

California College of Midwives
State chapter ~ American College of Community Midwives

Section Three

Incident Report Forms for Members of the California College of Midwives

∞ Purpose of an Incident Report: -- to memorialize in writing any unusual event at the time of its occurrence by a person who was a direct personal witness or participant

Incident Report Forms: Can be submitted as a simple typed report, dated and signed. The original should be added to the client's file. At the midwife's discretion a copy can be mailed to the administrator of the California College of Midwives.

The report should contain the names of all individuals who were present at the time of the incident and a non-judgmental description of events/circumstances ("just the facts, ma'am"). Initials (instead of full names) should be used for physicians or hospital staff to preserve their anonymity. However, the record of events constructed should be able to be verified in a court should that come to pass.

Reports received by the CCM are the confidential property of the CCM (would require a court order for discovery). They may be used anonymously for research purposes.

Examples of "Incidents":

1. Events or circumstances that might result in litigation or accusations by a regulatory agency against the midwife at a later date, including conversations in which a client family indicates they may file suit or a doctor or hospital employee threatens to "report" the midwife to the "authorities".
2. Events or circumstances observed in the course of interacting with medical providers or institutions in which the midwife was a direct observer of substandard care or harmful practices -- for example, serious errors in medical or nursing care, use of unsterile equipment or septic technique, failure to obtain parental consent before performing invasive procedures (episiotomy, etc), retaliation against homebirth parents by angry hospital staff or attending physician in which the parents were subjected to derogatory accusations (child abuse, etc.), subjected to unwanted and medically unnecessary procedures or refused care that was wanted or medically necessary (for instance, a doctor who refuses to provide pain medication or local anesthesia during procedures or refuses to deliver a precipitous breech baby, thus forcing the midwife or nurse to manage the delivery of the baby instead of the obstetrician).
3. Any other unusual occurrence that might be useful to have a written record for later use.

Non-judgmental Language: Please make every attempt to simply describe the events, without labeling or negative characterizations, and record exact quotes or paraphrases as precisely as possible. When some qualification is necessary, please choose your words carefully. For example if the nurse was incredibly rude to a homebirth mother after transport, one would characterize that in the neutral term of "Nurse's remarks were disrespectful to mother" and then if you can

remember what she said quote or paraphrase the nurse "Only a crazy person or hippie would try to have their baby at home," etc.

The same principles would be applied to the physician. For instance, after an emergency CS with stillbirth 10 hours after hospital admission of a mother not in labor, one doctor informed the father that his baby had died and that it was the father's fault for having chosen a midwife and said "If you had been under the care of an obstetrician this wouldn't have happened". Of course, the family had been under the care of an obstetrician - him!

Incident reports are especially helpful under circumstances of **emergency transfer of care** in which there is either a bad outcome or threats by physicians or hospital staff to report the midwife. Particularly with mortality or any permanent disability subsequent to midwife or home-based birth care the hospital or doctor may try to cover themselves by pointing the finger at the midwife, making it appear that what she did (or failed to do) caused the bad outcome when in fact we, as direct observers of medical or nursing care, noted either a failure to respond (would not believe information provided by the midwife) or a vast over-reaction which resulted in a cascade of complications.

In any event, you as a practitioner are best served by having your chart be in apply pie order and memorializing the events by filling out an incident report in a timely fashion (within 7 days if possible).