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PRACTICE STANDARD

Midwives: Medical Records

Introduction

This practice standard sets expectations for midwives related to the creation, content, ownership, custody, confidentiality and ongoing accessibility of medical records for themselves and their clients.

Standards

RECORD CONTENT

1. Midwives are expected to maintain comprehensive medical records that document all aspects of care provided during the antepartum, intrapartum and postpartum periods for each individual client. This includes copies of the following:
    a. all laboratory results;
    b. operative procedures;
    c. prescriptions issued;
    d. consultation reports; and
    e. discharge summaries.
2. Medical records must be legible, in English and include documentation of the following:
    a. relevant medical history;
    b. all clinical assessments and observations;
    c. informed choice discussions;
    d. recommendations;
    e. plans of management;
    f. consultations requested; and
    g. transfers of care.
3. All verbal and written communication (including but not limited to in-person, telephone, video chat, text message, email message, letter and fax) related to clinical care must be clearly documented and maintained as part of the medical record.
4. Medical records may be maintained in paper or electronic format.

5. Completion of relevant standardized perinatal forms[1] issued by Perinatal Services BC (PSBC) is mandatory.
6. Additional narrative notes should be maintained in a consistent, timely and organized format. All entries should be legible, logical and include the date, the midwife's identification (initials, signature and/or BCCNM number) and where required, the time.
7. Midwives must co-sign entries made by learners in the medical record.
8. Midwives may amend or alter a medical record, but in doing so they must clearly identify themselves as well as the time, date and reason for the changes made. Medical records may not be altered after a complaint or legal action has been initiated, unless a clinical fact is missing and a clear late entry is made to the record.

CONFIDENTIALITY

9. Midwives must maintain and store their medical records in a confidential, secure and systematically organized manner (paper or electronic format[2]) and in accordance with relevant legislation.

DATA STEWARDSHIP

10. In all situations where a midwife is creating or contributing to medical records in a group or shared medical record environment, an associated ***practice protocol must be in place.*** The protocol must address physical security, data sharing with other health care providers, backup of electronic data, user-based levels of access, how ownership, custody, confidentiality and enduring access by individual midwives and clients are addressed, including following relocation, retirement or death of the midwives.

RECORDS RETENTION AND DESTRUCTION

11. As required by the *Limitation Act*, medical records must be retained for a minimum period of sixteen years from either the date of the last entry or from the age of majority (19 years of age in British Columbia), whichever is later (i.e. 35 years), except as otherwise required by law.
12. Midwives have a responsibility to ensure that records are properly disposed of ***after*** the legal retention period has expired. As per the *Bylaws for the British Columbia College of Nurses and Midwives (BCCNM)*, paper records may be destroyed by secure shredding or controlled incineration, and electronic records must be erased in a manner that ensures all traces of original data are destroyed.
13. Original records are considered the best evidence in the case of a complaint or a lawsuit; midwives should consider retaining original client records for any case where an incident report has been filed or a complaint has been made. Likewise, if the image quality compromises the legibility of the client record, then an original paper copy of the record should be kept.

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[1] Or equivalent in hospitals with electronic medical records that do not use PSBC forms.

[2] Records may be retained in electronic form as long as the electronic record is complete, permanent and unalterable.

CUSTODY AND ACCESS

Sharing of records and records requests

14. Midwives must make copies of medical records available as follows:
    a. to an inspector or a quality assurance assessor for BCCNM under sections 26.1, 27, 28, 29, and 30 of the *Health Professions Act*;
    b. to another midwife or health care provider upon request by the client;
    c. to Perinatal Services BC (PSBC) (specifically, the standard perinatal forms) following a home birth for the purposes of perinatal data collection and analysis to the BC Perinatal Data Registry or alternate agency designated by BCCNM;
    d. to a client's legal representative when provided with a written, dated authorization from the client or client's legal representative specifying the records that are requested; and
    e. to the Coroner upon request. Coroners have the responsibility and authority under the *Coroners Act* to obtain copies of the complete medical record. Midwives are advised to consider seeking legal advice when involved in a coroner's investigation.
15. Midwives must also provide a copy of medical records to the client within thirty (30) days of the client's request. However, in accordance with section 29 of the *Personal Information Protection Act* (PIPA) the midwife may withhold parts of the client record which:
    a. are subject to solicitor-client privilege;
    b. contain confidential commercial information;
    c. contain investigative information on a matter still under investigation;
    d. contain information obtained in the conduct of a mediation or arbitration;
    e. through disclosure, could threaten the safety or physical or mental health of the patient or another individual; or
    f. contain personal information about another person.
16. Midwives may, for the purpose of providing or assisting in the provision of health care to a client, permit a health care provider within the client's circle of care to examine the client's medical record and may share with them information contained in the record. Client consent in this scenario is considered implicit.

Enduring access

17. Midwives must have access to copies of or the original medical records for any clients who were previously or are currently under their professional care for the length of the legal retention period. When a copy of a medical record is retained by a midwife, that midwife has the same responsibility for ensuring that it continues to be maintained in a confidential and secure manner as if it were the original.
18. Clients must have access their medical records for the length of the legal retention period.

Changing practices

19. When a midwife leaves a practice, the midwife may either retain copies of the medical records in which they documented care, or formally transfer custody of these records to another midwife. The original records may be kept at the midwifery practice or taken with the leaving midwife provided that all midwives involved in the client's care have access to a complete record that is properly stored and secure.

Ceasing practice

20. When a midwife ceases to practice (no longer holds practising licensure), BCCNM's Bylaws stipulate that all medical records for any previous or current clients under their professional care that remain within the legal retention period, must be transferred to another midwife, health care provider, person or organization who has been retained to take custody of the records. The midwife transferring the records must ensure the transfer of records is secure and retain documentation of this transfer. The receiving midwife, health care provider, person or organization must confirm acceptance of custody of those records in writing. The receiving midwife, health care provider, person or organization assuming custody of the original records is also then responsible for the secure storage, retention and enduring access to both the BCCNM and clients to those records.

21. Midwives who transfer custody of original medical records must obtain and retain a written contract for service that assures for the duration of the legal retention period:

    a. the safety and confidentiality of the records;
    b. that the midwife, health care provider, person or organization assuming custody of the records notify the transferring midwife and the BCCNM if the location or access details of the records changes;
    c. the transferring midwife right of access;
    d. the client's right of access; and
    e. the duration of record storage required and appropriate means of disposing of records.

22. Midwives who cease to practice and transfer medical records to another location must also take reasonable steps to notify clients of the location of their medical records.

LOST AND STOLEN RECORDS

23. If medical records containing personal information are stolen or lost, the midwife must notify the Midwives Protection Program, the midwifery practice's privacy officer, the police and the Office of Information and Privacy Commissioner (OIPC) immediately. The midwife must also notify the individual(s) whose personal information has been stolen or lost, telling them the kind of information that has been compromised and steps that are being taken to recover it.

Revision history

Version #	Approved by board	Bylaw in-force	Description
1.0	March 1, 2026	April 1, 2026	Initial publication

Effective April 1, 2026, this practice standard, and any amendments to it, is made a bylaw under the authority of the *Health Professions and Occupations Act, B.C.*

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