Oregon Midwifery Council
Peer Review Committee Charter

Purpose:
Peer review is the foundation of midwifery quality improvement in Oregon. Midwives attending home births and birth center births in Oregon participate in peer review to receive feedback from peer midwives about the care we have given in order to improve care and to engage in ongoing learning as individual midwives and as a community.

The Oregon Midwifery Council holds regular regional peer review meetings and also provides individual case review for sentinel events in order to:

- Improve outcomes and experience of care for midwifery clients
- Identify system level issues impacting client care
- Identify areas where continuing education is needed
- Improve the process of hospital transfer
- Support ongoing learning and growth for midwives

Structure:
Each OMC region holds a regular peer review meeting at least two times per year during which multiple cases are reviewed by the midwives present. The Oregon Midwifery Council regions are Portland area, Mid-Valley, Eugene area, Southern, and Central. Midwives outside of those regions are welcome to attend any regional meeting that works for them or contact OMC to organize a local or online peer review. Regular peer review meetings are open to midwives attending community births and students in apprenticeship accompanied by a preceptor.

Focused, individual case reviews are provided at the regional level or by the OMC Quality Improvement Committee as needed. Case review is used for sentinel events or when there is a request from a midwife, receiving hospital provider, client, or community member. Joint midwife and hospital staff case review is a best practice for sentinel events involving a hospital transfer and the OMC Quality Improvement Committee will facilitate a joint review in addition to the internal review whenever possible.

Peer review at the regional peer review meeting or during the case review process is confidential. No person who participates in the review may disclose any information acquired in the review, nor may any record of the review be released to any person. More information about the confidentiality of peer review in Oregon can be found in ORS 041.675.

Process:
The OMC Regional Representative of each region is responsible for scheduling and facilitating (or arranging facilitation for) a regional peer review meeting at least two times per year.

Midwives themselves are responsible for scheduling a case review when there has been a sentinel event and may contact their regional representative or the OMC Quality Improvement Committee to arrange this or may schedule the review privately with midwives who meet the criteria for case review. The OMC Quality Improvement Committee will contact a midwife to arrange a case review when there has been a request or complaint from another provider or community member.

At regular regional peer review meetings and at case reviews, the reviewers are responsible for providing feedback about midwifery care and may make individual recommendations for changes in practice and specific continuing education and system level recommendations to be brought back to OMC and the midwifery community for improving care for future midwifery clients.

OMC Guidelines for Peer Review and Case Review

Confidentiality

- All OMC peer review is confidential. No person who participates in the review may disclose any information acquired in the review, nor may any record of the review be released to any person.

Regular Regional Peer Review

- Regional regular peer review meetings are for the purpose of ongoing quality improvement
- Midwives and student midwives in clinical training are expected to participate regularly by:
    - Presenting their own cases for review
    - Reviewing the cases of their peers
- Each midwife will prepare for peer review by:
    - Bringing the chart or a copy
    - Preparing an outline including timeline, key lab results, relevant health history, etc
- Reviewers will be prepared to:
    - Maintain confidentiality
    - Listen with empathy to the midwife's experience
    - Give feedback on midwifery care and make recommendations as needed
    - Identify systems level problems that may need to be addressed

Case Review/Incident Review

- A more structured case review is required in the following situations:
    - Maternal hospitalization for infection
    - Maternal hospitalization requiring blood transfusion
    - Uterine Rupture
    - Maternal or Neonatal Death
    - Neonate admitted to NICU within 72 hours (except for observation or anomaly)
    - Emergent transports
    - Midwife self-requests
    - Suggestion or complaint from community or another midwife
- **Case Review Guidelines**:
    - Conduct review within 3 months of the incident
    - Review is scheduled for 2 hours
    - Review is done with at least 2 midwives who:
        - Are not part of the midwife's practice
        - Have attended at least 100 births as primary
    - The midwife provides a full copy of the chart for each reviewing midwife with identifying information blacked out.
    - The review includes:
        - Thorough chart review
        - Midwife narrates the sequence of events
        - Questions, comments, critiques and feedback from reviewers
        - Creation of a plan and written recommendations for the midwife if needed
    - All copies of chart will be returned to Midwife

The Intention of Case Review/Incident Review:

- Identify oversights/mistakes
- Identify systems level issues that need addressed
- Improve Charting
- Identify community standards
- Identify need for continuing education on specific topics