Perinatal Care & Documentation
Medical-Legal Issues

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Objectives
• Identify areas of risk within perinatal care and outline strategies to decrease liability
• Review the principles of documentation to better provide written accounts of patient care
• Discuss barriers that can impede competent communication
• Distinguish between information that is required for the medical record, and for an incident report
• Identify supportive resources for documentation & communication

Payment Analysis by Specialty
1985-2000

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Closed Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN</td>
<td>22,980</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>21,591</td>
</tr>
<tr>
<td>General &amp; Family Practice</td>
<td>19,043</td>
</tr>
<tr>
<td>General Surgery</td>
<td>17,974</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>16,440</td>
</tr>
</tbody>
</table>

Total indemnity paid for OB/GYN: $1.96 billion
Total indemnity paid in 2000: $115 million
Average indemnity paid: $399,658
Common Obstetrical Claims

- Non-reassuring tracing not recognized or addressed
- Delay of cesarean section
- Induction of labor without sufficient monitoring in TOLAC patients
- Induction in presence of macrosomia
- Untreated gestational diabetes
- Untreated group B strep

Common Obstetrical Claims

- Untreated pre-eclampsia
- Inadequate or altered documentation
- Delay in C/S following trial of vacuum
- Non-reactive NST but no intervention or further testing
- Lack of documentation of risk factors:
  - Domestic violence
  - Drug / Alcohol / Tobacco usage

Liability Issues: Electronic Fetal Monitoring

- Failure to recognize “fetal unhappiness”
- Failure to communicate or notify
- Improper nursing management
- Delay (of any kind)
- Interpretation issues
Fetal Monitoring

- Document interventions for non-reassuring pattern
- Be vocal about avoiding delays when urgency is a factor
- Involve the patient in the decision
- Encourage good communication between the HC team, don’t assume “they should know....”

Assessment Errors

- Failing to gather proper information
- Inability to recognize the significance of the information gathered

Assessment Error Example: Placental Pathology

- Maternal disease
- Sub-optimal outcome
- Limited/no prenatal care
- Maternal substance abuse
- Multiple gestation
- Cord knots
- Previous history of poor obstetric outcome
- Cord blood Ph<7
- Short or long cord (measure & document length)
- Eccentric Insertion
- Infant with dysmorphic characteristics
Planning Errors

- IPOC not well thought out
- Too many specialties not on the same page
- Lack of “anticipation of need”

Planning Error Example: Oxytocin/Pitocin

- Document discontinuation or adjustment of oxytocin; especially in the presence of non-reassuring pattern and the initiation of corrective measures aimed at optimizing perfusion

Intervention Errors

- Failure to care for a patient in a safe, effective manner
- Not implementing the six rights
- Not implementing patient safety goals
- “Cutting corners”
Failure To Communicate

- Failure to communicate significant information or changes in a patient’s status to supervisor, or physician

Vicarious Liability

- Liable for the actions of another if that person has knowledge that a co-worker’s behaviors are substandard
  - AND
- fails to take appropriate action

Joint-Action

- Liable for inappropriate delegation of tasks to a subordinate
  - RN to LVN or CNA
  - Charge RN to staff RN
Other Areas of Potential Risk:

**Contributory & Comparative Negligence**

- Not all accidents that occur in the healthcare setting are the result of negligence.
- In order to use the full protection of these laws, the healthcare giver must document non-cooperative patient behaviors.

Examples of Non-Cooperative Behavior

- Leaving AMA
- Refusing medication
- Failing to follow the IPOC
- Refusing to follow strict BR orders or ask for assistance to the BR when asked to do so
- Bringing unauthorized items into the hospital
- Failing to give a complete health history
- Family members tampering with equipment

Legal Terminology

- **DUTY**: One who undertakes care and treatment of a patient
- **BREACH OF DUTY**: Deviation from the accepted standard of care
- **CAUSATION**: Link between action and injury
- **MATERIAL EVIDENCE**: Physical evidence, carries the greatest legal weight
- **INCIDENT REPORT**: Formal account of an unusual or unplanned event
Legal Terminology

**DAMAGES** - Monetary award to the plaintiff

- **Economic**
  - Out of pocket, loss income, medical costs
- **Non-Economic**
  - pain & suffering ($250,000.00 limit in CA)
- **Punitive**
  - punishable to the defendant for malicious misconduct
  - not covered by insurance
  - no limit

Standard of Care

“*What a reasonable and prudent nurse would do in a similar situation in a similar environment*”

- SOC is different for each specialty of nursing
- Essence of care, what you will be judged against
  - Policies, protocols, procedures
    - Are they up to date?
    - Are you up to date?

Strategies to Decrease Liability

- Utilize practice standards
- Adopt standardized terminology
- Do case reviews
- Keep a copy of educational competencies
Principles of Documentation

Who Can Document?

• Only "authorized individuals" may make entries in the medical record. (Usually credential staff, defined by organizational policy, and have received training in fundamental documentation standards.)

• Linking each entry to the patient
  • correct patient
  • stamper plate ID

• Students, Orientees

Timeliness of Entries

• Entries should be made as soon as possible after an event or observation is made

• Date & time

• Pre-dating &/or back-dating is unethical & illegal

Documentation Content

• Specific
• Objective
• Complete
• Use of abbreviations
• Legibility
• Completing all fields
• Continuous entries
• Avoiding contradictions
• Change in condition
• Signatures & Counter-signatures

• Informed consent
• Admission/Discharge notes
• Notification or communication
• Delegation
• Incidents
• Appropriateness of entries
• Authentication
• Faxes
• Corrections & amendments
Documentation Strategies for Fetal Monitoring

• Baseline rate: Normal, Tachycardic, Bradycardic
• Variability: Moderate, Marked, Minimal Absent, Sinusoidal
• Decelerations: Variable, Late, Early, Shoulders, Overshoots, Prolonged, mechanism, recovery
• Accelerations: criteria met
• Non-periodic changes

Factors That Can Impede Competent Documentation

• High Risk situations
• Urgency in decision process
• Staff stress
• Technical competence
• Clinical competence
Communication: General Principles

- Know what the communication standards are within your institution
- Factors effecting communication
- Chain of Command
- Inability to comply with physician orders

Speaking with a Physician over the Phone

- Clear communication is crucial and expected
- Failure to report changes can lead to negligence charge
- Telephone orders may only be taken by an RN, confirmed for correctness and charted promptly
- Identify & report significant information especially change in condition

Speaking with a Physician over the Phone

- Question ANY order that is unusual, unclear
- Do not carry it out until you verify that it is correct – Repeat back what you have written
- Document date/time of contact, what was discussed, orders received (if any), and any changes in the plan of care
Computerized Documentation

- Privacy & Confidentiality
- Utilize computer safeguards
- Ethical responsibilities
- Public vs. Private information
- Audit Trail

Assessment

- Careful questioning of the patient
- Vital Signs at appropriate intervals
- Making frequent observations
- Re-examining a patient if the initial assessment was incomplete or inaccurate
- Recognize the significance of the gathered information and know when that information must be related to others

Plan

- Appropriate care plans based on the nursing process must be prepared for each patient
- Careful planning, with the right people involved
- Individualized for the specific patient
- Needs to change with patient status changes
Intervention

• Carrying out the plans derived from the assessment
• Implementation of physician orders (dependent practice)
• Nursing orders (independent and interdependent practice)
• High technology, basic techniques
• Patient advocate

Evaluation

• Evaluation of the plan of care
• Don’t be afraid to change it

Patient Relations

• Answering their questions
• Handling the “difficult” patient/family member
• Patient’s rights
• Right to pain management
Policies & Procedures

• Know your organization's P & P's, especially **Chain of Command**
• Know where to find them at 2:00 am!
• Know how to notify your hospital Risk Manager of adverse outcomes or potentially litigious events

Avoid Informal Discussions

• Avoid making personal/anecdotal notes
• Avoid discussions with patients &/Or "concerned family members"...these are discoverable
• Attorney-client privilege applies to communications with your Risk Manager
• Use incident reports (Evidence Code Section 1157)

Remembering the basics

• Anticipate need
  • **Patient**
  • **Physician**
  • **Family**
  • **Chain of command**
• Concise, competent documentation
• Communication must be timely, accurate & efficient
Communication

• Relationship driven
• Speak Up
• Barriers
  • Waiting until later
  • Feeling sorry for them
  • Not wanting to be yelled at
  • Not wanting to seem incompetent
  • Language barrier

Things To Avoid:

• Clinician incompetence
• Falsification documentation
• Lack of continuity
• “Battlegrounds”
• Block charting
• Parrot charting
• Non-quantitative descriptions
• Speculation
• Obliteration
• Incomplete records
• Multiple late entries

Excuses that don’t work:

• Nursing workload
• Technical complexity
• “I did what the doctor ordered”
Supportive Resources

- National Standards - ACOG/AWHONN
- Community Standards - RPS
- Institution’s:
  - Risk Management Division
  - Policy & Procedures
  - Standards &/or Guidelines of Care
- Books/Journals/Classes
- Malpractice Insurance Companies

Your patient has an adverse outcome.....What now?

- Don’t avoid the patient or family
- Inform them as soon as possible
- Use language they can understand
- Explain what occurred but do not offer “guess work”
- Show your empathy & concern
- Doing so is not an admission of guilt

Keeping a bad situation from getting worse

- Don’t panic if a complaint or accusation is made
- Don’t admit fault or become confessional
- Don’t take patients into your confidence in your self-criticism, hindsight or thinking
- If it’s not your hospital lawyer.....don’t talk to them. Tell them to contact your facility’s Risk Manager
“Knowing your institution’s protocols, and following them, is usually solid grounds for defense.”