>Blood investigation type</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>	<i>No</i>	<i>Not</i>	<i>Total</i>
		<i>clinician</i>		<i>clinician</i>	<i>sure</i>	
Full blood count	645 (96.7%)	97.39%	4 (0.6%)	0.56%	18 (2.7%)	667
Clotting screen	297 (45.07%)	44.07%	303 (45.98%)	48.02	59 (8.95%)	659

Clinician response breakdown by %age of clinician response

Respondents were divided quite evenly on whether they would expect to see ‘Clotting screen’ results commonly recorded in a maternity record.

A thematic analysis of the qualitative responses found that a common theme was that respondents would not expect clotting screening as a routine investigation and information on this investigation should only be recorded if the investigation has taken place.

The thematic analysis also identified the following common themes in regards to blood investigations which participants identified as missing: :

Antibodies (if relevant)	Ferritin	Virology/serology
BBV levels	Platelets	Blood type

4. Would you expect to see results of the following BLOOD group investigations commonly recorded in a maternity record during pregnancy?

<i>Blood group investigation type</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>	<i>No</i>	<i>Not</i>	<i>Total</i>
		<i>clinician</i>		<i>clinician</i>	<i>sure</i>	
Blood group	658 (98.65%)	99.25%	2 (0.3%)	0.19%	7 (1.05%)	667
Rhesus status	651 (97.75%)	98.13%	3 (0.45%)	0.56%	12 (1.8%)	666
Rhesus antibodies	644 (96.70%)	97.19%	3 (0.45%)	0.37%	19 (2.85%)	666
Kleihauer	361	55.68%	178	28.03%	118	657

(54.95%)

(27.09%)

(17.96%)

A significant majority of total survey respondents reported that they would expect to see 'full blood group', 'Rhesus status' and 'Rhesus antibodies' results commonly recorded in a maternity record.

Respondents were divided on whether they would expect to see 'Kleihauer' results commonly recorded. Those who did not expect to see Kleihauer recorded felt that this is not a routine investigation and results should only be recorded if the test has been undertaken. There was also a question on whether the test is undertaken during the antenatal period or postnatally.

Blood group investigations listed as missing are:

Fetal blood group for non invasive testing n women

Fetal DNA

5. Would you expect to see results of the following BIOCHEMICAL PROFILE investigations recorded in a maternity record during pregnancy?

<i>Biochemical profile type</i>	<i>Yes</i>	<i>Yes</i>	<i>No</i>	<i>No</i>	<i>Not</i>	<i>Total</i>
		<i>Clinician</i>		<i>Clinician</i>	<i>sure</i>	
C reactive proteins	320 (49.84%)	49.51%	227 (35.36%)	36.5%	95 (14.80%)	642
Urea and electrolytes	381 (58.71%)	58.35%	206 (31.74%)	32.82%	62 (9.55%)	649
Liver function tests	392 (60.49%)	59.52%	200 (30.86%)	32.31%	56 (8.64%)	648
Thyroid function tests	396 (61.21%)	60.12%	189 (29.21%)	30.25%	62 (9.58%)	647
Bile acid	336 (52.50%)	51.66%	207 (32.34%)	33.92%	97 (15.16%)	640

A relatively small majority expected to see urea and electrolytes, liver function tests, thyroid function tests and bile acid investigations results commonly recorded in a maternity record. Just under half of respondents expected to see the uric acid investigation results commonly recorded in maternity records.

A thematic analysis of the qualitative responses found that a common theme was that respondents noted that these are not routine investigations in maternity and would be requested only if the patient required the tests.

Tests listed as missing are:

Amylase

Folate

Uric acid

B12

Full thyroid, not just thyroid function test/ TSH

Urine protein creatine ration

Calcium

Urates

Vitamin D

6. Would you expect to see results of the following SCREENING FOR DISEASE investigations recorded in a maternity record?

<i>Screening for disease type</i>	<i>Yes</i>	<i>Yes Clinician</i>	<i>No</i>	<i>No Clinician</i>	<i>Not sure</i>	<i>Total</i>
Sickle cell	629 (95.45%)	95.65%	14 (2.12%)	2.08%	16 (2.43%)	659
Thalassaemia	626 (94.85%)	95.02%	15 (2.27%)	2.26%	19 (2.88%)	660
Glucose tolerance test	592 (89.70%)	90%	49 (7.42%)	7.36%	19 (2.88%)	660
Hb1Ac	436 (66.97%)	67.31%	159 (24.42%)	24.24%	56 (8.60%)	651
Lupus coagulant	260 (40.82%)	41.29%	271 (42.54%)	42.86%	106 (16.64%)	637
Diabetic retinopathy	251 (39.22%)	39.14%	292 (45.63%)	45.40%	97 (15.16%)	640
Karyotyping	228 (35.68%)	36.13%	282 (44.13%)	44.34%	129 (20.19%)	637

A large majority reported that they expect to see sickle cell, thalassaemia and glucose tolerance investigation results commonly recorded in a maternity record.

A thematic analysis of the qualitative responses found that a common theme was that Hb1Ac, lupus coagulant diabetic retinopathy and karyotyping investigations are undertaken only where there is clinical indication or an established risk factor.

Typical comments

GTT and HbA1c only required for some individuals, so not routinely needed. I would expect these to be present in maternity notes if required, and also lupus anticoagulant. I am not sure why karyotyping is included here but not other trisomy screening results.

Don't, for goodness sake, record investigations that are not universal. BE SELECTIVE. Screening is a complex act that should only be performed after fully informed consent on relevant people. It should NOT be assumed.

GTT and other tests only done if there are risk factors

Not as standard, specific to woman if needed these investigations

7. Would you expect to see results of the following SCREENING FOR INFECTION results recorded in a maternity record during pregnancy?

<i>Screening for infection type</i>	<i>Yes</i>	<i>Yes Clinician</i>	<i>No</i>	<i>No Clinician</i>	<i>Not sure</i>	<i>Total</i>
Rubella	353 (53.82%)	54.37%	287 (43.88%)	43.73%	15 (2.29%)	654
Syphilis	625 (94.55%)	94.92%	19 (2.87%)	3.01%	17 (2.57%)	661
Hepatitis B	633 (95.91%)	96.6%	13 (1.97%)	2.08%	14 (2.12%)	660
Hepatitis C	452 (69.97%)	70.77%	161 (24.92%)	25.00%	33 (5.11%)	646
HIV	628 (95.73%)	96.01%	15 (2.29%)	2.28%	13 (1.98%)	656
Parvo virus B19	286 (44.97%)	45.01%	259 (40.72%)	41.68%	91 (14.31%)	636
Toxo plasma	310 (48.82%)	48.82%	255 (40.16%)	40.98%	70 (11.02%)	635
Varicella-zoster serology	322 (50.47%)	50.00%	237 (37.15%)	38.28%	79 (12.38%)	638
Mid-stream urine	585 (89.59%)	89.54%	44 (6.74%)	6.49%	24 (3.68%)	653

A large majority reported that syphilis, hepatitis B, HIV and mid-stream urine investigation results are commonly recorded in a maternity record.

Investigations identified as missing are: Group B streptococcus, cytomegalovirus, herpes, and MRSA. Chlamydia is routinely investigation in pregnant persons under twenty-five years of age

Typical comments are:

Rubella is no longer part of routine screening and should not be included in the list

Hepatitis C, parvo virus B19, toxo plasma, and varicella-zoster serology investigation take place only where they are clinically indicated or the pregnant person has a history of exposure

Only record routinely those results that are PROVEN to be beneficial when applied to whole populations. 700 000 tests, their results and the effort of

putting into all records is NON TRIVIAL. please base the record on good NICE approved clinical practice

8. Is 'Family history - maternity' an appropriate overall heading to use?

<i>Yes</i>	<i>No</i>	<i>Not sure</i>	<i>Total</i>
443 (77.45%)	71 (12.41%)	58 (10.14%)	572

Three in four respondents reported that 'Family history – maternity' is an appropriate overall heading to use. They commented that it was clear and unambiguous and helped to signal that the history is that which relates to maternal and fetal health.

A thematic analysis of the qualitative responses found that a common theme was that respondents felt that the heading was clear and unambiguous and helped to signal that the history is that which relates to maternal and fetal health.

However the thematic analysis of those who reported that the use of the heading 'Family history – maternity' is not appropriate identified the following themes:

- 'Maternity' is superfluous as the whole record is related to maternity.
- Adding maternity causes confusion.
- Biological or genetic history would be a more suitable term than family history.

Typical quotes:

I wouldn't think that you need to add maternity not sure why you need to...

It makes it sound like it's the pregnancy history of family, not the medical history relevant to this pregnancy

Why are you adding the word maternity? This is a maternity record. Could mislead people as to the history required.

Biological Family/Genetic (or something more definitive) -Clear, to the point, supports clinicians in definition and also supports ensuring pertinent & concise answers relevant to foetus

GENETIC should replace 'family' which is morally loaded.

9. Do you agree with the overall description: *The record of relevant conditions or diagnoses in family relations of the fetus deemed to be significant to the care or health of the pregnant woman during pregnancy, the fetus and the child after birth. Family refers to the genetic family of the fetus and, where relevant, the surrogate*

Yes	No	Not sure	Total
472 (83.84%)	50 (8.88%)	41 (7.28%)	563

More than four out of five respondents reported that the description suggested is appropriate for use.

A thematic analysis of the qualitative responses from those who did not agree with the description identified the following themes:

- The description focusses on the medical model to the exclusion of the social determinants of health
- It is complicated as it contains fetal genetic history and the history of the surrogate
- Family relations should be changed to biological or genetic relatives: family relations could encompass step family and friends
- Fetus should be changed to unborn baby for systems that the pregnant person has access to
- Family history usually refers to first degree relatives only
- Alternative definitions were suggested

Concentrating on conditions, genetic or diagnosis focuses on the medical model, this may exclude other factors that may affect the health and wellbeing of the mother and the unborn child, such as mental health problems (without a diagnosis), alcohol and substance misuse which have a direct impact on the parent, the behaviours and risks associated with these factors may have an indirect impact on the health

I think this is too confusing. I think the heading needs to be clearer. If this is for Surrogate mother or egg donor this should say so.

Please change family relations to "relatives". Someone may think as Step mum or dad as "mum" or "dad" therefore would be grandparents but not "blood" relative in relation to carrying conditions the fetus may inherit.

'Fetus' can seem a rather impersonal term. Could say 'unborn child/baby' or 'children/babies'

[Alternative suggested] Any relevant conditions or diagnoses in blood relatives thought to be significant to the care or health of the pregnant woman, fetus

and child after birth. Blood relatives refers to a person related to the fetus, and where relevant the surrogate, by birth rather than by marriage or adoption.

[Alternative suggested] Needs to be shorter. Eg. 'The record of the relevant conditions or diagnoses in family relations of the fetus that may be significant to the care or health of the woman, the fetus or the child after birth.'

10. Is it appropriate to capture 'relationship to the fetus' when recording family history in a maternity record?

<i>Yes</i>	<i>No</i>	<i>Not sure</i>	<i>Total</i>
469 (83.6%)	57 (10.16%)	35 (6.24%)	561

A clear majority of respondents reported that it is appropriate to capture 'relationship to the fetus' when recording family history in a maternity record.

Thematic analysis of the qualitative responses found that a common theme was that respondents felt that knowing the family history of the fetus is important and were satisfied that the family history of surrogate was also being recorded.

However the thematic analysis identified the following common themes in those who did not think it a suitable heading:

- It is confusing
- The section on recording the family history of the surrogate needs further explanation
- Is it important to identify whether the condition is on the pregnant person's maternal or paternal side, if it is then the proposed model would not work

I actually found it a bit confusing using the family relations of the fetus descriptor. Normally when booking a woman you are asking about her own health and her and the baby's father immediate family's health.

[This is] for genetic conditions - however it may pose confusion as staff are used to looking at mother/father/sibling as first degree relatives to the mother, if we start recording the relationship to the fetus it would be maternal/paternal grandmother/grandfather, aunt/uncle which may cause the condition to be overlooked.

Yes but not as worded - this is dispassionate- unborn baby/ babies is more descriptive to the women who may not understand English language/ terminology

There are different types of surrogate (fully and partial surrogacy). FAMILY' is loaded and unclear. During pregnancy there is ONLY the maternal and paternal genetic material and the pregnant woman to consider.

11. Which terms should be used to describe the relationship to the fetus? (Respondents could choose more than one)

<i>Term</i>	<i>Yes</i>	<i>No</i>	<i>Total</i>
Sperm donor	410 (76.78%)	124 (23.22%)	534
Biological father	497 (89.71%)	57 (10.29%)	554
Egg donor	428 (80.60%)	103 (19.40%)	531
Biological mother	494 (89.33%)	59 (10.67%)	553
Surrogate	493 (90.13%)	54 (9.87%)	547

A clear majority reported that all terms could be used however, there was a higher percentage in favour of biological father and biological mother compared to egg and sperm donor. Analysis of parent/pregnant persons also shows a preference for biological mother and biological father.

Nine in ten of respondents expressed the view that 'surrogate' is a suitable term. Those who did not think it suitable suggested that the term(s) in relation to surrogacy should be more explicit.

Respondents also cautioned on the need to be aware of sensitivities:

on a clinical level, we're interested in relevant genetic information. The terms mother and father can carry great significance for parents, and using those terms in relation to the genetic link for the fetus may be difficult for parents using an IVF/surrogacy route

Not sure how you will describe a pregnant woman with donated eggs. Also if the record is accessed by others how they would feel about the descriptors

12. Question twelve asked for any other comments in relation to family history.

- The content looks relevant and the survey is well structured.
- It is important to be aware of sensitivities and the implications for patient held records; relationships ought to be described how the pregnant person wishes them to be described.

13. Is 'Clinical risk factors - maternity' an appropriate overall heading?

<i>Yes</i>	<i>No</i>	<i>Not sure</i>	<i>Total</i>
444 (82.37%)	45 (8.35%)	50 (9.28%)	539

A clear majority of respondents reported 'Clinical risk factors – maternity' to be an appropriate overall heading. They reported it as 'clear and concise'.

However the thematic analysis identified the following common themes in those who did not think it a suitable heading:

- The word 'risk' is inappropriate and pathologises pregnancy
- The risks should be associated with alert processes, and it is unclear where this is recorded
- This heading does not describe factors that could influence care but are not risk factors

Clinical risk factors alone would be adequate as we are completing maternity notes.

Risks are associated with alerts, what is the process for alerts?

As suggested by research and government directives we should not be using the word risk. Again pathologising pregnancy with medical terminology, women have complexities which may or may not impact on their life or pregnancy.

14. Do you agree with the description of clinical risk factor: *Factor shown to be associated with the development of a medical condition that poses a risk to the pregnant woman during pregnancy, fetus, or the child after birth.*

<i>Yes</i>	<i>No</i>	<i>Not sure</i>	<i>Total</i>
453 (84.51%)	52 (9.70%)	31 (5.78%)	561

A clear majority of respondents agreed with the description, describing it as clear, concise and specific.

This is appropriate in context. Similar to the previous regarding antenatal booking, but I felt that it was too open to misinterpretation. In this case, it would be dealt with entirely by clinicians so less likely to be misinterpreted

However the thematic analysis identified the following common themes in those who did not think it a suitable description:

- It is complex and unclear - examples would aid description
- The risk factors should include deterioration of a disease and not just development of a disease
- The risks should extend to cover postnatal period, and this should be made clear
- The term 'unborn baby' is preferred over 'fetus'
- Does not cover the social determinants of health

Unclear: Not sure what this refers to. Is it things like smoking and raised BMI leading to increased thromboembolic risk?

The 'risk factors' approach is very biomedical. It HIDES the real 'social determinants' of health.

this should cover postnatal too and it should be clear that it does

You say this is risks associated with development of a medical condition. Does this include social conditions too, or not? Need to be clearer on which risks are included. I suggest separate categories for medical illnesses and social conditions.

should be development or deterioration of a medical condition

[Alternative description] Factor linked to conditions that pose a risk to the woman or fetus

[Alternative description] Alternative description: Factor linked to conditions that pose a risk to the woman or fetus or "...poses a risk to the pregnant woman, the fetus, or the child after birth"

15. Question fifteen asked for any other comments in relation to clinical risk factors.

- Add the time that the risk assessment was undertaken
- Is there a place under clinical risk factors for the pregnant person's view to be captured?
- Location is superfluous

16. Is any of the proposed content irrelevant to the past pregnancy section of a maternity record?

<i>Yes</i>	<i>No</i>	<i>Not</i>	<i>Total</i>
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			<i>sure</i>
88 (16.51%)	436 (81.80%)	9 (1.69%)	533

Four in five of respondents felt that all the suggested content is relevant to a post pregnancy section of a maternity record.

However the thematic analysis identified the following common themes

- 'Is baby alive and well' is irrelevant. Also triggers difficult conversations if parents have had a previous child removed from their care.
- The section on complications needs more detail: whether there were any complications either in pregnancy, labour, birth or postnatal - both in maternal and fetal/baby condition
- Gender and sex of the baby is irrelevant
- Method of delivery would be best expressed as type of birth

'baby' could have grown to age 15 and died in an RTA or from an OD etc, so not relevant to current pregnancy. Maybe 'Are/were they a healthy baby?' covers the first year and captures anything relevant

Wording? What if baby is adopted/removes from care/ no contact

Is baby alive and well seems irrelevant. Also triggers difficult conversations if parents have had a previous child removed from their care.

method of delivery- can this be type of birth - the word delivery sounds like a parcel being delivered

whether there were any complications either in pregnancy, labour, birth or postnatal - both in maternal and fetal/baby condition

complications – maternal or fetal?

17. Is there any additional content for past pregnancies that you feel is missing?

<i>Yes</i>	<i>No</i>	<i>Not sure</i>	<i>Total</i>
229 (45.26%)	243 (48.02%)	34 (6.72%)	506

Almost half of respondents expressed the view that there is missing content. A thematic analysis of comments identified the following as themes for missing content:

- Pregnancy

- Be specific on the outcomes of previous pregnancies, eg miscarriage, terminations, ectopic pregnancy and heterotopic pregnancy
- Concealed or denied
- Morbidity during pregnancy
- Birth details and complications
 - Analgesia
 - Gestation
 - Location of birth needs to include midwifery led units (freestanding), obstetric units rather than hospital, and a birth centre
 - Home birth - planned/unplanned/BBA
 - Experience of previous birth (need to ask and capture birth trauma/poor experience as this will affect care and decision making regarding subsequent pregnancy)
 - Estimated blood loss
 - PPH specifically
 - Previous neonatal infections
 - Distinguish between complications in pregnancy for the woman, complications at the birth or complications following birth ie resuscitation.
 - APH, reduced FMs, problems with the placenta / growth / liquor, PPH, perineal infection, Pre GDM, PIH/PET/ etc.
- Postnatal
 - Postnatal health of mother, particularly mental health eg psychosis
 - Feeding experience - breast feeding
 - Full names of children, who they live with and if they are on any plans through social services

APH, reduced FMs, problems with the placenta / growth / liquor, PPH, perineal infection, Pre GDM, PIH/PET/ etc.

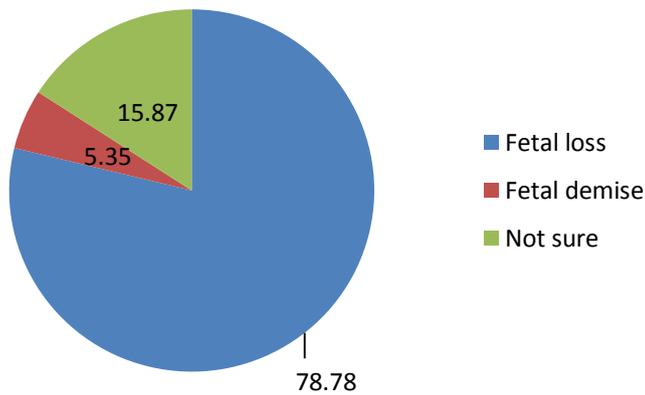
Experience of previous birth (need to ask and capture birth trauma/poor experience as this will affect care and decision making regarding subsequent pregnancy) This can be different to the woman than 'complications' which seems only medical

Where now? ie does the child live with you or with their father or adopted etc...

gestation, prematurity complication following birth admission to SCBU, RDS or other complications of being premature , follow up requirements, breast / bottle feeding , any other medical problems

18. When reporting pregnancy outcome before 24 weeks should we use fetal loss or fetal demise?

Table shows percentage breakdown of responses (n523)



Nearly four in five chose fetal loss compared to just over one in twenty choosing fetal demise.

19. Please explain your answer

Typical comments are:

A parent doesn't 'lose' a baby, it dies

We shouldn't use the word loss, but parents might not understand the word demise

Parents see it as a loss and health professionals should be aware of this.

Just document what the pregnancy outcome was specifically ie miscarriage, TOP etc Pregnancies ending before 24 weeks is a better heading. ie "have you had any pregnancies that ended before 24wks?" If you head it up as fetal demise or loss then those women who chose to have a termination are seeming to be judged.

20. Any other comments on the headings and definitions

Admission details

To adequately plan service provision, site code is not sufficient; we need maternity unit type (e.g. to distinguish between admission to alongside midwifery unit and co-located obstetric unit). Same for any other location identifiers, e.g. on transfer.

Professional summary	It would be very useful if this included risk status as per NICE intrapartum guidance (theoretically this could be automatically derived from other entries but if people forget things errors could occur).
Attendance details	All HCPs who provide care should be recorded not just the most senior, again reinforcing hierarchy and ignoring the input of equally valid but not as highly placed professionals. If someone is responsible but not present how are they responsible? The person providing care is responsible for the care they give. Look at the maternity review - care is increasingly being given in the community and not hospitals - women's homes should be increasing as a place of birth.
Safeguarding	Adverse Childhood Experiences should also be included in the safeguarding section.
Employment status	I could not see any employment status for the pregnant woman, the partner's employment status
Marital status	Irrelevant
Sex	Irrelevant
Organisation responsible	The organisation is defined as the organisation responsible. I work for a Community NHS Trust where the organisation responsible is blurred at times as the women are under our care and deliver within another Trust as we do not have a labour ward. This definition therefore needs to be clarified for our Trust
Mental health and well-being	The records should be worded so that they may ensure that psychiatric complications are also recorded appropriately - a checklist of physical issues or complications may restrict this. Open headings, or a more comprehensive checklist, would be useful.
Medication	If there are specific medication plans which require additional monitoring this should be done on maternity notes.