Objectives

- Identify areas of risk within perinatal care
- Outline basic elements of malpractice, liability and the standard of care
- Review principles of documentation to better provide written accounts of patient care
- Discuss techniques to enhance active communication with team and providers
- Illustrate supportive resources for documentation and communication

Areas of Risk: Data Analysis

ACOG Survey on Professional Liability: 2012

Obstetrics – Closed Claims Overview

Nurses: 2006-2010

Severity by Nurse Specialty

<table>
<thead>
<tr>
<th>Nurse Specialty</th>
<th>Percentage of Lost Income</th>
<th>Tuit paid income</th>
<th>Average paid income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrician</td>
<td>19%</td>
<td>$17,136</td>
<td>$34,272</td>
</tr>
<tr>
<td>Nurse midwife</td>
<td>16%</td>
<td>$11,136</td>
<td>$22,272</td>
</tr>
<tr>
<td>Generalist</td>
<td>12%</td>
<td>$7,136</td>
<td>$14,272</td>
</tr>
<tr>
<td>Childbirth nurse</td>
<td>11%</td>
<td>$6,136</td>
<td>$12,272</td>
</tr>
<tr>
<td>Surgical</td>
<td>9%</td>
<td>$4,136</td>
<td>$8,272</td>
</tr>
<tr>
<td>Emergency nurse</td>
<td>9%</td>
<td>$3,136</td>
<td>$6,272</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>$2,136</td>
<td>$4,272</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>$69,342</td>
<td>$138,684</td>
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</table>
Claims By Allegation Class
ACOG Survey on Professional Liability: 2012
Obstetrics Claims – Metrics

- About one out of every 4,000 births results in a medical malpractice claim with indemnity
- The average value of these cases, including defense, is about $1.4M
- The cost per delivery to cover liability is, on average, $304

Excuses that don’t work:
- Nursing workload
- Technical complexity
- “I did what the doctor ordered”

Common Obstetrical Claims
- Category II/III FHR tracing not recognized or addressed
- Delay of cesarean section; especially following TOL, vacuum
- Induction of labor without sufficient monitoring in TOLAC patients
- Induction with known macrosomia
- Untreated gestational diabetes, GBS
Common Obstetrical Claims cont'd
- Unrecognized pre-eclampsia
- Inadequate or altered documentation
- Non-reactive NST with no intervention or further testing
- Lack of documentation of risk factors (e.g. domestic violence, drug/alcohol/tobacco use, preterm labor)

Liability Issues: Electronic Fetal Monitoring
- Failure to recognize “fetal unhappiness”
- Failure to communicate urgency or notify chain of command
- Improper management of 2nd stage
- Delay (of any kind)
- EFM interpretation issues

Social Media
**Advantages**
- Disseminate information quickly to a large audience
- Send the message that “our institution is cutting edge”
- Provide a venue to chat about health topics
- Alert the community to relevant health information
Social Media

- **Disadvantages:**
  - Disseminate information quickly to a large audience
  - Can send the wrong message in the wrong hands
  - Provide a venue for unsupervised, embarrassing posts
  - Serves as a weapon in a lawsuit

Social Media Boundaries

- Should you accept a friend request?
- Should you comment on a patient’s blog?
- What if a parent or spouse asks for an update via text?
- What do you do about videotaping?
What Message Are You Sending?

- What about personal use?
  - What about when I am off the clock?
  - Does it really matter what I post?
  - Social media allows me to vent my frustrations!
  - Do you even know what you are posting?
Nursing/Medical Board Opinion

- 73% of State Boards would investigate a clinician for posts depicting intoxication
- 40% would investigate posts just involving alcohol.

Zimlich, Rachel, RN (2013). State medical boards offer insight on avoiding investigation over social media use, Medical Economics

Keep it Professional

- Social media impacts your professional reputation.
- Social media impacts your patients’ perception of you.
- Your posts can strengthen a plaintiff’s lawsuit against you and influence the jury’s beliefs about your care.

Assessment Errors

Failure to:
- Gather proper information
- Recognize the significance of the information gathered
Maternal Early Obstetric Warning System (MEOWS)

<table>
<thead>
<tr>
<th>Physiologic Parameters</th>
<th>Yellow Alert</th>
<th>Red Alert</th>
</tr>
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<tbody>
<tr>
<td>Respiratory rate</td>
<td>21-30</td>
<td>&lt;15 or &gt;30</td>
</tr>
<tr>
<td>Oxygen saturation</td>
<td>95</td>
<td>&lt;90 or &gt;100</td>
</tr>
<tr>
<td>Temperature</td>
<td>35-36</td>
<td>&lt;35 or &gt;38</td>
</tr>
<tr>
<td>Systolic blood pressure</td>
<td>150-160 or 90-100</td>
<td>&lt;90 or &gt;160</td>
</tr>
<tr>
<td>Diastolic blood pressure</td>
<td>90-100</td>
<td>&gt;90 or &gt;100</td>
</tr>
<tr>
<td>Heart rate</td>
<td>60-120 or 40-50</td>
<td>&gt;120 or &gt;40</td>
</tr>
<tr>
<td>Pain score</td>
<td>1-3</td>
<td>&gt;3-5</td>
</tr>
<tr>
<td>Neurologic response</td>
<td>102-124</td>
<td>&lt;102 or &gt;124</td>
</tr>
</tbody>
</table>


Normalizing the Abnormal Assessment

- **Hypoxemia**
  - Oxygen saturations are below 95%
    - “She is just sleeping”
    - “I just gave her some IV pain medicine; this is expected.”
    - “She was so stressed, and now she’s finally relaxed.”
  - Inability to obtain SpO2-faulty equipment vs critically low value
  - Increased respiratory rate-explained as anxiety

- **Tachycardia**
  - Heart rate >120 explained as pain and anxiety
  - Tachycardia documented, but Cardiac Assessment documented as “WNL”
Normalizing the Abnormal Assessment

**Hypotension:**
- Assumed to be a normal physiologic change in pregnancy- “she is hypotensive because she is pregnant”
- “She runs low blood pressures normally”
- “That is expected when you get an epidural”
- “The baby looks fine”

**Hypertension:**
- “But she feels fine”
- “She has chronic hypertension, this is her norm”
- “She is in pain”
- “She just had a fight with her mother”
- “She has too many visitors in the room”
- “Her pre-eclampsia labs are normal”

Abnormal Assessment Parameters

- Are hospital-specific and population-specific normal parameters defined?
- What should the RN do when assessment parameters fall outside of normal values?
- How are abnormal parameters documented?
  - Maternal HR=122, documented as WNL
Failure To Communicate

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

Communication: General Principles

- Know the communication standards within your facility
- Recognize factors affecting communication (staff stress, emergency situations, technical/clinical complexity)
- Enlist Chain of Command when indicated

Speaking with a Physician over the Phone

- Clear communication is crucial and expected
- Failure to report significant changes can lead to a negligence charge
- Telephone orders may only be taken by an RN, confirmed for accuracy and should be charted promptly
- Identify & report significant information especially when there has been a change in condition
Speaking with a Physician over the Phone

- Question **ANY** order that is unusual or unclear
- Do not carry it out until you verify that it is correct
- Read back what you have written; **not** “repeat back what you heard”
- Document date/time of contact, what was discussed, orders received (if any), and any changes in the plan of care

Nurse-Physician Communication

- Communication is **relationship driven**
  - Good communication depends on trust
- Don’t be afraid to **speak up**
- Be aware of common pitfalls:
  - “I’ll wait until later to call”
  - “My accent makes me hesitant”
  - “I don’t want to bother him”
  - “I’m afraid of being yelled at”
  - “I don’t want to seem incompetent”

Factors That Can Impede Competent Documentation

- High Risk situations
- Urgency in decision process
- Staff stress
- Technical competence
- Clinical competence
Planning Errors

Failure to:
- Coordinate the Interdisciplinary Plan of Care (IPOC)/ specialties
- Anticipate need

Example:
Uterine hyperstimulation
- Failure to document discontinuation or adjustment of oxytocin; especially in the presence of a Category II/III pattern
- Failure to document initiation of corrective measures aimed at optimizing perfusion

Intervention Errors

Failure to:
- Care for a patient in a safe, effective manner
- Implement the six rights of medication administration
- Implement patient safety measures (e.g. patient identification)
Rules of 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 Negligence

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

Examples of Non-Cooperative Behavior

- Leaving AMA
- Refusing medication
- Failing to follow the IPOC
- Refusing to follow strict bed rest orders
- Bringing unauthorized items into the hospital
- Failing to give a complete health history
- Family members tampering with equipment
Standard of Care (SOC)

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

- SOC is different for each specialty of nursing
- It is the essence of care, what you will be judged against
  - Know your facility policies, protocols and procedures

Malpractice & Liability

- **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

Malpractice & Liability

**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
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.)
- Link each entry to the patient
  - correct patient
  - stamper plate ID
- Students, Orientees
  - Do they need a counter-signature?

Timeliness of Entries

- Entries should be made as soon as possible after an event or observation is made
- Noting date **AND** time
- Pre-dating &/or back-dating is unethical & illegal
Computerized Documentation

- Be aware of Privacy & Confidentiality laws
- Utilize computer safeguards
  - Log off when you walk away
  - Use strong passwords
- Be ethically responsible
  - “Need to know”
- Know the difference between public vs. private information
- Be aware of the audit trail

Documentation “pearls”

- Be specific and objective
- Address all fields – fill-in or VOID spaces
- Use approved abbreviations and avoid slang
- Write/type legibly
- Avoid continuous entries
- Avoid contradictions
- Document any change in condition
- Perform signatures/witness where indicated
- Validate patient ID & that informed consent occurred
- Document specific admission/discharge instructions given to patient
- Entries must be appropriate
- Make corrections & amendments using approved method
- Keep up to date (MAR, orders, problem list)

Documentation Example

Note reason for visit:
- Patient’s chief complaint
- Onset & duration of symptoms
- If the patient did anything at home to relieve symptoms (e.g. take medication, lay down, etc.)

“patient c/o stomach pain, diarrhea and headache for two days. Has taken aspirin (2 tabs each time) on three occasions in last 48 hours”
Documentation Example

Note:
- Allergies
- Current medications
- Names of other physicians that the patient is currently seeing
- Begin generating a problem list off the prenatal record & intake questions

*Patient states allergy to PCN. Currently taking flagyl for vaginosis, atenolol for MVP grade II. Cardiologist is Dr. Green.*

Avoid Informal Discussions of the Events

- Avoid making personal/anecdotal notes.
- Avoid discussion with patients and/or “concerned family members”-these are discoverable.
- Attorney-client privilege applies to communications with your Risk Manager.
- Use Incident Reports (Evidence Code Section 1157)

Principles of Documentation – Fetal Monitoring

- Document interventions for Category II/III tracings
- Be vocal about avoiding delays when urgency is a factor
- Involve the patient in the decision
- Encourage good communication between your team, don’t assume "they should know...."
Principles of Documentation – Fetal Monitoring

- Baseline rate: Normal, Tachycardic, Bradycardic
- Variability: Moderate, Marked, Minimal, Absent, Sinusoidal
- Decelerations: Variable, Late, Early, Prolonged, Recurrent
- Accelerations: present or absent
- Periodic or Non-periodic changes (with Ucs)
- Uterine Tachysystole

Test your Knowledge – Fetal Monitoring Documentation

- Baseline: normal, bradycardia, tachycardia
- Variability: mod., min., absent, marked, sinusoidal
- Decels: present or absent?
  - If present, what type?
- Accels: present or absent?
- UCs: present or absent?
  - If present, regular or irregular?
- Periodic or Non-periodic changes?

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
- Get together with your team and plan on who will explain what occurred, but do not offer “guess work”
Dealing With Their Family

- Show empathy & concern
  - Doing so is not an admission of guilt
- Use common sense when handling a “difficult” family member
- Remember your patient’s rights when responding to family
  - Only provide information that the patient has authorized to be shared

If You are Involved in a Claim

Don’t:
- Panic if a complaint or accusation is made against you
- Admit fault or become confessional
- Take patients “into your confidence”
- If it’s not your hospital lawyer ……do NOT talk to them
  - Have them contact your facility’s risk manager

Incident Reporting

- Use incident reports (Evidence Code Section 1157) to document unusual or unplanned/unexpected events
- Document a thorough account without leaving out important facts
- Do not speculate
- Complete as soon as possible
- Answer the who, what, where, when & why
Supportive Resources

- National Standards - ACOG/AWHONN
- Community Standards – Regional Perinatal Systems
- Institutional Standards:
  - Risk Management
  - Policy & Procedures
  - Standards &/or Guidelines of Care
- Malpractice Insurance Companies
- Books/Journals/Classes

Policies & Procedures

- Know your organization’s policies & procedures, 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

Summary - Assessment

- Carefully question the patient
- Take vital signs at appropriate intervals
- Make frequent observations
- Re-examine a patient if the initial assessment was incomplete or inaccurate
- Recognize the significance of the information gathered and know when that information must be relayed to others
Summary - Plan

- Individualize a care plan for each patient
- Get the right people involved to meet the patient’s specific needs
- The plan may need to be modified with changes in the patient’s condition

Summary - Intervention

- Carry out the plans derived from your assessment
- Implement physician orders
- Implement nursing orders
- Be a patient advocate

Summary - Evaluation

- Evaluate the plan of care every shift or whenever there is a change in the patient’s condition
- Don’t be afraid to change the plan
Practicing within the standard of care and knowing your facility's policies & procedures is your best asset to a long and successful career.