Redesigning German Maternity Records: Results from a Pilot study

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Introduction: Many countries have implemented evidence-based antenatal care successfully. In Germany, maternity records were introduced in 1968. In 1974 a list of demographic and pregnancy-related factors was added. The list was amended in 1979 and again in 1986, but it has not been further revised since then. Just one factor out of the 52 items listed used to define a pregnant woman as being at risk during childbirth. Nowadays, a decision of the caregiver is required as to whether the pregnant woman should be considered to be at risk. This resulted in a reduction in the proportion of risk pregnancies to 27% in 2013. The factors listed in the maternity records have never been examined from the perspective of an evidence-based practice. The aim of this study was to evaluate whether a redesigned German maternity record (GMR) meets the needs of pregnant women and their care-givers for a more health-related rather than risk-related approach in the maternity records.

Methods: A revised version of the GMR was developed by a multidisciplinary panel of experts, focusing on health and salutogenesis. The new document highlights the uncomplicated pregnancies, and gives pregnant women the opportunity to make their own notes and to choose an appropriate place of birth after consultation with the doctor or midwife. The redesigned GMR, which followed the mandatory German maternity guideline (GMG) of 2011 comprised a 25-page booklet in B6 format. The existing list of 52 pregnancy-related factors was eliminated. In order to place the emphasis on normal pregnancies, the first page contained recommendations for women on how to use the maternity records and advice regarding health promotion during pregnancy. The next 4 pages provided space where expectant mothers could make notes regarding for example foetal movements, self-medication including intake of minerals and the woman’s preferred place for giving birth. These pages were followed by a structured survey on subjective psycho-social well-being. To test for user-friendliness and acceptance, 23 persons – 8 consultants, 7 midwives and 8 pregnant women – were asked to evaluate the revised GMR. Comments could be entered in the GMR itself and in an electronic survey. These comments were separated into 296 meaning units. These were examined by 2 reviewers and assigned by them to one of 7 predefined categories. Inter-observer agreement was kappa = 0.43, intra-observer agreement kappa = 0.55. After 6 weeks one of the reviewers repeated her evaluation.

Results: 20 of the 23 persons approached wrote comments in the document, 19 participated in the electronic survey. The 7 categories were defined as follows: (i) General comments regarding the overall impression of the maternity record (e.g. “I like the new maternity record”), (ii) General comments regarding particular topics (e.g. “table is nice”), (iii) Comments on content relating to antenatal care (e.g. CMV test), (iv) Structural aspects (e.g. layout of pages), (v) Specific comments on content not relating to antenatal care (e.g. “I had to pay fees for outpatient service”), (vi) Lack of understanding of the terms used (e.g. unknown abbreviation), (vii) Others (i.e. comments which do not fit into any of the above categories). Consultants and midwives predominantly stated that they would prefer to work with the revised GMR (92%). Pregnant women appreciated the space for their own notes (83%). Most respondents (90%) had a good general impression.

Discussion: This study demonstrates that a health-related concept of antenatal care records meets the needs of pregnant women and their caregivers. Further innovations would be desirable but could not be realised under the current mandatory, not entirely evidence-based maternity guidelines in Germany. It was our aim to avoid the risk concept of pregnancy. We therefore omitted the predefined list of pregnancy-related risk factors. This gave rise to a process of exploring issues of antenatal care such as has been applied in other countries as well. One of these is maternal well-being, which means that women’s individual preferences should be taken into account when specific care measures are planned. In times when there is a constant increase in the number of elective decisions to be made regarding the mode of birth, antenatal education has become an important issue which should not be burdened by an emphasis on potential risks. With the redesigned maternity record we aimed to provide a tool not only for mothers and their individual needs but also for the purpose of perinatal auditing, in order to detect those few high-risk pregnancies which require specialist perinatal care and a specifically selected place of birth. However, we consider that the results of this study provide evidence that further research will have to go beyond the current regulations if it is to meet the needs of best practice in antenatal care.

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