Obstetric Medical-Legal Review:

Pearls and Pitfalls of Clinical Documentation

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Obstetric Medical-Legal Review: Objectives

- Describe functions of UCSF’s Risk Management Dept.
- Describe the elements of professional liability action and how liability is determined
- Differentiate between defensive and defensible documentation
- List 3 ways to improve electronic documentation aimed to communicate patient assessments and care provided that is defensible
- Verbalize escalation steps for deteriorating or behaviorally difficult patient
Overview of Risk Management

Anatomy of a lawsuit
Please Use Risk Management

Too Many “411” and “911” Calls to Count

- Litigation Managers
- PARS
- Mediators
- Precautionary Incident Notification
- Educator
- Therapists
- Referees
- Critical Thinkers
- English Teachers
- Policy Wonks
- DeFacto Managers
- Good Cops, Bad Cops
- Common Sense
- Hand Holders
- The Enforcers

“Stop and Think”

“It sort of makes you stop and think, doesn’t it.”
UCSF Risk Management Functions

- Enhance patient safety and the quality of patient care we provide by review of adverse clinical outcomes
- Reduce the University’s financial exposure arising from the provision of medical care
- Oversee the professional liability program for faculty and staff—work with Third Party Administrator: Sedgwick
- Ensure compliance w/ Medical Center policies, bylaws, rules & regulations
- Respond to concerns regarding management of clinical care
Anatomy of a Lawsuit

- Litigation Process
- Patient Complaint/service of lawsuit
- Factual investigation
- Determination of course and scope
- Transfer of claim to Sedgwick (third party administer)
- Assignment of attorney
- Coordination Meeting with involved parties, Risk Management, Third Party Administrator
- Discovery—litigation
- Consideration of settlement/Defense
- Risk Management Committee Review
- Settlement or trial.
Some Basics: Notification of Risk

- Risk can assist with disclosure and will participate as appropriate.
- Risk needs to be advised of a Precautionary Incident Notification (PIN) defined as:
  - (1) an adverse event or complication resulting in death, brain damage, permanent paralysis, sensory deficits, partial or complete loss of hearing or sight, birth injury or disability, or other catastrophic damage or permanent disability; or
  - (2) an incident anticipated to result in potential liability exposure or a claim.
Nurses continue to be implicated in Malpractice Litigation:

- Every year thousands of nurses are called before their Board of Registered Nurses
- 18,000 RN’s per year are involved in malpractice cases

[Image: California Board of Registered Nursing]
Negligence that result in Malpractice Lawsuits

- Failure to follow standards of care
- Failure to provide reasonable care
- Failure to use equipment in responsible manner
- Failure to communicate
- Failure to document
- Failure to assess and monitor
- Failure to act as a patient advocate
Malpractice Claims Process

- Plaintiff intent to litigate
  - Obtains medical record
  - Plaintiff files complaint → summons issued

- Motion to Dismiss Filed
  - If granted → lawsuit dismissed
  - If → not motion to dismiss denied

- Discovery period
  - Depositions
  - Interrogations

- Pretrial hearing → case not resolved → Jury Trial → Verdict
How are medical malpractice and negligence defined

- Medical malpractice is defined as any act or omission by a nurse caring for a patient that
  1. Deviates from accepted norms of practice (standard of care)
  2. Causes injury to the patient
- Such deviations are known in the legal realm as “negligence”
Elements of Negligence

- Duty to behave reasonably
- Negligence - failure to act reasonably AND results in injury
- Must provide proof that the person accused failed to act reasonably when they had a duty to do so
- The failure to act reasonably caused an injury related to the breach of duty
- When a nurse fails to do what a reasonably prudent nurse would do under similar circumstances, the standard of care is considered breached
Jury Instructions:  Alternative Methods of Care:

“A nurse is not necessarily negligent just because he chooses one medically accepted method of treatment or diagnosis and it turns out that another medically accepted method would have been a better choice”
Jury Instructions:
Patient’s duty to provide for his/her own well-being

“A patient must use reasonable care to provide for his or her own well-being. This includes a responsibility to follow a nurse’s instructions {or seek medical assistance} when a reasonable person in the same situation would do so……”
The Case of the Resistant Patient &/or Significant Other

The patient conditions warrants an Emergent C-Section should be performed

• CASE EXAMPLE: Conflicting deposition testimony of VBAC patient & SO vs. OBGYN concerning discussion surrounding urgent C-Section & lack of adequate medical documentation

▪ When this happens

  • Consider RN/OB team approach with patient/SO conversation
    – time is of the essence

▪ RN may have stronger relationship with patient after several hours of labor than OB who may not be regular provider who is urgently/emergently recommending Csection

▪ Conversation needs to be clear and straightforward about risks to patient &/or baby i.e. “And you or your baby could die or have severe irreversible problems after birth.”

▪ Each person present needs to document exactly what was discussed with patient
Jury Instructions: Success Not Required

“A nurse is not necessarily negligent just because his/her efforts are unsuccessful or he/she makes an error that was reasonable under the circumstances. A nurse is negligent only if he/she was not as skillful, knowledgeable, or careful as other reasonable nurses would have been in similar circumstances”
The Expert Witness

- Expert Witness testimony is necessary to establish standard of care/damages
- Cases can become battle of the experts; Jury is asked to consider:
  - The expert’s training and experience
  - The facts the expert relied on
  - The reasons for the expert’s opinion
Determining Standard of Care

- Established by expert testimony
- State and federal laws and regulations
- California Nurse Practice Act
- Accrediting and oversight organizations
- TJC, CMS, NQF
- Professional journals, association standards & guidelines
  - AGOG, SMFA, AWHONN, ACNM, ANA, AORN, SOAP
- Facility bylaws, policies and procedures
- P & P are a key resource in legal proceedings
- “Reasonably prudent practitioner under same or similar circumstances”
Common Issues in the OR/PACU

- Not following policies e.g.
- Sponge Count
- Breaking during significant times
- Universal protocol—we still have patients who get into the OR without a signed consent form!!
- Hand-offs—from OR to PACU; from PACU to the floor
- Concurrent surgery—Following “surgeon presence in the OR”
- Communications during surgery
- Pressure Injuries and position
- Vendors in the OR
- Not asking about Oral Advance Directive
Recent Observations of Problems in OR

- Staff are not charting in “true or accurate time”. Lots of pre-charting is being done.
- Staff has documented and printed pathology specimens that have not been removed.
- Staff is releasing micro/cytology specimen orders the morning of surgery prior to patients coming to the OR.
- Staff is incorrectly documenting implant catalog numbers.
- Staff does not always document accurate supply catalog numbers, therefore the wrong supplies are being charged to the patient.
ANA Scope and Standards of Practice

Documentation is to demonstrate:

- Nursing process carried out in a responsible, accountable, and ethical manner
- An outcome-focused plan-of-care, stating outcomes as measurable goals
- Implementation of the plan-of-care
- Evidence for practice decisions and modifications to the plan-of-care
- Problems and issues in a manner that facilitates evaluation of outcomes
- Coordination of care and communication with consumers and team members
- Results of evaluation of care and outcomes
- Relevant data in a retrievable form
- Using standardized language and recognized terminology
The Evolution of the Role of Nursing

- You have asked to be treated as professionals
- No longer passive, servile employees*
- Purport to be assertive, decisive health care providers*
- Are you all acting as professionals?
- Are you exercising good judgment or relying on others to tell you what to do?
- Do you engage in professional development?
- Do you understand your role and responsibilities as a nurse
- Do you understand your chain of command and escalation?

* Bleiler v Bodnar, 1985
Escalation

An abnormal parameter requires:

- Prompt reporting to a physician or other qualified clinician
- Prompt bedside evaluation by a physician or other qualified clinical provider with the ability to activate resources in order to initiate emergency diagnostic and therapeutic interventions as needed
• Legal argument and implied duty that RN will notify nursing leadership when plan of care or team members behavior is questionable
• Provides healthcare staff with a formal process to use when attempting to get satisfactory resolution or to report concerns

Include:
Name of individual notified
Date and time of notification
Information conveyed
Clinical decision that was made
“Incompetence”…..

- As defined by the California Nursing Board
- “the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse”
- Note: this is the legal definition of negligence, not incompetence
Obstetric Legal Concerns

• Disclosure
• Informed Consent
• HIPPA
• EMTALA
• Senate Bill 1152
Labor & Delivery: A Unique Domain

ED + OR + ICU + NICU = L&D

- High stakes
- High payouts
Reducing Obstetric Litigation Through Alterations in Practice Patterns

Steven L. Clark, MD, Michael A. Belfort, MD, PhD, Gary A. Dildy, MD, and Janet A. Meyers, RN

- 189 perinatal claims identified from 2000-2005 were analyzed ($168 Million)
- 4 Major patterns emerged from the analysis
  - **Substandard care**

### Table 1. Analysis of 189 Closed Claims

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Cases (%)</th>
<th>Care Substandard (%)</th>
<th>Cost (% of Total Dollars Paid)</th>
<th>Payment (Mean and Range in U.S. $)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal monitoring/hypoxia, non-VBAC</td>
<td>64 (34)</td>
<td>60 (94, 85-98)</td>
<td>53</td>
<td>1,392,629 (25,500-16,850,428)</td>
</tr>
<tr>
<td>Minor injury</td>
<td>46 (24)</td>
<td>31 (67, 53-79)</td>
<td>2</td>
<td>74,478 (173-724,955)</td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>26 (14)</td>
<td>6 (23, 11-42)</td>
<td>6</td>
<td>429,480 (30,617-3,248,262)</td>
</tr>
<tr>
<td>Maternal injury/death</td>
<td>19 (10)</td>
<td>16 (84, 62-95)</td>
<td>15</td>
<td>1,331,816 (24,488-4,600,369)</td>
</tr>
<tr>
<td>VBAC</td>
<td>10 [5]</td>
<td>6 (60, 31-84)</td>
<td>6</td>
<td>992,703 (30,873-3,707,348)</td>
</tr>
<tr>
<td>Fetal trauma</td>
<td>9 [5]</td>
<td>2 (22, 6-55)</td>
<td>2</td>
<td>425,532 (58,281-1,949,747)</td>
</tr>
<tr>
<td>Group B streptococcus</td>
<td>3 [2]</td>
<td>3 (100, 44-100)</td>
<td>1</td>
<td>218,669 (1,500-577,492)</td>
</tr>
<tr>
<td>Nonobstetric</td>
<td>6 [3]</td>
<td>NA</td>
<td>10</td>
<td>2,446,389 (56,346-10,960,856)</td>
</tr>
</tbody>
</table>

CI, confidence interval; VBAC, vaginal birth after cesarean.
The 95% CIs are reported using no continuity correction.

98% settled prior to or during trial
Only 2% went to verdict
Obstetric Anesthesia Liability Concerns

Evaluated changing liability trends 1980-2011: >10,500 cases

68% Cesarean Section / 32% Vaginal Delivery

- Maternal Death was most common claim (24%)
  - Failure to adequately manage: hypertension, pulmonary edema, hemorrhage, VS after C/S
- Newborn with severe brain damage (16%)
- Newborn Death (13%)
Areas of Liability for Perinatal Nurses

- Fetal Heart Rate interpretation, communication and documentation
- Telephone Triage
- Induction of Labor
  - Misoprostol/Cervidil/Pitocin
- Shoulder Dystocia—Fundal Pressure
- Forceps and Vacuum assisted birth
- Resuscitation Errors
- Improper medication administration
- VBAC

Simpson & Knox, 2003; Simpson, 2008
Induction Bundle

- **Verify Informed consent**
  - provider has discussed the indications and potential risks/benefits of IOL

- **Verify indication for induction**
  - Documented in the medical record

- **Assessment of gestational age**
  - (ensuring that gestational age is greater than or equal to 39 weeks)

- **Pelvic assessment (Document Bishop’s score)**
  - Cervical status, fetal station, presentation
Patient Safety Checklist

INPATIENT INDUCTION OF LABOR

Date __________  Patient ____________________________  Date of birth __________  MR # __________

Physician or certified nurse–midwife ________________  Last menstrual period ________________

Gravidity/Parity ____________________________

Estimated date of delivery ________________  Best estimated gestational age at delivery ________________

Indication for induction ____________________________

Fetal Presentation (1)

☑ Vertex
☑ Other ________________

☐ If other, physician or certified nurse–midwife notified

Estimated fetal weight ________________

☑ Patient has a completed medical history and physical examination

☐ Known allergies identified ____________________________

☐ Medical factors that could affect anesthetic choices identified ____________________________

☐ Pertinent prenatal laboratory test results (e.g., group B streptococci or hematocrit) available (2, 3)

☐ Other special concerns identified (e.g., medical problems and special needs): ________________

☐ Patient counseled about risks and benefits of induction of labor (1)

☐ Consent form signed as required by institution

Bishop Score (see below) (1): ________________
Liability Issues with Intrapartum Nursing

- Component of Malpractice Process
- Nursing Liability
- Intrapartum Nursing Specifics
- Strategies to avoid malpractice claims
Even the best….
Can make a mistake

- Well-rested/fed
- Highly confident
- Highly motivated

High Alert Medications
- Oxytocin
- Magnesium
- Epidural infusion
- Opioids
- Heparin
- Insulin
Question: How many hours of sleep did you have prior to your last worked shift?

a) Less than 2 / or you worked a double shift  
b) Less than 4  
c) Less than 6  
d) Less than 8  
e) Greater than 8
Errors and Mistakes

- **Individual**
  - Assessment
    - Missed diagnosed
    - Improper disposition: to: ED, Home,
    - Not timely
    - Handoffs

- **System**
  - Long waits
  - Crowding
  - Delays in consulting
  - EMR
  - Handoffs
Value of the Nursing Role

- 1st to evaluate
- Detect abnormal s/sx
- Alert the team
- Optimize patient outcome
OB Triage, Active Labor, and EMTALA

- Emergency Medical Treatment and Labor Act
- Signed into federal law in 1986
  - Enacted as part of Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Case review
  - Claudia Thomas: 19yo G2P1 @ 36 weeks
- Overall intent to ensure emergency services
  - Regardless of: ethnicity, insurance coverage, citizenship
- Pregnant women seek care for a urgent pregnancy problem
  (Instructed by their OB to go to hospital)
EMTALA:
Emergency Medical Treatment and Labor Act

Definition:

- Acute symptoms of sufficient severity (including severe pain such that the absence of immediate medical attention could pose serious jeopardy for mother or unborn child)

- A pregnant woman having contractions where there is inadequate time for transfer and may pose a health or safety threat to the mother or unborn child
EMTALA: Emergency medical condition

- Mandates all pregnant women presenting to an ER, L&D, or OB Triage unit must have a medical screening examination (MSE).

EMTALA Requirements for Emergency Medical Treatment

POLICY 6.03.09
Patient Care EMTALA Requirements for Emergency Medical Treatment Issued:
September 2000 Last Approval:
December 2011
Categories of Risk in OB Triage

**Patient Safety**

- Assessment in a timely manner
- Appropriate and complete evaluation and documentation
- Discharge from OB Triage without evidence of
  - Fetal well-being
  - Recognizing active labor /discharged the woman in false labor
  - Delay in timely response from consultants
  - The use of clinical handoffs
Categories of Risk in OB Triage: Patient Safety

- **Pregnant women contracting have priority**
  - Must R/O active labor
  - Avoid treatment delays – consider chain of command

- **Determine what parameters are indicated for fetal assessment**
  - Fetal monitor $\rightarrow$ reactive tracing $\rightarrow$ further fetal testing
  - Implement intrauterine resuscitative measures

- **Prompt notification to Provider**
Legal Requirements of OB Triage

1. Perform a medical screening exam (MSE)
2. If emergency exists, notify MD and begin stabilization
3. Consider patient transfer
4. Arrange proper transfer
5. Patient evaluation and treatment cannot be delayed to obtain financial information
6. Women in labor are considered unstable from latent phase through delivery of placenta

Mahmeister and Van Mullen, 2000
EMTALA: Requirements for Transfer

- Medical Screening Exam
- Stabilization within the abilities of transferring facility
- Need for services not available at transferring facility or medical benefits of transport outweigh risks or patient/responsible person requests transfer
- Contact with receiving hospital to approve/accept transport
- Written certification by request of physician of need
- Records sent with the patient
- Appropriate method of transport used

Source: EMTALA (1986) in Angeli
EMTALA: Common Violations

- Improper refusal to accept a medically stable patient
- Improper refusal for an on-call practitioner to come in to see and examine in a timely manner
- Failure to properly complete a transfer certificate
- Failure to properly inform risk/benefit of transfer
- Failure to transfer an unstable patient with appropriate equipment and personnel
- Failure for a physician to rule out false labor
- Failure to accept a patient because of lack of ability to pay
- Failure to stabilize a patient to the facilities’ maximum ability prior to transfer
Errors and Mistakes

- Individual
  - Assessment
    - Missed diagnosed
    - Improper disposition: to: ED, Home,
  - Not timely
  - Handoffs

- System
  - Long waits
  - Crowding
  - Delays in consulting
  - EMR
  - Handoffs
Recognizing active labor and transfer of pregnant woman with high risk fetus

**Question:**

When a woman who presents to triage with uterine contraction and fetus with a cardiac anomaly?

a) Admit - plan for delivery, notify Pediatrician/Neo

b) Admit - Notify Peds, Consult MFM, consider transfer

c) Don’t admit – transfer woman to Tertiary Care

d) Have her partner drive her to Tertiary Care – it’s faster
California Senate Bill 1152

Background and Purpose

• In order to standardize the level of discharge planning service hospitals provide, California Legislature passed, and the Governor signed SB 1152.

• The law took effect, January 1, 2019

• Purpose is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter and other supportive services

• The law does not require hospitals to find or create service that do not exist in the community.

• Documented compliance with elements of this legislation are required by 1/1/2019.
California Senate Bill 1152

**Services that Must be Offered to Homeless Patients Before Discharge**

1. Physician Examination and determination of stability for discharge
2. Referral for follow up care
3. Referral for behavioral health care if it’s determined that the patient requires behavioral health care
4. Food
5. Weather appropriate clothing
6. Discharge medications (prescriptions)
7. Infectious disease screening
8. Vaccinations appropriate to the presenting medical condition
9. Transportation within 30 minutes or 30 miles of the hospital
10. Screening for and assistance to enroll in affordable health insurance coverage
Documentation: 3 P’s

Purpose, Pearls, and Pitfalls

Documentation as Communication &
Documentation of Communication
Common Documentation Errors

- Per Susan Penney JD and Lindsay Bolt RN, CNS: Documentation is part of health care

- Role of Risk Management to alert RN staff of concerns aimed to defend care so they don’t get involved in a law suit.

  - RN’s will say “I can’t do it all” I can’t care for the patient and document in the EMT” I can do one or the other; but, I can’t do both”
Importance of Charting

- Primary communication tool among the health care team –
  - Essential to provide quality patient care
- Utilization & financial record that provides the basis for billing & insurance payments
- Medical records are the primary source of evidence in defending malpractice claims & determining potential liability
Documentation

- Issues with EMR
  - Is it a time saver?
  - More likely or not able to engage with patient
  - Copy/paste function
  - Potential for errors
EPIC: Coping verses Not-coping IN LABOR!
Documentation as Communication

- Intake and Output
- Vital Signs
- Medication Administration
- Was it given? When?
- Did it help improve a problem?
- Pain Scores
- How is the patient doing with regimen?
- Care Plan Notes
- Summary of patient’s progression or regression
- Wounds
- Documentation shows the progression of healing
- Your words provide the historical record of care
- Should align with provider documentation
The Plan of Care

- Communicates patient progression toward well-being
- Care plans are completed by all inpatient nurses
- Care plans are enjoyed by few inpatient nurses
- This is a fact.

- So...
- Look at a suggested methodology for individualizing and updating care plans
- Discuss when goals should be updated and why
So what are common mistakes RN’s make that contribute to patient harm and litigation

- Lack of documentation - out of compliance with policies
  - The policy requires documentation, but nothing was documented
    - vital signs, DTR’s, oxytocin, magnesium, insulin/BG, FHR interpretation
    - All P&P’s must be handed over if requested by the plaintiff attorney
    - P&P’s are not “privileged”
    - Risk managers will ask for the P&P right away and begin to “help” not “torture”
    - There may be times deviated from a policy was reasonable – was it documented?
    - Looking for the “crumbs” so the care that was provided can be defended
So what are common mistakes RN’s make that contribute to patient harm and litigation

- Not giving the record the benefit of your thinking
- Failure to fill out a template or checklist that is mandatory will be difficult to defend
  - (Oxytocin continued to infuse despite Category 2 tracing)
  - (the template for an IV extravasation was blank)
- Documentation inconsistent as between MD and Nursing
- Often staff does not look at each other’s charting (especially MD’s)
  - MD’s and RN’s working in separate silos
    - Hierarchy observed by Susan Penney
So what are common mistakes RN’s make that contribute to patient harm and litigation

- Late entries being marked in real time (remember the **audit trail**)
  - Anytime you document it shows when and where you were at the time
    - Did you document physical assessments from the **bedside** or the **nursing station**
      - Coping with labor
      - Fundal checks
      - FHR interpretation, fetal movement

- Inappropriate documentation
  - When bad things happen, good people panic (late entry noted **24 hrs after** patient coded)
    - This is a **red flag** for plaintiff attorneys

- Inconsistent documentation systems among nurses (e.g. turning, skin)
  - **New staff** sticking with the way they charted at previous employer

- Defensive Charting – what needs to get done – MD isn’t calling back – escalation
I wish I had called Risk Management about……

- Whether or how I should write a late entry
- An adverse event
- A patient elopement and the patient has been missing for 2 days (SFGH case)
  - Resulted in policy change – requires call to risk management 24/7 - weekends
- An equipment failure and now I don’t know which device was involved and the data from the machine was deleted – (this info can help defend a case)
- Clarification on a policy or procedure
- A patient who has been misbehaving for several days and now is out of control
- Whether I should have agreed to pay for a patient’s missing property
  - Inventory patients property protects you: loaded gun, cocaine, Louie Viton purse
Care related to care and resuscitation and treatment

- Miller v. HCA
  - Infant born at 23 weeks was resuscitated against their wishes
    - Went to trial – jury verdict in favor of parents
      - Appealed and reversed
        - Family appealed reversal → case was heard in Texas State Supreme Court
        - Court upheld the reversal
  - The need to evaluate the appropriateness of resuscitation occurs at the time the infant is born, not in discussions that occurred prior to birth.
Periviable Birth: 20+0/7 - 25+6/7

Extreme preterm, micro preemie, threshold of viability

- Survival rates in general (variance)
  - 0% @ 20 weeks
  - 50% @ 25 weeks

- An overview of survival and morbidity

- The possibility of long-term neurological and neurodevelopmental problems

- The possibility that expectations for the baby may change after birth depending on the condition of the newborn

In general, tocolytics are not indicated for use before neonatal viability and no data exists regarding the efficacy of corticosteroid use before viability.

ACOG Practice Bulletin Number 171 October 2016
Question: Periviable Birth

- How often are you physically present when the OB, MFM, or Neonatologists is counseling a patient between 20+0/7 and 25+0/7?
  
  A. 100% - this is high priority
  
  B. 75% -
  
  C. 50% - if it works out with my workflow
  
  D. 25% -
  
  E. I rarely if ever am present during MD/Patient consultation
ALL information needs to be placed somewhere on a written or computerized chart.

- Lab results
- Fetal test results
- Fetal status
- Conversations with consultants – recommendations
- Interventions performed
- Plan of care
- Follow-up plans
- Instructions – verbal, written
- Patient understanding
OB Triage Case

- A G3, P1, 38-yo woman @ 29+2 weeks arrives to OB Triage
  - Hx of dry cough X’s 3 days – fever/aches past 24 hrs.
  - VS: T 40.3°C (104.5°F); BP, 119/60 mm Hg; pulse 125, RR 36
  - (SaO2), 95%.
- FHR 175 bpm with minimal variability.
- The patient had no uterine cramping or contractions
- Patient reported diffuse body aches and rated her pain 10/10
**Figure:** Pathogenesis of multiorgan system failure in sepsis. Reprinted with permission from Alex Yartsev.¹⁰
Based on the AWHONN MFTI what is the priority?

a) Priority 1
b) Priority 2
c) Priority 3
d) Priority 4
e) Priority 5
What needs to happen

a) Begin Early Goal Directed Therapy (EGDT)
b) Begin The 1 Hour Bundle it replaces the 3 Hour Bundle
c) Bolus with 1,000 mL NS follow with 500mL/hr untill BP is >90/50
d) The optimal fluid replacement for pregnant patients is unknown
e) Administer antibiotics once blood cultures have been obtained
f) b & d
Uterine Rupture: Medical Legal Risks

• Many VBAC lawsuits hinge on alleged:
  ➢ Inappropriate use of oxytocin
  ➢ Failure to interpret the FHR tracing
  ➢ Failure to perform a timely C/S
Patient Safety Concerns

- Follow your guidelines: induction of labor, cervical ripening, oxytocin
  - What does that mean at Natividad Regional Medical Center?
  - Where do you see potential risks for women who desire TOLAC?
  - What can be done to keep patients as safe as possible?
Vaginal Birth After Cesarean Delivery

- Assess the likelihood of VBAC including individual risks
- Review Risks and Benefits of TOLAC in various clinical settings
- Provide practical guidelines for counseling patients and managing women who desire vaginal birth after cesarean delivery
Table 1. Composite Maternal Risks From Elective Repeat Cesarean Delivery and Trial of Labor After Previous Cesarean Delivery in Term Patients

<table>
<thead>
<tr>
<th>Maternal Risks</th>
<th>ERCD (%) [One CD]</th>
<th>TOLAC (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious morbidity</td>
<td>3.2</td>
<td>4.6</td>
</tr>
<tr>
<td>Surgical injury</td>
<td>0.30–0.60</td>
<td>0.37–1.3</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>0.46</td>
<td>0.66</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>0.16</td>
<td>0.14</td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>0.02</td>
<td>0.21</td>
</tr>
<tr>
<td>Maternal death</td>
<td>0.0096</td>
<td>0.0019</td>
</tr>
</tbody>
</table>
### Table 2. Composite Neonatal Morbidity From Elective Repeat Cesarean Delivery and Trial of Labor After Previous Cesarean Delivery in Term Infants

<table>
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<tr>
<th>Neonatal Risks</th>
<th>ERCD (%)</th>
<th>TOLAC (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antepartum stillbirth</td>
<td>0.21</td>
<td>0.10</td>
</tr>
<tr>
<td>Intrapartum stillbirth</td>
<td>0–0.004</td>
<td>0.01–0.04</td>
</tr>
<tr>
<td>HIE</td>
<td>0–0.32</td>
<td>0–0.89</td>
</tr>
<tr>
<td>Perinatal mortality</td>
<td>0.05</td>
<td>0.13</td>
</tr>
<tr>
<td>Neonatal mortality</td>
<td>0.06</td>
<td>0.11</td>
</tr>
<tr>
<td>NICU admission</td>
<td>1.5–17.6</td>
<td>0.8–26.2</td>
</tr>
<tr>
<td>Respiratory morbidity</td>
<td>2.5</td>
<td>5.4</td>
</tr>
<tr>
<td>Transient tachypnea</td>
<td>4.2</td>
<td>3.6</td>
</tr>
</tbody>
</table>
Vaginal Birth after Cesarean Delivery 2017

- Most published findings demonstrate 60-80% successful VBAC
- No prediction model has been shown to improve pt outcomes
- External cephalic version is not contraindicated
- 2 prior LT cesarean deliveries is reasonable
- An upper oxytocin limit has not been established
- Epidural is not considered necessary
- Continuous fetal monitoring by staff who are familiar with complication of TOLAC
- Postpartum bleeding or signs of hypovolemia may indicate uterine rupture and requires complete MD evaluation of genital tract
Uterine Rupture: Medical Legal Risks

• Many VBAC lawsuits hinge on alleged:
  ➢ Inappropriate use of oxytocin
  ➢ Failure to interpret the FHR tracing
  ➢ Failure to perform a timely C/S
Case Review

- 34 yo G2P1 Hx of C/S in 2014 (Breech)
- Scheduled for Repeat C/S in 4 days (39 +0)
- Arrives to L&D at 08:00 am contracting (38+5)
  - VE: 2/80/-2
14 minutes left
Call for Help Early

Who responds?

• Rapid Response Team?
  – What is the SBAR?
  – What is their role?
  – Who is leader?

I wonder why we were called?

Gee...she looks pretty good to me...
Surgical Emergency

- STAT Cesarean
  - No counts
  - No standard prep
- 2nd IV
- Blood transfusion
- GYN/Onc Surgeon
- Baby to NICU – cooling
- Emotional support for partner/family
Prompt neonatal resuscitation
Appendix Q
Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings

Category 1
Moderate variability w/o late or variable decels

May observe

May observe. Apply corrective measures*

Acceleration or return of mod variability

Cautiously observe. Increase frequency of assessments

If abnormal pattern persists or returns

Category 2
Non-clinically significant decels* in the presence of marked or mod variability or accelcs

Apply corrective measures** and scalp stimulation

No acceleration or return of mod variability

Notify provider. Repeat scalp stimulation every 20-30 minutes. If pattern persists for 60 min without accelerations or return to moderate variability, then begin prep for urgent delivery

Category 3
Minimal variability w/ clinically significant decels for > 50% of contractions; OR absent variability w/ decels

Begin prep for urgent delivery and initiate corrective measures** and scalp stim if not already done

Prolonged decel ≤ 60 BPM (or < 80 BPM if remote from delivery)

Begin transport to OR by 3 min. Deliver without delay should decel persist > 10 min

Absent variability w/ decels or w/ bradycardia (baseline rate < 110 BPM); or sinusoidal pattern

Begin prep for urgent delivery and initiate corrective measures** and scalp stim if not already done

If no improvement, deliver within 30 min
**Clinically significant decelerations include:**
- Variable decels lasting > 60 sec with a nadir > 60 BPM below baseline
- Variable decels > 60 sec with a nadir < 60 BPM regardless of baseline
- Late decels of any depth
- Any prolonged decel as defined by NICHD


**Corrective measures include:**
- Oxygen administration
- Maternal position change
- Fluid bolus
- Reduction or discontinuation of pitocin
- Administration of terbutaline for tetanic contraction or tachysystole
- Administration of pressors, if hypotension present
- Amnioinfusion for deep, repetitive variable decelerations

(Miller LA, Miller DA. *J Perinat Neonatal Nurs.* 2013;27(2):126-133.)
Response

- Begin prep for urgent delivery and initiate corrective measures** and scalp stim if not already done
- Begin transport to OR by 3 min. Deliver without delay should decel persist > 10 min

- Begin prep for urgent delivery and initiate corrective measures** and scalp stim if not already done
- If no improvement, deliver within 30 min
Case Presentation

- 36 yo Hispanic woman G4 P3 to L&D for IOL
- IVF Pregnancy
- 3 Prior vaginal births: 7.12, 8.1, 8.5 (NCB)
- Late to care – EDC ~ 40-41 weeks
- GDM Type A2 – somewhat uncontrolled
- 4’11”
- Hx of Lupus
- BMI 40
- Gained ~ 40 lbs during pregnancy
Shoulder Dystocia

- **Incidence**
  - 0.2 to 3% of births

- **Definition:**
  - Diagnosed when the fetal head emerges and there is a failure of the shoulders to deliver spontaneously or with gentle traction
  - **Prolonged** head to body delivery time
    - > 60 seconds and/or the necessitated use of ancillary obstetric maneuvers

Shoulder Dystocia

- Generally due to impaction of the anterior shoulder behind the symphysis, above the pelvic inlet

- Classified as mild if only McRobert’s maneuver and/or suprapubic pressure is needed

- Classified as severe if other maneuvers required

Patient Safety Checklist

Number 6 • August 2012

DOCUMENTING SHOULDER DYSTOCIA

Date ___________ Patient _______________________________ Date of birth ________ MR # ___________
Physician or certified nurse–midwife _______________________ Gravidity/Parity_________________________

Timing:
Onset of active labor __________ Start of second stage ______
Delivery of head __________ Time shoulder dystocia recognized and help called ______
Delivery of posterior shoulder __________ Delivery of infant ______

Antepartum documentation:
☐ Assessment of pelvis
☐ History of prior cesarean delivery: Indication for cesarean delivery: ______________________________
☐ History of prior shoulder dystocia
☐ Largest prior newborn birth weight ________ ☐ History of gestational diabetes
☐ Cesarean delivery offered if estimated fetal weight greater than 4,500 g (if the patient has diabetes mellitus) or greater than 5,000 g (if patient does not have diabetes mellitus)
Debriefing as a Strategic Tool for Performance Improvement  Corbett, et al., 2012

- 4 → 14 Kaiser Hospitals
  - Establish high reliability units
  - Improve communication, teamwork and system
  - Create a “Just Culture”

- Standardized debriefing for critical events
  - Apgar ≤6 at 5 minutes
  - Intrapartum fetal demise
  - Emergency Cesarean Section
  - Postpartum Hemorrhage
  - Seizure
  - Preterm delivery on antepartum unit
  - Shoulder Dystocia (beyond McRoberts/Suprapubic)
  - Unexpected maternal transfer to higher level of care
  - Unexpected term infant admission to NICU
Promote High Reliability

- Lucky verses Good
- By conducting a drill:
  - TOLAC → Uterine Rupture → Fetal Bradycardia → STAT C/S

- You can actually test your department’s capability to handle a rare obstetrical or neonatal emergency

- Measure outcomes in minutes
  - Time from MD notification to bedside
  - Time entered the OR
  - Time of birth after bradycardia began
  - Quality of neonatal resuscitation
  - Time of Pediatrician arrival
COMMITTEE OPINION

• Number 590 • March 2014 (Replaces Committee Opinion Number 487, April 2011)

• Committee on Patient Safety and Quality Improvement

• This document reflects emerging concepts on patient safety and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

• 722 VOL. 123, NO. 3, MARCH 2014 OBSTETRICS & GYNECOLOGY
Examples of Tools for Managing Clinical Emergencies

Availability of appropriate emergency supplies in a resuscitation cart (crash cart) or kit

Development of a rapid response team

Development of protocols that include clinical triggers

Use of standardized communication tools for huddles and briefs (eg, SBAR)

Implementation of emergency drills and simulations

Abbreviation: SBAR, Situation–Background–Assessment–Recommendation.
Critical Incident

“A critical incident has been described as any sudden unexpected event that has the power to overwhelm the usual effective coping skills of an individual or a group and can cause significant psychological distress in usually healthy persons”

Roesler and Short, 2009
Preventing Malpractice Claims

- Spontaneous labor
- Normal labor progress continues
  - Without augmentation
- Absence of significant FHR abnormalities or other indications of fetal compromise
Monitoring Labor

- 20% - 40% of TOLAC is unsuccessful

- High risk for labor abnormalities 1:1 Nursing

- Once labor begins call for OB Provider evaluation

- Continuous FHR monitoring
  - Scalp electrode early
  - IUPC not beneficial

- Heightened surveillance
  - Shoulder pain, anxiety, restlessness, dizziness, shock
TOLAC Summary

- Common sense should prevail
  - Appropriate candidate selection – informed consent

- 24 hour personnel may not be practical for rural hospitals
  - Role of Charge Nurse, available staffing, financial costs on on-call

- Epidural is useful but not mandatory
  - Adequate pain relief may encourage women to choose TOLAC
  - Should not mask pain associated with uterine rupture

- Prostaglandins
  - Misoprostil is contraindicated
  - Cervidil heightened risk of rupture

- Oxytocin
  - Use with caution – least amount to achieve desired effect

- Ultrasound is unreliable to detect uterine rupture

- If rupture occurs implement emergency response
  - Multiple care teams, possible MTP

- Stabilize mother and evaluate infant for cooling

- Provide postpartum F/U and emotional support for women who required emergency CS
Case Presentation

- 36 yo G3 P2, 37 + 2
- Spanish speaking woman admitted to L&D with her English speaking cousin as her support person. FOB not involved.
- Hx GDM diet controlled
- Precipitous birth 37+2 – Apgar 8, 9
  - Blood glucose at delivery 130
- IV Fentanyl x 1: (Repair of 2\textsuperscript{nd}) Pain= 4/10
- Patient complaining of headache
  - T: 98.8, Pulse: 96  BP: 156/92,  R: 20
How Errors Occur

Defenses

Safeguards
Stop the line
Standard work
Flexible staffing
Self-checks

Policies
Resources
Training
Communication

Culture

Failures

Harm

Case Presentation

- **05:20** Ms. Davis is admitted to L&D as an outpatient - (out of network)
- 36 yo G4 P2 at 35+3 weeks gestation
- C/O upset stomach and pain around diaphragm
- VS: 98.6, HR 68, R 18, BP 161/85, re√ 140/84,
  - **Pain 7-8/10**
- FHR tracing on L&D 05:30 – 07:33
- Baseline 140, Moderate variability, accelerations to 165 no decelerations noted (Category I)
HELLP

A variant of severe preeclampsia

- **Hemolysis**
  - Red blood cell destruction – hemolysis on peripheral smear

- **Elevated Liver Enzymes**
  - Elevated bilirubin ≥ 1.2 mg/dL
  - Elevated LDH > 600
  - Elevated AST ≥ 70

- **Low Platelets**
  - Decreased < 100,000
How did this happen?

Defenses

- Culture
- Policies
- Resources
- Training
- Communication

Safeguards
- Stop the line
- Standard work

Flexible staffing
Self-checks

Failures

Harm
How to Accurately Measure Blood Pressure

- Patient seated comfortably, legs uncrossed, back and arm supported
- Use the correct sized cuff so that it fits correctly around the upper arm and line the middle of the BP cuff with the level of the right atrium (middle of the sternum)
- Patient should be relaxed and instructed not to talk during the measurement
  - Ideally a resting time of several minutes should elapse before the BP is taken

- If initial assessment elevated
  - Repeat after several minutes to determine if hypertension persists

ACOG, 2013; CMQCC, 2013
## Diagnostic Criteria

**TABLE E-1. Diagnostic Criteria for Preeclampsia**

| Blood pressure | Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation in a woman with a previously normal blood pressure  
|                | Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within a short interval (minutes) to facilitate timely antihypertensive therapy  

and

| Proteinuria | Greater than or equal to 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection)  
|            | Protein/creatinine ratio greater than or equal to 0.3*  
|            | Dipstick reading of 1+ (used only if other quantitative methods not available)  

*Protein/creatinine ratio greater than or equal to 0.3*  

Or in the absence of proteinuria, new-onset hypertension with the new onset of any of the following:

- **Thrombocytopenia**  
  - Platelet count less than 100,000/microliter  

- **Renal insufficiency**  
  - Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease  

- **Impaired liver function**  
  - Elevated blood concentrations of liver transaminases to twice normal concentration  

- **Pulmonary edema**  

- **Cerebral or visual symptoms**  

* Each measured as mg/dL.
Severe Features of Preeclampsia

**BOX E-1. Severe Features of Preeclampsia (Any of these findings)**

- Systolic blood pressure of **160 mm Hg** or higher, or diastolic blood pressure of **110 mm Hg** or higher on two occasions at least 4 hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time)
- Thrombocytopenia (platelet count less than 100,000/microliter)
- Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses, or both
- Progressive renal insufficiency (serum creatinine concentration greater than **1.1 mg/dl** or a doubling of the serum creatinine concentration in the absence of other renal disease)
- Pulmonary edema
- New-onset cerebral or visual disturbances
Committee on Obstetric Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period
Antihypertensive Medications

SBP $\geq 160$ OR DBP $\geq 105-110$?

- Medications should be given NO MORE than 1 hour after presenting in hypertensive emergency*
  - Aim for no more than 30 minutes
- This is the biggest step in decreasing morbidity and mortality

- Aim to return BP to a range where intracranial hemorrhage not a risk, but not to normal range
  - Goal: 140-160/90-100

*Hypertensive emergency: acute-onset, severe hypertension that persists for $\geq 15$ minutes
Anithypertensive Medications

First Line Agents

<table>
<thead>
<tr>
<th></th>
<th>IV Labetalol</th>
<th>IV Hydralazine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose (IVP over 2 minutes)</td>
<td>20 mg</td>
<td>5-10 mg</td>
</tr>
<tr>
<td>Onset</td>
<td>2-5 minutes</td>
<td>5-20 minutes</td>
</tr>
<tr>
<td>Peak</td>
<td>5 minutes</td>
<td>15-30 minutes</td>
</tr>
<tr>
<td>24 hour max</td>
<td>220 mg</td>
<td>25 mg</td>
</tr>
</tbody>
</table>

** If no IV access, PO nifedipine should be used
- Nifedipine PO 10 mg may repeat in 30 min
- Onset: 5-20 min
- Peak 30-60 min
## Maternal Early Warning Criteria

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Blood Pressure (mm Hg)</td>
<td>&lt;90 or &gt;160</td>
</tr>
<tr>
<td>Diastolic Blood Pressure (mm Hg)</td>
<td>&gt;100</td>
</tr>
<tr>
<td>Heart rate (beats per minute)</td>
<td>&lt;50 or &gt;120</td>
</tr>
<tr>
<td>Respiratory rate (breaths per min)</td>
<td>&lt;10 or &gt;30</td>
</tr>
<tr>
<td>Oxygen saturation on room air, at sea level %</td>
<td>&lt;95</td>
</tr>
<tr>
<td>Oliguria, mL/hr for ≥2 hrs</td>
<td>&lt;35</td>
</tr>
<tr>
<td>Maternal agitation, confusion, or unresponsiveness</td>
<td></td>
</tr>
<tr>
<td>Woman with preeclampsia reporting a non-remitting headache or shortness of breath</td>
<td></td>
</tr>
</tbody>
</table>
Maternal Early Warning Systems

- Abnormal physiologic signs and symptoms precede critical illness
- Early intervention will avoid severe M&M occurrence
- Effective policy of escalation of care

Nip it in the bud
Question

Your patient arrives to OB Triage
You introduce yourself and take her vitals.
You note the BP is 156/114.
What should you do?

A. Lower her head, turn her on her side and retake her blood pressure with the cuff on the up arm
B. She looks a little “Fluffy” go get a larger cuff then it’ll be “normal”
C. Retake the BP in her lower leg, it’s the same as the arm
D. Ask when she last ate – maybe she’s hungry
E. None of the above
What about this position?

“Her blood pressure was elevated when she first presented to triage but I had her rest on her side to cycle her blood pressures and all other measurements have been within normal limits”
**Hypertension**

**READINESS**

Every Unit
- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe pre eclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension/eclampsia
  - Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include order guide for administration and dosage.
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

**RECOGNITION & PREVENTION**

Every Patient
- Standard protocol for measurement and assessment of BP and urina protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia
Hypertension

Minimum requirements for protocol:
- Notification of physician or primary care provider if systolic BP ≥ 160 or diastolic BP ≥ 110 for two measurements within 15 minutes
- After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)

- Includes onset and duration of magnesium sulfate therapy
- Includes escalation measures for those unresponsive to standard treatment
- Describes manner and verification of follow-up within 7 to 14 days postpartum
- Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

REPORTING/SYSTEMS LEARNING

Every unit
- Establish a culture of huddles for high-risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of all severe hypertension/preeclampsia cases admitted to ICU for systems issues
- Monitor outcomes and process metrics

Note: “Facility-wide” indicates all areas where pregnant or postpartum women receive care. (E.g., L&D, postpartum critical care, emergency department, and others depending on the facility)
Documentation:

Bonus Section
Documentation

- Audit Trail
- Record “Wars”
- Copy & Paste
- Inflammatory Notes
- Late Entries
- Vague and risky Language
Words to Avoid

- Accidentally
- Apparently
- Appears
- Assume
- Confusing
- Could be
- May be
- Miscalculated
- Mistake
- Names of others (roommates)
- Somehow
- Unintentionally
Supportive test results, pathology reports, findings

- The Placenta
  - Causation evidence
    - Physical abnormalities: infarcts, mass, vascular thrombosis, malodor, shape
    - Small or large size or weight for gestational age
    - Funisitis
- Umbilical cord lesions: thrombosis, true knot, single artery, absence of Wharton's Jelly
  - Short umbilical length <32cm or Long cord >100cm
  - Marginal or velamentous insertion, vaso previa
Bonus: Fall Risk - SCDs - Discharge Education

- Nurses are big part of preventing DVT
  - Documentation of use or refusal of interventions is essential
  - SCD Documentation
    - Can make it a box on your “brain” to help you remember to place & document
- DC Documentation: Key Elements
  - Education Activity in EMR
  - How do you know they are ready to go?
  - Discharge Teaching Records vs Teaching Points
Missing or NO Umbilical Cord Blood Gases!

Without Standing Orders:

- RN’s have to “remind” or “ask” the provider for an order at time of birth
  - Task saturated
    - RN unable to provide immediate postpartum nursing care
  - EMR order entry
    - Omission → easy to forget
    - Provider declines

- Umbilical Cord Gases provide evidence of infant’s condition at birth relative to acidosis & labor - obtain both umbilical and arterial
What About UCSF OB cases?

- Some of our largest cases have involved "birth injury" cases
- Lots of folks involved and care transfers from OB to Peds—different providers
- Issues:
  - Prenatal care and evaluation of risk
  - Fetal heart monitoring
  - Quality of hand-offs—Labor can last a long time
  - Stage of labor
  - Interference by outsiders or family—birth plans
  - Delayed c-section
  - Communication between nurses and MD’s
  - Speculation on causation
How to Contact Risk Management

Consider Risk Management as a resource that is available to you 24/7

RM Website via UCSF Intranet:
http://intranet.ucsfmedicalcenter.org/

Under Browse Medical Center Sites, Click on “Risk Management”

- PAGER: 443-2284
- PHONE: 353-1842
Some Basics: Notification of Risk

- Risk can assist with disclosure and will participate as appropriate
- Risk needs to be advised of a Precautionary Incident Notification (PIN) defined as:
  - (1) an adverse event or complication resulting in death, brain damage, permanent paralysis, sensory deficits, partial or complete loss of hearing or sight, birth injury or disability, or other catastrophic damage or permanent disability; or
  - (2) an incident anticipated to result in potential liability exposure or a claim.
Disclosure - In Summary....Do:

- Disclose errors (if error confirmed)
- Have the Attending MD lead the disclosure
- Involve nursing as appropriate (nursing error)
- Apologize
- Maintain the relationship with the patient and family
- Inform that there will be an investigation with follow up to the patient and family
- Seek help from Risk Management in cases which are multidisciplinary, complicated, or where significant harm occurred
- Seek debriefing for yourself and your own medical team from an objective resource (chaplain or palliative care social work)
Disclosure - In Summary....Don’t

- Speculate
- Deflect blame to others
- Document emotion or blame in the medical record
- Avoid the patient/family
- Project your own emotional response (i.e., feelings of guilt) in the disclosure

- Disclosure is a Process that takes Discipline & Institutional Will
The Incident Report - Confidentiality is Key

- Incident Reporting Policy 3.06.03
- Purpose of IR:
  - Provide confidential information
  - Notifies supervisors and managers and senior leaders
  - Notifies Risk Management to minimize liability, facilitate communication
  - Assists in identification of SYSTEM issues that have quality, safety or risk implications
  - NOTE: The policy does not mention as a purpose discipline, labor or HR action
Second Victim

• Julie Thao Story

• Medical errors should not be criminalized
• Fear is a major barrier to action
Social Media: Standard of Care

- Understand that everything you type, post, share, text, blog, vlog, or otherwise put into the internet is discoverable
- Not showing a patient’s name does not mean you are not violating HIPAA
- Lawyers and employers are looking at your social media personas
Discoverable Items

- Personal notes, diaries, journals, email, instant messages

CASE EXAMPLE: During Labor RN’s deposition she admitted to having personal journal discussing delivery. Unfortunately court required RN to produce her journal in which RN was very critical of OBGYN’s care.

- This made the case more difficult to defend for all defendants and likely more costly to settle.

In another case texting of a casual nature made author of the text appear unprofessional

- Missed bradycardia on FHR tracing – no notification to MD
- Infant was born in poor condition – cerebral palsy
  - RN was found to be negligent
    - case settled with high pay-out
UCSF Case Study
Case Presentation

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Documentation: assessment, vital signs, medication. etc</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40 yo G6P5 BIBA MB Peds ED  c/o vomiting blood stated she was pregnant and she appeared pregnant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical Hx: Atrial Fibrilation, Congenital heart disease, Pulmonary Embolism, Delusional psychiatric disorder</td>
<td></td>
</tr>
</tbody>
</table>
Legal considerations in this case?

- Homeless
- Use of chemical restraints
- Use of 4 point restraints
- Respectful Care
Addiction is a chronic disease not a moral failing

Criminally targeting women for chronic health conditions in pregnancy is medically and ethically inappropriate and reinforces societal stigma

Treating addiction as a criminal act has proven to be ineffective and inappropriate

We advocate for improved access to opioid maintenance therapy and social services to improve healthful pregnancy outcomes

We decry recent trends in the criminalization of addiction nationwide.
Thank You

Nurses are a valuable source of information and support for women and their families.