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Supplementary material

Integrated care among healthcare providers in shared maternity care: what is the role of paper and electronic health records?

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Fig. S1. Mater paper hand-held record (PHR). See following pages.

GP's please refer to materonline.org.au (maternity services) for the MMH/GP shared care protocol; guidelines for consultation and referral and the antenatal appointment schedule.

(affix identification label here)

MRN:
Family name:
Given name(s):
Address:
Medicare number:
Date of birth:

Mother's section | Medical information | Clinic notes | Screening tools

Always carry this record with you

You must bring this record with yc health care professional / hospital

Mater Mothers Hospital

Antenatal Clinic: 3163 8330
General Enquiries: 3163 8111
Pregnancy Assessment Unit: 3163 7000

In an emergency dial 000

Model of care:

☐ Medicare ineligible Comments:

Mother's information

Preferred name:

Are you of Aboriginal or Torres Strait Islander origin? (both may be ticked)

☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No

Country of birth:

☐ Australia ☐ Other

Interpreter required?

☐ Yes, language:
☐ No

Shared Care Contact Information

Consultant:	Primary maternity carer name:

General Practitioner (GP) / Midwife (stamp or print details):

Name:	Shared care: ☐ Yes ☐ No ☐ Discontinued
Address:	Phone:
	Fax:
Email:	Pager:

Name:	Shared care: ☐ Yes ☐ No ☐ Discontinued
Address:	Phone:
	Fax:
Email:	Pager:

Useful Phone Numbers

13 HEALTH	13 43 25 84
DVI Hotline	1800 811 811

Anti D Prophylaxis (for Rh Negative women only)

☐ Yes → Week 28: (initial) ☐ Week 34–36: (initial) ☐
☐ No

Disclaimer

This document is not nor should it be treated as a complete obstetric record for the mother. Copies of the complete obstetric record for the mother will be made available to the mother's treating health practitioner/s on request. Any notes in this document must be read in conjunction with the documents attached to it. This document will be updated at each visit.

Queensland Health does not warrant that this document is a comprehensive or up to date record. In no event shall Queensland Health be liable for any damages (including without limitation, direct, indirect, special or consequential) whatsoever including damages connected with or resulting from the information contained in this document or reliance on it.

This document does not replace the need to obtain a valid consent from the mother in relation to any procedure.

DO NOT WRITE IN THIS BINDING MARGIN

PREGNANCY HEALTH RECORD

v2.00 - 12/2010
Mat. No.: 10179298
SW071

Mother's section

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Best Contact Person

Full name:

Relationship: ☐ Partner ☐ Other (specify):

Home phone: **Work phone:** **Mobile phone:** **Email address:**

Address

Additional Contact Person

Full name:

Relationship: ☐ Partner ☐ Other (specify):

Home phone: **Work phone:** **Mobile phone:** **Email address:**

Address

Important Information

It is very important that you tell your health care providers about any problems you or your baby had in previous pregnancy, labour and/or post-birth.

Call your GP / midwife / obstetrician or birth suite:

1. If you are unsure about what is happening to you or if you think you are in labour
2. If your 'waters' break (membranes rupture)
3. If you are experiencing any of these complications:
   - Any vaginal bleeding during pregnancy
   - Your baby is moving less than usual
   - Uncontrollable vomiting or diarrhoea
   - Abdominal or back pain
   - Unusual headaches and/or blurred vision
   - Fainting
   - Urinary problems

Please phone the following number prior to arriving at the hospital.

You may be in early labour and still be able to remain at home. A phone call to the hospital may reduce your anxiety and prepares staff for your arrival if necessary.

When to see your GP / midwife / obstetrician

Please refer to the Recommended Minimum Antenatal Schedule on page 8. If you have any concerns, please discuss this with your health care provider.

Types of pregnancy / antenatal care available

Shared care with hospital or hospital based midwife / doctor care / midwife in private practice or GP.
Most hospitals offer 3 or 4 models of pregnancy / antenatal care. Please ask for details.

Referral for Booking In

Where was the referral sent?	Referral sent by: ☐ Fax ☐ Mail ☐ Other: ☐ Electronically

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Mother's section

Consent to Carry

I acknowledge that:

1. I have been provided with a copy of a brochure entitled *Pregnancy Health Record (PHR)*. I have read and understood the contents of that brochure.
2. I have also read the disclaimer on the front page of this document and have understood it.
3. My PHR is not intended to replace the advice I receive from my treating health practitioners.
4. My PHR is not intended to replace the need for me to provide informed consent to any treatment or procedure.
5. If I elect to carry my PHR, I accept:
   a. My PHR contains confidential health information about myself as well as confidential information about the father of my child.
   b. The safekeeping of my PHR and the information contained in my PHR will be my sole responsibility.
   c. It will be my sole responsibility to produce my copy of the PHR at all appointments and birth with all my treating health practitioners. I understand my record will be updated at each visit.
   d. It will be my responsibility to ensure that the PHR is updated at every visit to any health professional in Queensland Health.
   e. It will be my responsibility to ensure that relevant information is included in my PHR at any appointment or during any episode of care from a non-Queensland Health health practitioner.
   f. A photocopy of this document will be kept in my Hospital file. The original will be retained by the hospital after the birth. I may then take the photocopy for my personal records.

☐ I would like to carry my PHR
☐ I would **NOT** like to carry my PHR

Signature:

Date: / /

Record of Copies Made

Copied for:	Hospital	GP	Midwife	Mother
Copied by:				
Date of copying:	/ /	/ /	/ /	/ /

Staff Signature Log

Initials	Signature	Print name	Designation	Facility

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Birth Preferences

Please complete by 34 weeks after talking with your GP, midwife or obstetrician. You may tick more than one box. These plans are flexible and can be changed at any time, even through labour and birth.

Mobility and positions for labour

☐ Walking ☐ Standing ☐ Squatting
☐ Kneeling ☐ Lying (bed/floor mat)
☐ Other:

Relaxation and personal comfort

☐ Massage Oils ☐ Heat pack ☐ Music-relaxation CD/Tapes
☐ Shower/Bath ☐ Aromatherapy ☐ Relaxation techniques

Be aware

Circumstances can change due to a long and/or difficult labour or preterm baby. I may require:

☐ More pain relief than you anticipated
☐ Assisted birth [ie. forceps, ventouse (vacuum)]
☐ Caesarean section (operative birth)
☐ Episiotomy

Support / Cultural needs

Name of main support person: Name of second support person:

Comments:

Plans for home discussed

I have discussed with my health provider

☐ Vaginal birth, expected discharge 6–48 hours
☐ Caesarean birth, expected discharge within 4 days
☐ My preferred discharge time. May be within 24 hours, mother and baby condition permitting ⇨ Day 3–5 GP check.
☐ Community midwifery service – postnatal home visiting / phone contact
☐ Community Child Health Services
☐ Day 5–10 baby check with GP
☐ 6 weeks postnatal check with GP
☐ Postnatal depression information
☐ Postnatal follow up regarding pre-existing medical condition(s) – see page 13
☐ SAFE sleeping and SIDS information
☐ Recommended discharge time is by 10am
☐ How to register a compliment or complaint about the service

Birthing aids

☐ Bean bag ☐ Bath ☐ Shower
☐ Mirror ☐ Birth stool ☐ Gym ball
☐ Other:

Pharmacological pain relief

☐ Entonox gas
☐ Narcotic intramuscular injection
☐ Epidural

Placenta – 3rd stage management

☐ Active – oxytocic injection given to mother following baby's birth to reduce the risk of bleeding as recommended by hospital guideline
☐ Modified active – discuss delayed cord clamping
☐ Physiological – as discussed with care givers (comments):

Screening and Vaccinations recommended for all babies following birth

I have received information and would like my baby to have:

Vitamin K	☐ Yes	☐ No
Hepatitis B vaccination	☐ Yes	☐ No
Neonatal screening blood test	☐ Yes	☐ No
Healthy Hearing screening	☐ Yes	☐ No

Consent will be sought for the above when you have your baby

Whooping cough vaccination

☐ I have received information about whooping cough vaccination for my family and for me

Seasonal flu vaccination

☐ I have received information about seasonal flu vaccination

Meals

☐ I will require normal hospital food
☐ I will require a special diet:
☐ Vegetarian ☐ Vegan ☐ Diabetic
☐ Halal ☐ Gluten free
☐ Other:

Comments and questions

Awareness statement

Safety for you and your baby will be paramount in any decision making.

I understand that this is a guide to my preferences and acknowledge that circumstances can change, sometimes suddenly. I understand that if things do not happen as indicated then the primary maternity carer will discuss options with me in consultation with the specialist team on duty. I have information about and have indicated my choices for screening and vaccinations following birth.

Mother's signature: Doctor's/Midwife's signature: Doctor's/Midwife's name: Date / /

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

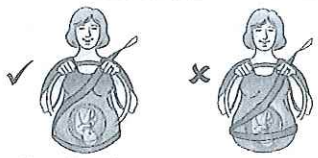
Date of birth:

Mother's section

Correct use of seat belts in pregnancy

Place the lap seat belt as low as possible, positioned below your baby.
It should be below uterus, and across upper thigh.

The sash part of the seat belt should pass above level of uterus and between breasts and over collarbone.



Brown. Trauma in Pregnancy. Obstet Gynecol 2009.

What to Bring to Hospital

What to bring for mother

- ☐ Pregnancy Health Record
- ☐ Comfortable clothing
- ☐ Toiletries, tissues etc
- ☐ Minimum of 4 packets of maternity sanitary pads
- ☐ Maternity bras
- ☐ Massage oil, barley sugar, glucose drinks, music (For use during labour)
- ☐ Pen

What to bring for baby

- ☐ 2 dozen newborn size disposable nappies
- ☐ 6 newborn singlets
- ☐ 6 newborn jumpsuits
- ☐ 6-8 bunny-rugs or small cotton blankets
- ☐ Baby wipes
- ☐ 3 face washers for baby bath

Other things to consider

- ☐ Access to phone (eg. use of mobile, phone card)
- ☐ Baby car seat for discharge (mandatory)

Mother's Notes / Your Questions

Things you may like to talk about with your GP / midwife / obstetrician / allied health:

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Feeding Your Baby

Have you breastfed before?	Have you experienced difficulties with breastfeeding in the past?
☐ Yes → Duration: ☐ No	☐ Yes → Give details: ☐ No

Sign and date each section as it is discussed		Date	Initial
Advantages of breastfeeding for your baby	- Breastmilk is a complete food for your baby. It is a living fluid constantly changing according to your baby's needs and packed full of minerals and antibodies to boost your baby's immune system. - A breast fed baby is less likely to develop allergies, diabetes, some childhood cancers, gastroenteritis and obesity		
Advantages of breastfeeding for the mother	- Breastfeeding may assist the bonding and attachment between mothers and babies. - Breastfeeding promotes faster maternal recovery from childbirth and women who have breastfed have reduced risks of breast and ovarian cancers later in life.		
Advantages of breastfeeding for the family	- Breastfeeding is free, safe, convenient and environmentally friendly - No preparation required; ready anytime, anywhere		
Importance of skin-to-skin contact after birth	- Holding baby close after birth keeps them warm and calm, promotes bonding and helps breastfeeding. Bathing and weighing should wait until after the first feed.		
Importance of good positioning and attachment	- Problems are most often caused by baby not being well attached; ask for help when you are starting out		
Getting breastfeeding off to a good start	- Keep your baby with you while in hospital (getting to know each other) - Feed baby when shows signs of hunger (hands to mouth, searching) - Dummies and teats can sometimes cause problems when getting started		
No other food or drink for the first 6 months	- Giving formula to breastfed babies in the first six months can reduce some of the health benefits of breastfeeding and decrease breastfeeding duration - Breastfeeding is still important for babies health after the introduction of solids at around six months of age, breastfeeding has ongoing health benefits for mum and baby for as long as it continues		
Who can help support you to breastfeed?	- Your partner—partners can help in a lot of ways other than feeding (settling, bathing) - Your family and friends by giving practical support and help at home		
Signs baby is getting enough breastmilk	- 6–12 feeds per day can be normal - 5–6 wet nappies each day - A breastfed baby may poo many times a day or none for a few days		
Where to get help in the community	- Australian Breastfeeding Association www.breastfeeding.asn.au - **1800 mum 2 mum** (1800 686 2 686) 24 hour helpline - Lactation consultants (see Yellow Pages) - General practitioners - Community Child Health (see Yellow Pages) - 13HEALTH (**13 43 25 84**)		

Mothers who formula feed their baby will be shown how to safely prepare, store and transport feeds before discharge from hospital

I have had all the above information discussed with me and all my questions answered to my satisfaction.

Mother's signature: **Date:**

DO NOT WRITE IN THIS BINDING MARGIN

Glossary of Terms

This list is an explanation of some of the terms or abbreviations you may see printed or added to this Pregnancy Health Record. Ask your GP, midwife or obstetrician if you don't understand any of the terms or words they use.

A B O Rhesus human blood types; checks are done to see that there is no problem between the mother's and baby's blood.

Amniocentesis fluid (also called liquor) is taken by needle from the mother's uterus to do tests

Antenatal the period of pregnancy – before the birth

Antibodies proteins produced by blood (checks are done to see that there is no problem between the mother's and baby's blood)

BGL blood glucose level – to be watched for early signs of diabetes

BMI body mass index – A measure of weight and height

BP blood pressure

Br, Breech unborn baby is lying bottom-down in the uterus

C, Ceph unborn baby is lying head down in the uterus – cephalic presentation

CVS chorionic villus sampling, taking a small sample of placenta for testing for Down syndrome etc.

Cx (Pap) smear vaginal examination where a sample is collected to detect early warning of cancer of the cervix

E, Eng, Engaged unborn baby's head is positioned in the mother's pelvis, ready to be born

EDD estimated date of baby's birth – it is normal for the baby to be born up to 2 weeks before/after this date.

EDS, EPDS Edinburgh Depression Scale

Episiotomy surgical incision to enlarge the vaginal opening to help the birth

Fetal heart rate unborn baby's heartrate

Fetal movements unborn baby's movements

Fetus developing human baby

FH (H) fetal heart

Fifths above brim position of unborn baby's head in relation to mother's pelvis assessed by examining the abdomen

FMF; FMNF fetal (baby) movements felt; fetal movements not felt

Forceps instruments supporting baby's head to assist in childbirth

Fundal height size of the uterus – expected to increase 1cm per week from 20 – 36 weeks of pregnancy

GDM gestational diabetes mellitus – diabetes in pregnancy

Gestation number of weeks pregnant

Gestational hypertension a rise in blood pressure during pregnancy which will require close monitoring

Glucose challenge test (GCT) screening blood test for gestational diabetes which may develop during pregnancy

Glucose tolerance test (GTT) diagnostic blood test for gestational diabetes which may develop during pregnancy

GP, general practitioner family doctor

Gravida the number of times you have been pregnant, primigravida means first, multigravida means more than 1

Hb, haemoglobin the red cells in your blood, which carry oxygen and iron

Hepatitis A B or C inflammation or enlargement of the liver caused by various viruses. Baby may be immunised at birth against Hepatitis B.

HIV human immunodeficiency virus, the virus that may lead to AIDS

Hypertension high blood pressure

IOL induction of labour – labour that is initiated by medication or surgical rupture of membranes

Liquor fluid around baby

LNMP last normal menstrual period

MC miscarriage

Midwife professional healthcare worker who specialises in providing care for women and their families throughout pregnancy, labour and birth, and after the birth

MSU mid-stream specimen urine – tested to check for infection

NAD no abnormality detected

NE not engaged (see engaged)

Nuchal Translucency one of the special measurements taken of the unborn baby during an ultrasound scan

Obstetrician Medical specialist who specialises in providing care for women and their families throughout pregnancy, labour and birth, and after the birth

Oedema swelling generally of ankles, fingers or face

Parity the number of babies you already have had

PET pre-eclampsia or pre-eclampsic toxaemia (elevated BP in pregnancy associated with protein in the urine)

Placenta the baby's lifeline to you, also known as after-birth

Posterior the unborn baby is lying with its spine alongside mother's spine. This can cause backache in labour

Postnatal period of time after the birth of the baby

Presentation the position of the baby in the uterus before the birth (referred to as vertex, breech, transverse)

Primary maternity carer the health care professional providing the majority of your maternity care

Primigravida mother pregnant for the first time

Rubella German measles, a disease that can cause major abnormalities in an unborn baby

Spontaneous labour labour that occurs naturally

STI sexually transmitted infections: includes syphilis, gonorrhoea, chlamydia and herpes.

T, FT, Term full-term, baby is due to be born (37–42 weeks)

Transverse unborn baby is lying crossways in the uterus

US, scan, Ultrasound sound waves passed across the mother's abdomen are used to make pictures of the unborn baby.

Uterine size size of the uterus relative to stage of pregnancy

Uterus, womb hollow muscle in which the baby grows

UTI urinary tract infection

VE vaginal examination (an internal check of the mothers cervix)

Venous Thrombus Embolism a blood clot in a vein

Ventouse/Vacuum Extraction suction cap to baby's head to assist birth

Vx, Vertex unborn baby is lying head down in the uterus – the most common position for birth

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Medical information

Recommended Minimum Antenatal Schedule

First visit GP/Midwife visit preferably before 12 weeks	» Pregnancy confirmed- maternal counselling including tobacco/alcohol/other drug cessation » Pre-pregnancy weight, height and BMI » Urine dipstick/MSU » **Antenatal blood tests ordered with consent and counselling** » Blood group and antibodies **(status checked/identified)**, full blood count, syphilis, rubella, hepatitis B, hepatitis C, HIV » **Ultrasounds ordered** » Antenatal screening bloods Free Beta-hCG and Papp A after 10 completed weeks and preferably 3–5 days prior to Nuchal USS **Note:** Request slip to include EDD and current maternal weight » Nuchal Translucency 11 weeks–13 weeks $^{+6 \text{ days}}$ » Diagnostic Morphology 18–20 weeks » Booking in referral sent » **Genetic Counselling and testing discussed as appropriate** » Chorionic Villus Sampling 11–13 weeks/Amniocentesis 16–18 weeks
12–18 weeks Midwife booking in visit	» Booking in Visit – demographic, social, medical and obstetric history ± allied health referrals » SAFE Start or similar tool, tobacco/alcohol/other drug cessation and EDS (EPDS) completed » Maternal counselling including tobacco/alcohol/other drug cessation, and breastfeeding (see pages 6, 18 and 19) » **Models of care discussed and preference identified**
20 weeks Hospital staff visit	» Post diagnostic morphology ultrasound assessment and general health check » Appropriate model of care confirmed (after risk assessment completed) » Maternal counselling including tobacco/alcohol/other drug cessation and breastfeeding » Rh negative women—Consent for prophylactic Anti D stapled inside Pregnancy Health Record
24 weeks Standard antenatal visit with primary maternity carer	» Full assessment including abdominal palpation and fetal auscultation » **Request slip given** for blood tests to be performed between **26–28 weeks** » Full blood count, Rhesus Antibody blood screen and Glucose Challenge for all women
28 weeks Standard antenatal visit with primary maternity carer	» Check pathology results » 1st dose of Anti D for Rhesus negative women
30–32 weeks Standard antenatal visit with primary maternity carer	» Standard antenatal visit including maternal counselling on tobacco/alcohol/other drug cessation and breastfeeding » Discuss birth preferences, length of hospital stay and postnatal community supports
34 weeks Standard antenatal visit with primary maternity carer	» 2nd dose of Anti D for Rhesus negative women » EDS (EPDS) completed
36 weeks Hospital staff visit	» Standard antenatal visit including maternal counselling on tobacco/alcohol/other drug cessation and breastfeeding » Perform Full blood count, Rhesus Antibody blood screen
38 weeks Standard antenatal visit with primary maternity carer	» Discuss signs of early labour and when to come to hospital » Review blood results
40 weeks Standard antenatal visit with primary maternity carer	» Standard antenatal visit including maternal concerns
41 weeks Hospital visit	» Assessment of maternal and baby wellbeing (arrange for CTG if indicated) » Uncomplicated pregnancy - offer IOL for T^{+10-14} i.e. 42 weeks

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medical number:

Date of birth:

Antenatal Care Checklist

Additional appointments may be required according to individual need. Please discuss any questions or concerns you have during your antenatal, labour or postnatal period with your care providers.

Visit	Activity	Notes
First Visit Preferably before 12 weeks	☐ Discuss/order/perform routine investigations and genetic counselling **Bloods**—group and antibodies, FBC, syphilis, hepatitis B&C, rubella, HIV and urine dipstick/MSU **Antenatal screening**—Nuchal Translucency + Bloods at week 11–13+6 Diagnostic morphology 18–20 weeks ☐ Offer pap smear if due ☐ Discuss normal breast changes / examination ☐ Send hospital referral. Note interest in birth centre care if applicable. ☐ Discuss folate and iodine supplementation	
12–18 Week Midwife Booking in Visit	☐ Discuss preferred model of care ☐ Commence smoking/alcohol cessation counselling ☐ Complete SAFE Start or similar tool and EDS (EPDS) ☐ Discuss recommended weight gain/nutrition ☐ Discuss physiotherapy ☐ Discuss reasons to breast feed ☐ Offer antenatal classes: ☐ Accepted ☐ Declined	
20 Week Visit	☐ Obtain consent for Anti D prophylaxis ☐ Confirm expected date of birth ☐ Confirm model of care ☐ Review blood/scan results ☐ Discuss skin to skin contact ☐ Discuss initiation of breast feeding/baby led feeding ☐ Discuss positioning and attachment of baby	
Subsequent Visits A minimum of every 4 weeks until 28 weeks	☐ Discuss benefits of rooming-in (baby/mother staying together) ☐ Discuss exercise and rest ☐ Week 26–28: Obtain GCT/FBC/antibodies (GTT when indicated) ☐ Review blood results ☐ Week 28: Provide first dose Anti D if applicable ☐ Discuss home safety and hazard identification for injury prevention	
30–32 Week Visit with Midwife	☐ Discuss birth preferences ☐ Discuss discharge planning including post-natal supports ☐ Discuss exclusive breast feeding for six months	
34 Week Visit	☐ Week 34: Provide second dose Anti D if applicable ☐ Discuss expressing breast milk and safe storage ☐ Review EDS (EPDS)	
36 Week Visit Then as clinically indicated every 1–2 weeks until 41 weeks	☐ Discuss signs of early labour, when to come to hospital ☐ Book elective caesarean section (if applicable) ☐ Review blood results ☐ Review breastfeeding information	
41 Week Hospital Visit	☐ Discuss induction of labour for week 40 +10–14 days plus or minus membrane sweep ☐ Monitoring if indicated as per current fetal surveillance guidelines	

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Details of Baby's Father

Full name: | **Age:** yrs

Aboriginal or Torres Strait Islander origin? (both may be ticked)
☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ No

Country of birth: | **Preferred language:**

Reside together? ☐ Yes ☐ No

Details of smoking / alcohol use:

Health status:

Hereditary conditions:

Mother's Health History

Consult with your health care professional to complete this section

Health Directive in place? ☐ Yes → ☐ Copy in chart ☐ No (tick if yes and comment as appropriate)

✓	**Gynaecological**
	Pap smear *(specify date/result)*: Previous abnormal pap smear: ☐ Yes ☐ No
	Fertility problems:
	STI:
	Gynaecological problems:
	Antenatal Diagnosis Counselling:
	Other:

✓	**Medical**
	Asthma / Chest diseases:
	Heart disease:
	High blood pressure:
	Kidney disease / UTI:
	Incontinence ☐ Frequency ☐ Urgency ☐ Dysuria ☐ Stress Incontinence ☐ Bowel ☐ Referral
	Diabetes (specify treatment):
	Thyroid disorder:
	Neurological
	Gastrointestinal:
	Liver disorders:
	Epilepsy:
	Musculoskeletal disorder:
	Mental health issues / Eating disorders:
	Postnatal depression:
	Childhood illness / Vaccinations:

Haematological (blood) conditions
☐ Autoimmune
☐ Other

Venous thrombus embolism (VTE) risk assessment

Assess if the mother has any of the following VTE risks:	Consider referral to obstetric or medical service if:
☐ Major medical illness	☐ Age over 35 years
☐ Personal history of DVT, PE	☐ Weight over 80kg or BMI ≥30
☐ Family history of DVT, PE	☐ Parity 4 or more
☐ Thrombophilia: Congenital or acquired	☐ Gross varicose veins
☐ Antiphospholipid syndrome	☐ Current infection
	☐ Preeclampsia
	☐ Prolonged immobility

Surgical history:

☐ Blood transfusions
☐ Previous anaesthetic

Medications
(including over the counter, natural remedies, vitamins etc.)

Maternal family history
☐ Asthma
☐ Heart disease
☐ High blood pressure
☐ Diabetes
☐ Postnatal depression
☐ Thyroid disorder
☐ Mental health issues
☐ Hearing
☐ Multiple pregnancies
☐ Genetic disorders / congenital abnormalities

Other / Comments:

Signature: Date:

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Previous Pregnancies

Gravida:	Parity:	Pregnancy loss:

Date of birth	Gestation	Place of birth	Type of labour	Duration of labour	Type of birth	Sex	Birth weight	Duration of B/F	Comments / Name
/ /			☐ Spont ☐ Ind				g		
/ /			☐ Spont ☐ Ind				g		
/ /			☐ Spont ☐ Ind				g		
/ /			☐ Spont ☐ Ind				g		
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/ /			☐ Spont ☐ Ind				g		

Guidelines for Calculation of Estimated Due Date

1. First day of LNMP Date / /

Certain? ☐ Yes ☐ No

Assisted conception? ☐ Yes ☐ No

☐ Pill or other contraception

Comments:

2. Menstrual cycle ☐ Regular ☐ Irregular

Number of bleeding days:

Usual length of cycle:

3. Due date based on period and cycle: / /

4. Due date by ultrasound: / /

Gestation at ultrasound: / 40

LNMP consistent with early ultrasound scan (within seven days)? ☐ Yes ☐ No

5. Estimated Due Date / /

Person who calculated (print name):

Date: / /

Position:

Physical Examination at First Booking Visit

Date: / /

Pre-pregnancy weight: kg

Height: cm

Pre-pregnancy BMI:

Booking weight: kg

Comments:

Cx (Pap) smear: ☐ Up to date ☐ Offered ☐ Performed ☐ Declined ☐ Deferred postpartum → ☐ Referral arranged

Dental:

To be completed by a medical officer:

Breast / Nipples:

Cardiovascular:

Respiratory:

Abdominal:

Skeletal:

Thyroid:

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Medical information

Laboratory Results

		5–12 weeks	26–28 weeks	36 weeks			
Date		/ /	/ /	/ /	/ /	/ /	/ /
Blood group							
Antibody screen							
Antibody screen 28/34 weeks for Rh negative							
Hb g/L							
GCT							
RPR / TPHA							
Hep B							
Hep C							
Rubella titre							
HIV							
Urine dipstick/MSU							
Optional (if indicated)	GTT						
	Group B Strep Status (GBS)						
	Varicella Consider if history uncertain						
	Chlamydia screening (first catch urine)						

Ultrasound Results

Date of US	Gestation	Findings	Follow up (only if required)
		Estimated due date by dating scan	
		Combined first trimester screen: • PaPP-A and free bhCG after 10 completed weeks • Nuchal translucency 11–13 weeks + 6 days	☐ Low risk ☐ High risk ☐ Counselling ☐ Amnio/CVS considered ☐ Tertiary referral offered
		Morphology Scan Placenta: ☐ Anterior ☐ Posterior ☐ Fundal ☐ Low lying Fetal morphology: ☐ No abnormalities detected ☐ Review result	☐ Rescan 34 weeks

Model of care

Is the mother eligible for low risk care?

☐ **Yes** → ☐ GP Shared Care ☐ Hospital midwife ☐ Community midwife ☐ Birth Centre ☐ Midwifery Group Practice

☐ Other:

☐ **No,** state reason:

Print name:

Doctor's signature:

Date: / /

Additional Notes

EDS (EPDS) completed (initial): Score:	Gestation: Comments:
Mental health referral completed (initial):	Comments:
Safe Start completed (initial):	Comments:

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

Best estimate due date:

/ /

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Adverse Reactions

Document below *or* ☐ Nil known

Allergy	Date of reaction	Type of reaction	Severity of reaction	Intervention required

Medical and Obstetric Issues and Management Plan

Diagnosis:

Antenatal management

☐ Anaesthetic review—date: / / ☐ Neonatology review—date: / /

Peripartum management

Postpartum management

Postpartum follow-up

Pap smear

Contraception

Signature: Date:

Best estimate due date:

/ /

(affix identification label here)

URN:

Family name:

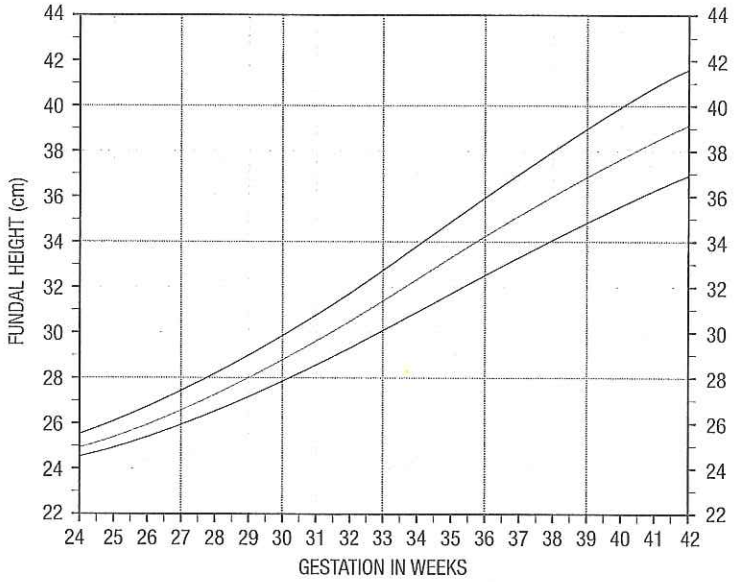
Given name(s):

Address:

Medicare number:

Date of birth:

Fundal Height Chart Plot at each visit



Visit Notes 1 of 4

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/ gestation calc	Gestation clinical (cm)	Presenta-tion	Descent/ Fifths above brim	Fetal heart rate	Fetal move-ments	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

DO NOT WRITE IN THIS BINDING MARGIN

Best estimate due date:

/ /

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Visit Notes

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/ gestation calc	Gestation clinical (cm)	Presentation	Descent/ Fifths above brim	Fetal heart rate	Fetal movements	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

DO NOT WRITE IN THIS BINDING MARGIN

Clinic notes

Best estimate due date:

/ /

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Visit Notes 3 of 4

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/ gestation calc	Gestation clinical (cm)	Presenta-tion	Descent/ Fifths above brim	Fetal heart rate	Fetal move-ments	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)

Notes:

Registered interpreter present? ☐Y ☐N | Name: | Position: | Signature:

Notes:

Registered interpreter present? ☐Y ☐N | Name: | Position: | Signature:

Notes:

Registered interpreter present? ☐Y ☐N | Name: | Position: | Signature:

Notes:

Registered interpreter present? ☐Y ☐N | Name: | Position: | Signature:

Notes:

Registered interpreter present? ☐Y ☐N | Name: | Position: | Signature:

Clinic notes

DO NOT WRITE IN THIS BINDING MARGIN

Best estimate due date:

/ /

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Visit Notes

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/ gestation calc	Gestation clinical (cm)	Presenta-tion	Descent/ Fifths above brim	Fetal heart rate	Fetal move-ments	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

Notes:

Registered interpreter present? ☐Y ☐N	Name:	Position:	Signature:

DO NOT WRITE IN THIS BINDING MARGIN

Clinic notes

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Tobacco Screening Tool

Smoking is proven harmful to mothers and their unborn children. To help smokers there is smoking cessation support available.

Date: ..... Gestation: ..... ☐ Clinician has advised that smoking is harmful to mothers and unborn children

1. Ask

Which of these statements best describes your current smoking?

- ☐ I have never smoked
- ☐ I smoke daily now, about the same as before finding out I was pregnant
- ☐ I smoke daily now, but I've cut down since finding out I was pregnant
- ☐ I smoke every once in awhile
- ☐ I quit smoking since finding out I was pregnant
- ☐ I wasn't smoking around the time I found out I was pregnant – I had smoked within the last 12 months

If currently smoking, number of cigarettes per day: .....

Does your partner smoke? ☐ Yes ☐ No ☐ N/A

Does anyone residing in or regularly visiting your household smoke? ☐ Yes ☐ No ☐ N/A

2. Assess

Quitting stage

☐ 1. Not ready ☐ 2. Unsure ☐ 3. Ready ☐ 4. Staying a non-smoker ☐ 5. Relapse

Barriers to quitting ☐ Withdrawal/cravings ☐ Partner smoking ☐ Weight gain ☐ Stress ☐ Other

Notes .....

.....

3. Advise

Benefits of quitting

☐ *Pregnancy*
- ↑ Oxygen and nutrients to baby
- Normal birth weight
- ↓ Risk of complicated birth
- ↓ Risk of pre-term birth

☐ *Baby*
- More settled
- ↓ Risk of SIDS, asthma
- Baby more likely to be discharged with mother
- Fewer colds, ear, respiratory infections

☐ *Breastfeeding*
- ↑ Intention to breastfeed / duration of feeding
- No chemicals in milk to baby

☐ *Families*
- ↓ Risks of passive smoking
- Healthy environment

☐ *Mother / partner*
- ↑ Self esteem
- ↓ Cancers
- ↓ Cardiac / respiratory disease
- ↑ Energy, breath easier
- Save money

4. Assist/arrange

Education

- ☐ Affirm positive change
- ☐ Give encouragement
- ☐ Discuss supports: GP, Quitline
- ☐ Discuss nicotine replacement therapy (NRT)

Written resources given *(for mother)* ☐ Yes ☐ Declined

Written resources given *(for partner)* ☐ Yes ☐ Declined

☐ **Quitline number offered 13 QUIT (13 7848)** ☐ **Quitline declined**

Referral to Indigenous Health Clinic ☐ **Faxed** ☐ **Declined** ☐ **N/A**

5. Ask again

Please complete the following at every opportune visit for smokers and recent quitters

Visit date	Weeks gestation	1. Cigarettes per day	2. Quitting stage	3. Advice offered Benefits of quitting	4. Support / Assistance given
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		

DO NOT WRITE IN THIS BINDING MARGIN

(affix identification label here)

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Alcohol and Drug Screening Tool

No alcohol in pregnancy is the safest option — please ask — you can make a difference

1. Ask

DURING THIS PREGNANCY:

How often have you had a drink containing alcohol in it?
- ☐ Never *(0)*
- ☐ Monthly or less *(1)*
- ☐ 2 to 4 times a month *(2)*
- ☐ 2 to 3 times a week *(3)*
- ☐ 4 or more times a week *(4)*

How many standard drinks have you had on a typical day when drinking?
- ☐ 1 or 2 *(1)*
- ☐ 3 or 4 *(1)*
- ☐ 5 or 6 *(2)*
- ☐ 7 to 9 *(3)*
- ☐ 10 or more *(4)*

How often have you had six (6) or more standard drinks on one occasion?
- ☐ Less than monthly *(1)*
- ☐ Monthly *(2)*
- ☐ Weekly *(3)*
- ☐ Daily or almost daily *(4)*

Scoring

Add the scores (shown in brackets) for each of the three questions for a total score out of 12

Score: ..... /12

0	No risk drinking
1–3	Some risk drinking
4–5	Risky drinking
≥ 6	High-risk drinking

2. Assess

Readiness to stop drinking (Ask: 'how ready are you to stop drinking now you are pregnant?')
- ☐ 1. Not ready
- ☐ 2. Unsure
- ☐ 3. Ready
- ☐ 4. Staying a non-drinker
- ☐ 5. Relapse

Barriers to stopping drinking
- ☐ Withdrawal/cravings
- ☐ Partner drinking
- ☐ Stress
- ☐ Other

Notes .....

3. Advise

0 No risk drinking ····► ☐ Congratulate and reinforce no safe level of drinking whilst pregnant

1–3 Some risk drinking ····►
- ☐ Reinforce there is no safe level of drinking whilst pregnant
- ☐ May indicate harm for baby

4–5 Risky drinking ····►
- ☐ Reinforce there is no safe level of drinking whilst pregnant
- ☐ May indicate harm for baby
- ☐ Reinforce benefits of stopping at any time
- ☐ Discuss potential effects of current drinking levels, including health concerns for both mother and baby
- ☐ Fetal Alcohol Spectrum Disorder (FASD)
- ☐ If unsure or ready to cut down or stop:
  - ask how confident she is about succeeding
  - ask if she would like some assistance
  - offer referral to local support service

≥ 6 High-risk drinking ····►
- ☐ Advise same as 'risky drinking' section above
- ☐ Refer to local support service for assessment and support
- ☐ Discuss concerns with treating team

4. Assist/arrange

Education ☐ Affirm positive change ☐ Give encouragement ☐ Discuss supports—family, GP, ATODS

Written resources given *(for mother)* ☐ Yes ☐ Declined

Written resources given *(for partner)* ☐ Yes ☐ Declined

Referral to local support service ☐ **Faxed** ☐ **Declined** (midwife to follow up at next visit)

Referral to Indigenous Health Clinic ☐ **Faxed** ☐ **Declined** (midwife to follow up at next visit) ☐ **N/A**

5. Ask again

Please complete the following at every opportune visit

Visit date	Weeks gestation	1. Drinks per day	2. Stage of readiness (As above, in ASSESS)	3. Advice offered Risks of drinking	4. Support / Assistance given / Referral
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		
			☐1 ☐2 ☐3 ☐4 ☐5		

Drug Screening ☐ Check medical record

In the past 3–6 months have you used any prescribed, non-prescribed or herbal drugs? ☐ Yes ☐ No

If *Yes*, - specify: .....
- refer to local support service for assessment and ongoing support.

Ask again:

Visit date 1	Weeks gestation	Support / Assistance given	Visit date 2	Weeks gestation	Support / Assistance given

Appointments

Date	Time	Type of Appointment	Where

Antenatal Education Classes

Date	Time	Type of Appointment	Where

Acknowledgements

This document has been an initiative of the Queensland Health Statewide Maternity and Neonatal Clinical Network including the Queensland Health Antenatal Hand Held Steering Committee and Working Group.

We wish to thank the South Australian Department of Health, Townsville Health Service, Royal Brisbane and Woman's Health and the Southern Area Health Service Maternity Network for providing their pregnancy health records to aid in the design of this document.

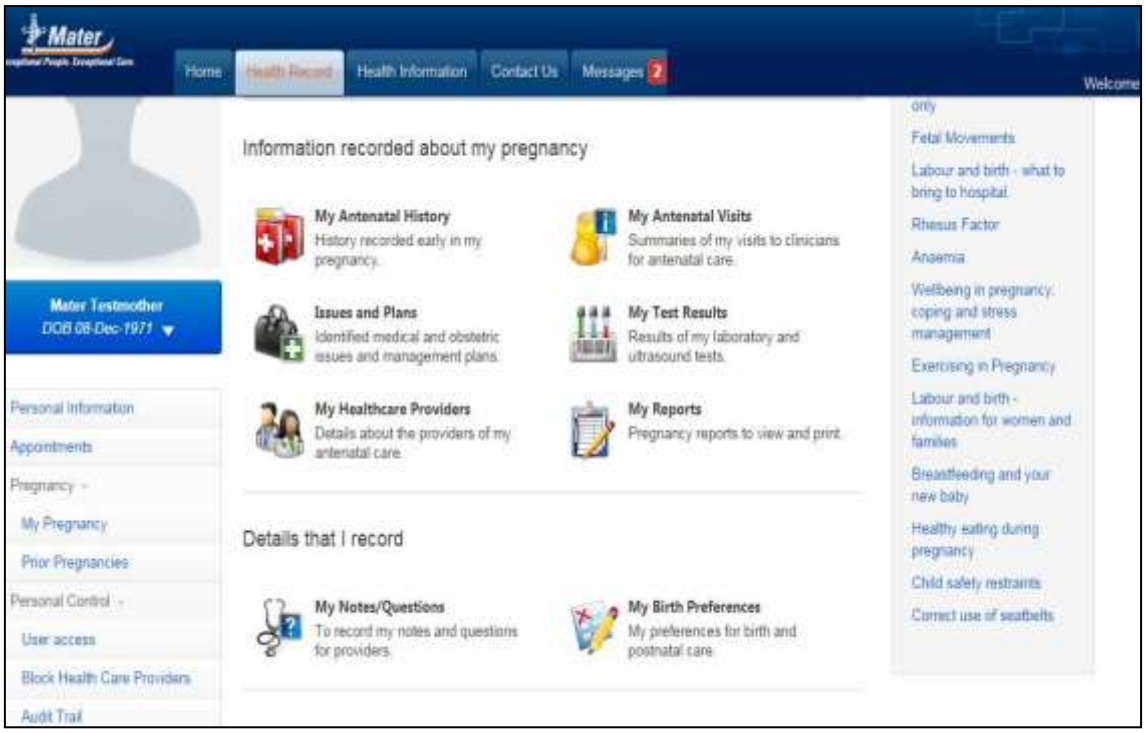


Fig. S2. Mater shared electronic health record (MSEHR) icons as viewed through the women's patient portal.

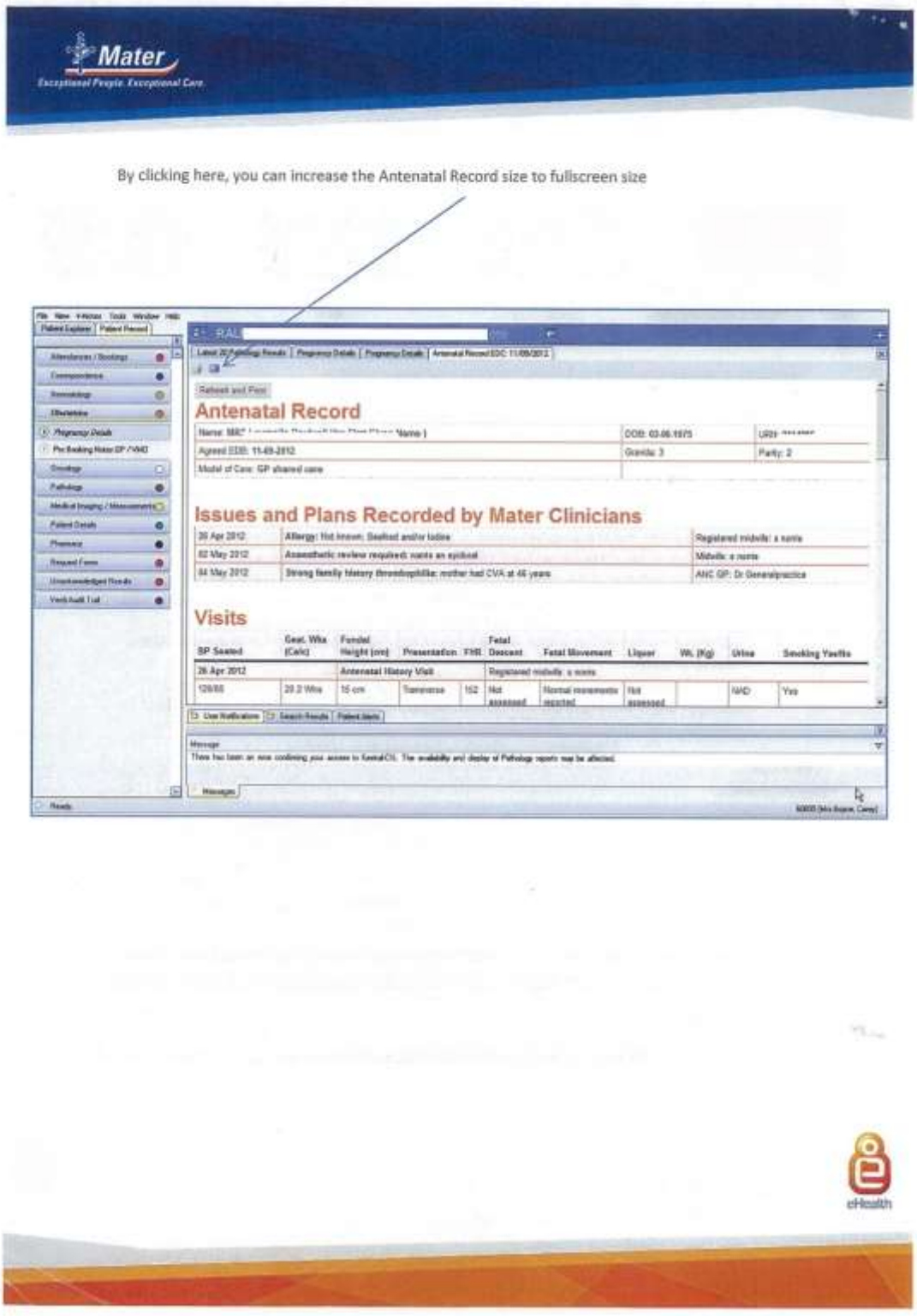


Fig. S3. View of health summary sheet generated from the Mater shared electronic health record.

Table S1. Comparison of the paper and electronic fields

Paper hand-held record Pages are divided into sections of:		Electronic health record Icons viewed through patient portal:	
Pages 1–3	Mother and GP details	Antenatal history	History recorded early in pregnancy
Pages 4–5	Important antenatal signs and symptoms of concern Birth preferences	Issues and plans	Identified medical and obstetric issues and management plans
Pages 6–7	Baby feeding intentions, glossary and what to bring to hospital, additional notes section	Healthcare providers	Details about the providers of maternal care
Pages 8–9	Antenatal visit schedule and care checklist	Antenatal visits	Summaries of visits to clinicians for antenatal care
Pages 10–11	Father and mother health history Previous pregnancy information	Test results	Results of laboratory and ultrasound tests
Pages 12–13	Laboratory and ultrasound results Medical and obstetric issues and management plans	Reports	Pregnancy reports to view and print
Pages 14–17	Fundal height chart Visit notes	Details recorded by women	
Pages 18–20	Tobacco and alcohol screening Additional scheduling section	Notes and questions	To record my notes and questions for providers
		Birth preferences	Preferences for birth and postnatal care

Table S2. All Themes_Groups_Nov2014

Notes to use when completing table (numbered for convenience): 1, Not used as journal at all; 2, Allied Health - Even though did not access – had positive impressions and thought would look at in future; 3, Thought e-record would empower women and was important; 4, All health care professional groups thought EHR would improve safety and privacy; 5, Integration of care was not shown to improve with EHR – not accessed enough; 6, Integration of users – thought info was duplicated in paper and e-record; 7, Women, midwives and doctors did think the EHR had links to good resources and education; 8, All groups felt disconnected or not from EHR or not engaged; 9, All groups had positive perceptions of EHR if they were more aware of capabilities and had improved access; 10, Midwives and hospital doctors thought information was more available – so not missing; 11, Women and HCP thought EHR would be good for communicating but it was not used for this presently. Definitions: EHR, electronic health record; HCP, healthcare practitioner

Theme	Sub-theme	Groups			
		Midwives	Doctors	Allied Health	GPs
All Users_Phase 1					
Selective use of the record	1. Specific clinical role - prepare and reflect	✓	✓	×	✓
	2. Feature of care	✓	✓	×	✓
	3. Sensitive nature of issues recorded	×	×	×	×
	4. Privacy	✓	✓	×	✓
Communication of care	1. Engagement	×	×	×	×
	2. Contribution – reduce missing information acceptance, relevant, comprehensive, access to results, resources, education and empowerment	✓	✓	×	✓
	3. Physical attributes – design	✓	✓	×	✓
	4. Safety resource	✓	✓	×	✓
Negativity using the record	1. Frustration – irrelevant information, superfluous, discriminate, duplication and sensitive	×	×	×	×
	2. Disconnection, overwhelmed and disillusion – confused and indifference	×	×	×	×
	3. Information technology (IT) issues	Nil	Nil	Nil	Nil

Theme	Sub-theme	Groups			
		Midwives	Doctors	Allied Health	GPs
All Users_Phase 2					
Selective use of the record	1. Specific clinical role - prepare and reflect	×	×	×	×
	2. Feature of care	Nil	Nil	Nil	Nil
	3. Sensitive nature of issues recorded	×	×	×	×
	4. Privacy	✓	✓	×	✓
Communication of care	1. Engagement	×	×	×	×
	2. Contribution – reduce missing information acceptance, relevant, comprehensive, access to results, resources, education and empowerment	✓	✓	×	✓
	3. Physical attributes – design	✓	✓	×	×
	4. Privacy	✓	✓	✓	✓
Negativity using the record	1. Frustration - irrelevant information, superfluous, discriminate, duplication and sensitive	×	×	×	×
	2. Disconnection, overwhelmed and disillusion – confused and indifference	×	×	×	×
	3. IT issues	×	×	×	×

Table S3. Coding Midwives_BirthSuite

Questions used were semi-structured. From Midwives_BirthSuite in hase1 of the study (is using a PHR). PHR, paper hand-held record; EHR, electronic health record.

Black – positive responses from questions; bold – negative responses from questions

Interview page	Question in interview	Comments from interview	Descriptive codes (initial)	Interpretive codes (sub-theme)	Analytical themes
	Antenatal Care Role			Antenatal info	Introduction
Page 3	How does PHR fit into good antenatal care?			Antenatal info	Introduction
		I liked them because you knew exactly where things were. You could just flip through to the page. There was no waiting for something to load up. You could get to it very quickly.	Like paper – can flip through it, no waiting for anything to load. No waiting.	Antenatal info	Introduction
		The woman had easy access to it as well.	Easy access		
		What I don't like (about PHR) if there was anything the woman did not want to share with her partner, for example if there was previous termination of pregnancy, that would be on the record.	**Information not hidden**	**Irrelevant**	Selective
		Something like that (termination information) wasn't always necessary; other things may have been necessary.	**Information not hidden**	**Irrelevant**	Selective
Page 2	Which parts of the record are good?	Bloods, ultrasounds, health history and previous deliveries.	Results good	Clinical	Selective
Page		Calculation of Estimated date of delivery (EDD).	EDD	Clinical	Selective
		An overview of the summary		Clinical	Selective
		Results available Yep. It was always a backup anyway.	Results available		Selective
	Other than results – what do you refer to?	To see if they are smoking.	Smoking		Selective
		Within half an hour you have got the chart. That is sometimes a long time. They don't always		**Open access**	**Communication**

Interview page	Question in interview	Comments from interview	Descriptive codes (initial)	Interpretive codes (sub-theme)	Analytical themes
		remember to carry it with them, they left it in the car or work.			
		I will look at the visit notes to see if it was documented, to get a follow-up.	Use record to follow up on visits	Reflection	Communication
		Gaps - people not always filling in when there are prompts.	**Sometimes info – dates missing**	**Missing**	**Selective**
Page 11		When I have used it in the past they are generally filled in well.	Utilised well	Missing info	Selective
		They are not always completed.	**Sometimes info – dates missing**	**Missing**	**Selective**
	Do women refer to record?	I think they think it is a safety thing. When we tell them in the clinic, 'This is your record. You take it to your doctor or take to it the hospital. This is a way we can all communicate', it is a safety thing for them.	Always carry with them	Safety	Communication
		People love to read through their own history. That is accessible. If I have got that with me in the shopping centre and I collapse, the ambo can have a look through it. A lot of women like that.	Women like to look at it	Reflect safety	Selective communication
Page 12		We have not been using just paper for some time. It is hard to cast our mind back to when we only had this. It is hard to remember what we used to do and what was not available on the computer (database).	Have had paper for a long time with a database		
		You make a bit of a leap assuming that what is not here is on Matrix. This is an assumption we have made.			
Page 7		There was someone with a blood group different from Verdi, a different clinical result; it was transcribed wrongly into Matrix.	Transcription error	Safety	Communication
Page 11	Out of clinic – in assessment unit	I don't remember ever really documenting in the paper record. It is documented in the notes, on the Pregnancy assessment outpatient unit (PAOU) form and in Matrix.	Out of clinic- PHR not used	**indifference**	Negativity
Page 13		PHR useful when woman transferred	Good for out of hospital	Journal	Communication

Interview page	Question in interview	Comments from interview	Descriptive codes (initial)	Interpretive codes (sub-theme)	Analytical themes
		We have had women who attended PAOU before us finalising their booking in. They have no paperwork from their previous hospital, they have no paperwork from here and they ask for their record or something when they get to PAOU. It is because we have only just linked them to the Mater and we have not finished everything yet. It is hard for them because they have nothing.	If have an EHR, information is not complete as it is when a PHR is used		
	PHR value	This document is to engage women in their care and the process that now is taking place moves them away from that.	Intention of PHR is to make women more involved	Empowerment	Communication
		It is something that has moved away from a safe basis that was put together to engage women in their health care with this hand-held record and it demonstrates the confusion when even the staff are not aware of what the electronic information is.	**EHR has caused havoc - chaos**	**Confusion**	**Communication**
Page 16		This document provides information the woman can look at, when the kids are asleep and things have settled down, of concerns that would be really important for her to contact the doctor about. It engages her when the baby is due and to be part of her birth plan. I know she has the birth plan there. Most women are using that now. Women are starting to value the opportunity to be involved through their birth plan. That is really good.		Reflect empowerment	Communication
	Do women look at record	I think they do, particularly when you involve them in it, when they come to antenatal and you are using their hand-held record that they are going to take it home and write on it and document on this.	Intention of PHR is To make women more involved	empowerment	Communication
		There is a piece of paper here, and here it is, that they can write questions on. They will forget the	Intention of PHR is to make women more involved	Empowerment	Communication

Interview page	Question in interview	Comments from interview	Descriptive codes (initial)	Interpretive codes (sub-theme)	Analytical themes
		question they thought of when they are peeling the vegies or whatever.			
		There is safety in women asking questions, there is safety in women being involved.	Intention of PHR is to make women more involved	Empowerment	Communication
Page 18		**I have just seen a couple upstairs (indicating) and, honestly, you would think they were at a picnic. They have had the baby. She is on her phone, he is on his phone. Where is the baby? In the cot. Engagement is what it is all about.**	**Not being engaged with baby – why??**	**Indifference**	**Negativity**
		It was 1996. We couldn't afford continuity of care but we could have continuity of care and this was the little document that was set up to do it.			
		They can have continuity of care based on this document.	Continuity	Journal	Communication
		If you see her for the first time you can see what has happened, you can see what she has been involved in. You can use it as an educational tool		Journal	Communication
Page 15	**EHR**	There is more education to be done. There is confusion about all the different ones: Matrix which feeds to Verdi. We have got the electronic held record, the Mater version versus the national version. People hear all these acronyms. There are these weird things bandied about electronically. A portion of our staff are confused by what you mean when you say, 'Electronic health record'.	Staff don't know about EHR	**Confusion**	**Negativity**
		The IT people confuse all the terms. We don't know what they are talking about.	Non-familiar terms	**Confusion**	**Negativity**
Page 17	**PHR**	**The staff are confused. When we get people into the birth room, the number of times they have still got their hand-held records - the staff are not aware of the value of this hand-held record.**	**Staff don't take PHR at delivery**	**Confusion**	**Negativity**

Interview page	Question in interview	Comments from interview	Descriptive codes (initial)	Interpretive codes (sub-theme)	Analytical themes
		Because it is not available. It is not correct to assume that everybody has access to computers. I have met people who don't have a phone, never mind a computer.		**Open access**	**Communication**
	GPs using record	To my knowledge, I don't - it doesn't seem to me that GPs are adding information into that when they are shared caring. I have never seen a person on shared care have anything - presumably that should come up on Verdi. I saw it once and I was like, 'What is this?'	GPs use own systems	**Sharing**	**Communication**
	When woman forgets record	I can remember women turning up without their records. It was annoying.	When woman turns up without record	**Safety**	**Communication**

Table S4. Example summary table of coding from Midwives_Themes and Sub-themes in Phase 1

Xs describe number of responses to questions asked. Summary tables were combined from each group of participants to collate a complete summary of findings

			Focus groups			
Research question	Theme	Sub-theme	Facilitators	Barriers	Facilitators	Barriers
			Midwives Birth SuiteS Phase 1		Midwives Antenatal Clinic Phase 1	
1. Experiences of users	1. Selective use of the record	1.1 Preparation	XXX			
		1.2 Reflection	XXX			
		1.2 Confusion		XXX		XXXX
		1.3 Referral				
		1.4 Journal	XXXX		XX	
		1.5 Empowerment	XXXXX	X		
		1.6 Safety	XXX			X
		1.7 Open access		XX		XXX
	2. Negativity using the PHR	2.1 Physical attributes	X	X		
		2.2 Acceptance	XXX			XX
		2.3 Indifference		XX		XX
		2.4 Disconnection				XXXX
	2. Negativity using the EHR	2.5 Familiarity	XXXX			
		2.6 Comprehensive	XXXX			
		2.7 Disillusion				XXXX
2. Integration of care	3. Communication of care	3.1 Missing information	X	XXXX		XXX
		3.2 Irrelevant information		XX		XX
		3.3 Clinical results	XX		XX	
		3.4 Resources	X	X	X	XX
		3.5 Sensitivity				
		3.6 Duplication		X		XX