Midwives' Association *of* Washington State

Incident Review

MAWS Incident Review is a formal process to review and freely discuss clinical cases involving sentinel events with their peers in a supportive learning environment with the goal of improving clinical practice and future outcomes. MAWS Professional Members are required to participate in MAWS self-reporting and Incident Review.

1. Incident Self Report From

If a Sentinel Event occurs in your practice, fill out an Incident Self Report Form and fax it to the QMP at 206-691-8203 within 14 days of the event. If you realize later than 14 days that you have a case that meets criteria, you are still expected to file a report.

When filling out a Self Report Form, please be concise but include pertinent clinical information including age, parity, risk factors, clinical events, outcomes, and any other relevant information that will help the QMP committee understand what has occurred and determine whether a review is warranted. Do not include chart notes or any other protected health information (PHI).

If there is one other person, such as a colleague midwife, student, or other healthcare professional involved in the case who should attend the review, please indicate that in the report.

***We recognize that there are some midwives who are members of multiple professional organizations. WARM and PMA also have state-sanctioned Incident Review Programs. If you are a MAWS member but wish to conduct Incident Review through either of those organizations, you are welcome to do so but are still expected to notify the QMP of a sentinel event and the resulting review using this form: **MAWS Incident Report Form**.

2. QMP Response

Expect to hear back from the QMP within 2 months, after the next QMP meeting. Responses may fall into the following categories:

i. Doesn't meet sentinel event criteria, bring to peer review
ii. Meets criteria but doesn't warrant review, bring to peer review
iii. Warrants review, expect to be contacted by a QMP member within the month.
iv. More information necessary to make a decision; please submit a second form with the requested information.

3. Coordinating the Incident Review Panel (IRP)

If a review is warranted, the lead QMP member will reach out to you, along with 2 other current MAWS members, and coordinate a review. As the midwife being reviewed, you may have some say as to who the other reviewers are, depending on logistical feasibility. For example, if you are a midwife from an underrepresented group such as (but not limited to) midwives of color or

nonbinary midwives and would feel safer being reviewed by those who share that identity or known allies, please let us know. We recognize that being reviewed can be a very vulnerable experience and we are committed to honoring these requests whenever possible.

Coordinating a group of 4 professional midwives can take time. Expect the Incident Review to take place within 2-6 months of the Sentinel Event.

4. Conducting the Incident Review Panel

At the review, the Midwife being reviewed is expected to provide either paper copies of the chart for all reviewers, or access to electronic health records. All participants will sign a confidentiality agreement. The Lead QMP member will guide the review, which will include an in-depth review of the chart, question and answer, and in-person feedback and discussion. This should be conducted with respect, honesty, and humility on the part of both reviewers and reviewees. During the review, each participant is asked to complete a Feedback Form. The QMP Committee uses these forms to evaluate and improve the Incident Review Process.

5. Closure

After the review is complete, findings are reviewed at the next QMP meeting. The QMP may recommend some follow up actions such as repeating NRP or CPR, taking a fetal surveillance continuing education class, or revising/creating practice guidelines. The intention is to be fair and reasonable, and not punitive, but also to uphold standards of clinical excellency. Expect to receive a letter within 1-2 months of the Incident Review either closing the case or recommending follow-up action.