Midwife's Practice Name, Logo, Contact Info

# Example Policy & Procedure: Charting and Clinical Documentation

Effective Date: [Insert Date]

Last Reviewed: [Insert Date]

Next Review Due: [Insert Date]

## Purpose

To ensure that all clinical care is documented in a timely, accurate, and defensible manner in accordance with Washington State regulations, professional standards, and risk management principles.

## Policy

All client encounters, assessments, interventions, communications, and outcomes shall be documented promptly, thoroughly, and objectively in the clinical record. Documentation must reflect the actual events of care, support informed decision-making, and protect the client and provider in the event of review or legal scrutiny.

## Procedure

1. General Standards

    - Documentation shall be completed within 24 hours of the encounter or event.
    - All entries must include:
        - Date and time (actual or approximate)
        - Signature and title of the person making the entry
    - Late entries must be clearly labeled as such and dated as of the time of writing.
    - All entries must be authenticated in the EHR, or if handwritten, must be legible, clear, and written in permanent ink.

2. Content Expectations

    - Subjective reports (client's words, complaints, symptoms)
    - Objective findings (vital signs, exam results, labs, FHTs, etc.)
    - Assessment or clinical impression
    - Plan of care or next steps
    - Any client refusals, questions, or concerns
    - Any communication with other providers, EMS, hospitals, or consulting clinicians

3. Corrections and Addendums

- Addendums should include the current date/time and clarify the context of the addition.
- If handwritten note:
    - Do not erase or obscure original entries.
    - Strike through errors with a single line and initial/date the correction.

4. Confidentiality

- All documentation must be stored securely in accordance with HIPAA.
- Access should be limited to authorized personnel only.

## Responsible Parties

All licensed midwives, birth assistants, students, and staff who contribute to the client record must follow this policy.

## Review Process

This policy shall be reviewed annually or as needed in response to changes in regulation, scope of practice, or risk exposure.