MATERNITY UNIT

GUIDELINE: CLINICAL CASE REVIEW - MATERNITY

SCOPE:

All health professionals who provide care to women during a pregnancy or postnatal related event

AUTHOR:

Director of Midwifery

DEFINITIONS:

Complaint - A complaint is an expression of dissatisfaction by a complainant. In many instances, complaints are incidents that have occurred in a health or disability service, but that have been reported by a consumer, carer or family member, service user or resident.

Contributing factor - A contributing factor is defined as a circumstance, action or influence (such as poor rostering or task allocation) which is thought to have played a part in the origin or development of an incident, or to increase the risk of an incident.

DOM – Director of Midwifery

HOD – Head of Department

ME – Midwife Educator/Quality Coordinator

PMMRC – Perinatal & Maternity Mortality Committee

PURPOSE:

To inform all relevant personnel of the purpose and process of a case review relating to care provided to a women during a pregnancy or postnatal related event

To ensure internal and external identification of issues received about service and practice will be dealt with in a prompt, sensitive and safe manner and that the information gained from this resolution process will be used to:

(a) Ensure continuous improvement occurs

(b) Counsel families

(c) Support health professionals

GUIDELINE:

1. Issue identified internally or externally, this may be through an incident report or complaint or verbally.

Author: DOM    Date of first approval: Feb 2009
Authorised By: HOD Obstetrics    Date last review completed: June 2019
Clinical Care Manager, Woman, Child & Youth    Version 3
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Page: 1 of 4
2. All issues identified are to be referred to the Director of Midwifery (or the Midwife Educator/Quality Coordinator (ME) in the absence of the DOM) and/or the Head of Department for Obstetrics (HOD).

3. The DOM/HOD/ME will acknowledge and thank the identifier of the issue and outline what steps will be taken to achieve resolution.

4. The DOM/HOD/ME will then determine the relevant process to be undertaken. If any immediate actions are required to correct an issue, the DOM/HOD/ME will ensure these are actioned immediately.

5. The DOM/HOD/ME will identify all of those involved in the clinical care of the patient.

6. DOM/HOD/ME will agree and organize a venue, date and time for the case review after looking at relevant the rosters.

7. All staff involved will be sent an electronic invite to the case review with a ‘hot debrief’ (see appendix one) attached to complete for their own reference and preparation for the case review.

8. An administration person will be allocated to scribe any learning outcomes during the case review

Procedures during the Case Review

1. Facilitator commences the meeting clarifying the reasons this case was nominated and introducing the case review process highlighting that its purpose is to:
   - develop recommendations for continuous improvement (not intended as a ‘name and blame’ process);
   - provide relevant information with which to counsel a family effectively
   - but NOT designed to resolve relationship issues that arise between stressed colleagues – other forums are needed for this.

2. Involvement of clinicians in the case review is then chronological i.e. the clinical sequence is discussed so as to identify and highlight all detail, decision making processes, etc.

3. Any contributing factors will be openly discussed.

4. Learning outcomes/recommendations are agreed – these are captured by the scriber

5. Those present are informed that they will be emailed the agreed learning outcomes/recommendations so they have the opportunity to ensure these have been recorded correctly, the time scale to respond will be one week from the email being sent.
6. At the conclusion of the review, all those involved should be thanked for their participation and Team Leaders reminded of their responsibilities arising from the learning outcomes/recommendations.

7. Once the week has passed, if there are any suggested changes these will be discussed and agreed between the DOM/HOD/ME and relevant changes made.

8. If the case review was in response to a complaint or the patient had been informed of the case review and offered to be informed about the outcome. The DOM/HOD/ME will contact the patient at this point in time to share the learning outcomes/recommendations from the case review and what actions will be taken.

9. DOM/HOD/ME will present the learning outcomes/recommendations at the next PMMRC meeting, if this was a serious/sentinel event then these will also be presented to Clinical Governance committee.

10. ME will monitor:
   • Implementation of recommendations

11. Any related incident report will now be closed off.

**EVALUATION:** Case review learning outcomes/recommendations to be included in annual quality report

**ASSOCIATED DOCUMENTS:**

Appendix 1 – Hot debrief

**Date of Approval:**

**Next Review Date:**

__________________________

Authorised By (HOD Obstetrics)

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Authorised By (Clinical Care Manager Woman, Child & Youth)

**Date of Approval: November 2019**

**Next Review Date: November 2022**
## Participant – Hot Debrief Notes

Case review

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<th>What did not go/work well?</th>
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<th>What could have been done differently?</th>
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<th>Recommendations &amp; what can be improved?</th>
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