Staff Support Following an Incident

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Scope:	Maternity Service

Associated Policies and Written Control Documents

Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Initial issue of SOP	01/09/2026
2		

1.0 Procedural Information

1.1 Scope

This SOP outlines the process for clinical supervision of midwives following a clinical incident, near miss, or significant event. It aims to support reflective practice, staff wellbeing, learning, and service improvement while promoting safe, effective, and evidence-based maternity care. The SOP applies to all midwifery staff involved in incidents, but does not replace formal incident investigation, governance, or disciplinary procedures.

1.2 Introduction

Clinical incidents can have a significant impact on women, families, and healthcare professionals. Clinical supervision provides a structured and supportive process through which midwives can reflect on practice, explore the circumstances surrounding an incident, and identify opportunities for learning and improvement. Effective supervision promotes professional development, staff wellbeing, and patient safety while fostering a culture of openness, accountability, and continuous quality improvement. This SOP outlines the process for undertaking staff support following a clinical incident and supports a consistent approach across maternity services.

1.3 Purpose

The purpose of this SOP is to:

- Provide a clear and consistent framework for clinical supervision and staff support following a clinical incident, near miss, or significant event.
- Support midwives to reflect on their practice in a safe, confidential, and supportive environment.
- Promote learning and professional development through reflection and constructive feedback.
- Support the emotional wellbeing of staff involved in clinical incidents.
- Identify factors that contributed to the incident and opportunities for improvement in practice.
- Enhance patient safety and quality of care by facilitating shared learning and the implementation of lessons learned.

- Foster a culture of openness, accountability, and continuous improvement within maternity services.

1.4 Acronyms and Definitions

- PTHB – Powys Teaching Health Board
- CSfM – Clinical Supervisor for Midwives
- SOP – Standard Operating Procedure

2.0 Incident Process and Staff Support

2.1 - 10 Steps to Staff Support

1. Incident report submitted via Datix by the staff member involved in the incident where possible.

2. Datix notification received by the CSfM team via email once assigned by governance team. This is for information only purposes to initiate support.

3. Initial wellbeing check (Appendix A) offered by the CSfM ideally within 24 hours to provide immediate support following the incident (or by the Bronze Midwife when the CSfM is unavailable out of hours). This will be completed within 24 hours where possible and when staff involved in the incident available.

4. Initial debrief (Appendix B) offered and undertaken by the CSfM ideally within 72 hours, providing a psychologically safe environment to reflect on the incident (either face-to-face or via Microsoft Teams). This will be completed within 72 hours where possible and when staff involved are available.

5. Completion of documentation, including wellbeing check (Appendix A) and debrief with an agreed action plan for ongoing support (Appendix B). All documentation will be saved in the staff members Clinical Supervision Personal File on SharePoint. Progress notes can be added to Incident Report by the CSfM.

6. Ongoing support provided by the CSfM, including attendance at rapid review meetings where required, and support with identifying and discussing any immediate learning.

7. Follow-up contact completed with the staff member within 7 days, or sooner if indicated, with the opportunity to arrange reflective supervision and support sessions as appropriate.

8. Occupational health and wellbeing resources signposted and/or facilitated (e.g. Vivup), with referral or escalation processes initiated where necessary.

9. Following completion of the formal incident review, any additional learning outcomes are shared with the staff member(s) involved.

10. Continued monitoring, wellbeing support, and clinical supervision provided by the CSfM as required.

2.2 Roles and Responsibilities

Head of Midwifery and Sexual Health

The Head of Midwifery and Sexual Health Service must:

- Ensure clinical supervision processes are in place following incidents
- Promote a culture of learning, openness, and patient safety
- Support the wellbeing of midwifery staff involved in incidents
- Ensure learning from supervision informs practice and service improvement
- Ensuring all staff read and understand this procedure

Assistant Head of Midwifery

The Assistant Head of Midwifery and Sexual Health Service must:

- Ensure dissemination of this document to all relevant staff
- Support implementation of clinical supervision following incidents within the maternity service
- Coordinate and facilitate access to clinical supervision for midwives involved in incidents
- Provide support and guidance to clinical supervisors
- Ensure timely follow-up of actions and learning identified through supervision sessions
- Contribute to monitoring compliance with the guideline and escalating concerns where needed
- Assist in embedding a culture of reflective practice, openness, and continuous improvement
- Support staff wellbeing and signpost to additional support services when appropriate

Consultant Midwife

The consultant midwife must:

- Provide expert clinical leadership and advice on clinical supervision following incidents
- Support reflective practice and ensure supervision is evidence-based
- Facilitate or contribute to clinical supervision sessions for complex or high-risk incidents
- Promote a culture of learning, openness, and psychological safety within the maternity service

Women and Children's Risk and Governance Lead

The Women and Children's Risk and Governance Lead must:

- Provide oversight of governance processes related to clinical incidents and subsequent clinical supervision
- Ensure alignment of clinical supervision with incident reporting, investigation, and risk management systems
- Ensure actions and learning identified through incident reporting are documented, tracked, and completed in a timely manner and shared with clinical supervisor for midwives to disseminate
- Monitor and analyse themes, trends, and learning arising from incidents and supervision outcomes
- Support the development of a learning culture by promoting shared learning and dissemination of best practice
- Liaise with senior midwifery teams to ensure safety concerns are escalated appropriately

Clinical Supervisor for Midwives

The Clinical Supervisor for Midwives must:

- Provide structured and supportive clinical supervision following incidents
- Facilitate reflective discussions to explore practice, decision-making, and contributing factors
- Support midwives to process emotional impact and maintain professional wellbeing
- Identify any learning needs or professional development required
- Promote safe, evidence-based, and woman-centred practice
- Promote psychological safety by ensuring supervision is a supportive, non-judgmental space that encourages open reflection, honest discussion, and a strong culture of learning and continuous improvement.

- Contribute to identifying themes and shared learning to improve practice and patient safety

Bronze Midwife

The Bronze Midwife must:

- Undertake an initial wellbeing check for any staff member involved in a significant clinical incident when the CSfM is unavailable.
- Assess immediate welfare needs and ensure the staff member is safe to continue working or arrange appropriate support if required.
- Escalate any concerns regarding staff wellbeing to the senior leadership team and arrange follow-up by the CSFM at the earliest opportunity.
- Ensure the wellbeing check and any actions taken are documented and handed over to the CSFM or relevant manager for ongoing support.

Midwives

Midwives must:

- Participate in clinical supervision following involvement in an incident, near miss, or significant event
- Engage openly and honestly in reflective discussion to support learning and improvement
- Reflect on clinical decision-making, actions taken, and contributing factors
- Identify personal learning needs and contribute to agreed development plans
- Apply learning from supervision to future practice to improve care and patient safety
- Support a culture of openness, accountability, and continuous learning within the maternity service
- Access additional support services if required to support emotional wellbeing following an incident

3.0 Additional Information and or Appendices

Appendix A: Maternity Services – Initial Wellbeing Check Form following an Incident (2026).docx

PTHB Maternity Services – Initial Wellbeing Check Following an Incident (To be completed within 24 hours of the incident and/or datix submission)

Date:
Time:
Completed by:

Staff Member(s) Present:

Immediate Wellbeing Check

How are you feeling right now?

Any reasonable adjustments required?

What Happened? (facts only):

What Went Well:

What Could Be Improved:

Emotional Impact / Staff Wellbeing Considerations:

Immediate Support Offered:

Further Support / Follow-up Actions:

Signature (Check in Facilitator):

Appendix B - Clinical Supervision Record 1-1 (2026).docx

1:1 Clinical Supervision Session Record

Staff Name:
Date:
Supervisor:

Reason for Supervision:

Summary of Discussion:

Key Reflection / Learning:

Actions Agreed:

Follow-up Required: ☐ Yes ☐ No
If yes, details:

Additional Notes

Appendix C - Incident list to trigger CSfM support.docx

Incident list to trigger CSfM Support from Datix

The examples listed are not exhaustive, and CSfM support may be requested following any event as appropriate.

Maternity Adverse Occurrence	· Eclampsia · Postpartum haemorrhage · Uterine Rupture · Undiagnosed malpresentation including breech birth · Fetal loss · Cord Prolapse · Admission to ITU following birth or transfer · Maternal death
Neonatal Adverse Occurrence	· Shoulder dystocia · Unexpected fetal abnormalities · Preterm birth · Unexpected admission to NICU > 37 weeks gestation · Apgar < 7 at 5 minutes · Neonatal resuscitation · Stillbirth > 24 weeks · Neonatal death

4.0 References and Bibliography

Welsh Government (2017) Clinical supervision for midwives in Wales. Cardiff: Welsh Government. Available at: https://www.gov.wales/sites/default/files/publications/2019-03/clinical-supervision-for-midwives-in-wales.pdf (Accessed: 16 July 2026).

5.0 Equality Impact Assessment

It is not mandatory to complete an Equality Impact Assessment (EIA) for a written control document. If you feel it would be of benefit, please complete the box below and attach an EIA as an appendix to this document.

Has an Equality Impact Assessment (EIA) been completed	YES:	NO: **X**
Name of the person giving this response	E.Doman-Jones	
If NO:	Not required for this SOP	
If YES:	Attach EIA as an appendix to this document	