Legal Issues in Perinatal Care

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Objectives

- List the most frequent allegations against nurses in a lawsuit
- Describe the necessary components of documentation

Standards of Care

- What is a Standard of Care?

Standards describe methods and techniques of nursing practice that currently are acceptable and used by recognized authorities.

Standard of Care - Obstetric Nurse

- ...a registered nurse who specializes in obstetrics has a duty to exercise the degree of skill, care and learning expected of a reasonably prudent obstetric nurse in the State of Washington acting in the same or similar circumstances at the time of the care or treatment in question

Negligence

- Failure to exercise such skill, care and learning constitutes a breach of the standard of care and is negligence
Standards of Care

- How are standards defined?
- Where do they come from?
- How do they impact practice?

National Standards

National organizations will publish "guidelines" but in actuality, if litigation occurs, both defense and plaintiff attorneys offer these publications as "standards".

AWHONN
- Association of Women's Health, Obstetric and Neonatal Nurses
ACOG
- American College of Obstetricians and Gynecologists
AAP
- American Academy of Pediatrics
ACNM
- American College of Nurse Midwives

Importance of Standards in Litigation

- Basic premise in all malpractice actions—the health care provider (MD/CNM/RN) failed to meet the standard of care
- "Would a reasonably prudent health care provider with like training and experience, do the same under similar circumstances?"

Human Factors in Healthcare

"Human factors refer to environmental, organizational and job factors, and human and individual characteristics which influence behavior at work in a way which can affect health and safety. A simple way to view human factors is to think about three aspects: the job, the individual and the organization and how they impact people's health and safety-related behavior."
Common Allegations

- Often result from
  - Lack of knowledge of current standards, guidelines, and evidence
  - Lack of commitment to practice based on current standards, guidelines and evidence

Causation

- There may be no cause and effect relationship between plaintiff’s allegation and injury but... evidence discovered to support the allegation may make a claim difficult to defend ex. Nurse forgets to document vital signs per protocol and fetus sustains injury

Common Allegations in Nursing

- Telephone Triage... failure to:
  - Accurately assess maternal/fetal status over the phone
  - Correctly communicate m/f status to provider
  - Of provider to come to the hospital to see the patient when requested by the nurse

- Telephone advice should be limited to:
  - Call your provider
  - Come in to the hospital to be evaluated

What if you are the “provider”

- Utilize protocols for telephone advice that are recognized and approved
- When in doubt, have patient come in to hospital
- Document conversation and recommendations

EMTALA (Emergency Medical Treatment and Active Labor Act)

- Allegations include failure to:
  - Comply with components of EMTALA
  - Perform/delay in performing medical screening exam
  - Have a policy delineating conditions requiring a bedside evaluation by a doctor/midwife prior to d/c by RN
  - Accurately assess maternal/fetal status

- Transfer/discharge of a woman in active labor or with an unstable medical condition
- Transfer/discharge of a woman in active labor (dumping)

Transfer/Discharge

- In hospitals where nurses perform medical screenings, documentation must state what screening may be done and by whom (includes validation of competence)
- If hospital does not offer high risk svcs, transfer must occur through qualified personnel and transferring hospital liable
- Must document in the medical record that woman is not in active labor prior to d/c
Fetal Heart Rate Information
- Common allegations include failure to:
  - Accurately assess m/f status (distinguish Maternal from fetal information)
  - Appreciate a deteriorating fetal condition
  - Correctly communicate m/f status to provider
  - Of provider to respond appropriately when notified of deteriorating status
  - Institute chain of command when clinical disagreement occurs between nurse and provider

Standards, Guidelines, Recommendations
- Adopt a common language for discussing FHR information
- Establish collaborative EFM educational programs
- Ensure/document that all care providers are competent to interpret EFM data
- Define fetal well being on admission, prior to d/c and prior to initiation of epidurals, oxytocin, etc

EFM, cont’d
- Consider initial electronic EFM on those moms who will have intermittent auscultation as primary surveillance
- Ensure timely, ongoing and accurate determination of fetal well being in labor
- Review actual tracing rather than computer screen for ongoing surveillance
- Use scalp/acoustic stimulation to evaluate well being in times of ↓/Ø variability

EFM, cont’d
- Use intrauterine resuscitation techniques in a timely manner
- Continuous EFM means that both the fetus and uterine activity are monitored continuously until delivery
- Organizational resources should be in place to support staff and patients when the tracing is concerning

Induction of Labor
- Common Allegations include failure to:
  - Fully inform the woman of risks and benefits of induction
  - Accurately determine gestational age prior to elective induction
  - Recognize and treat tachysystole (with or without fetal sequelae)
  - Accurately assess m/f status during induction

Misoprostol
- Common allegations include:
  - Use of excessive doses that result in uterine hyperstimulation
  - Uterine rupture as a result of miso use
  - Use of miso in a patient with prior uterine scar
  - Failure to accurately assess m/f status
Other Allegations in the Perinatal Arena

- Additional allegations surround care related to:
  - Pain relief during labor and delivery
  - Fundal pressure during the 2nd stage of labor
  - Shoulder dystocia
  - Second stage management
  - Operative vaginal delivery (forceps/vacuum)
  - 30 minute rule for cesarean delivery
  - VBAC
  - Multiple Gestation
  - Iatrogenic Prematurity
  - GBS disease
  - NRP

Decreasing Liability Exposure

- Follow national guidelines/standards
- Document in a timely, non-evaluative manner
- Communicate clearly with members of team
- Institute emergency drills for providers/RNs, etc

Nursing Competency

- It is the personal responsibility of each nurse to maintain competency in practice. The nurse must be aware of the need for continued professional learning and must assume personal responsibility for currency of knowledge and skills

Nursing Accountability

- “Nurses are accountable for judgments made and actions taken in the course of nursing practice. Neither physician’s orders nor the employing agency’s policies relieve the nurse of accountability for actions taken and judgments made.”

Team Communications

- RN-shift/shift report
- RN/MD-CNM report
- Staff/patient/family communication
- Other providers? ie Anesthesia, MSW, Pharmacy, etc

SBAR Communication

- Situation
- Background
- Assessment
- Recommendation
Using SBAR

- Get the provider's attention and express/convey your sense of urgency
- Identify the patient and describe the problem and your reason for calling
- Tell them your appraisal of what is happening
- Tell them what you want them to do (FYI, action request, etc)

Chain of Command

- Communicate clearly about what you want
- Notify charge RN
- If provider doesn't share your urgency and you believe the safety of the pt or baby is at stake
- Know your institutional chain of command
- Institute the chain of command

Medical Record

- Reflects the sequence of events
- Serves as a communication tool
- Allows subsequent review
- Must show that the SOC was met

Electronic Nursing Notes

- Very important in a lawsuit
- The chart is the witness that never dies and never lies
- Years later, the chart is the only valid record of events
- "If it wasn't written, it wasn't done?"
- Documentation is part of caring for the patient

Documentation in Nursing Notes

- Clear, concise
- Non judgmental (no blame or value)
- Just the facts
- Per documentation standard (more if indicated)
- If sentinel event occurs, write incident report (not discoverable)
Documentation Summary

- Reflect that SOC was met
- Professional responsibility
- (Potential) court exhibit