DOCUMENTATION IN THE OBSTETRICAL ARENA - ARE YOU AT RISK?

Presented by: Marilee Clausing
IRMS OB Risk Managers meeting
May 8, 2025

HALL PRANGLE LLC

POST COVID LITIGATION

A New Frontier

Verdicts are higher

Settlements are higher

Jurors seem willing to entertain exorbitant "asks"

Mistrust of corporate healthcare

Healthcare providers are the path to the corporate defendant

DOCUMENTATION & COMMUNICATION

The Basic Truths

60% - 70% of claims occur because of communication issues

Effective communication results in better care

Effective communication with patients can prevent lawsuits

Poor communication may leave patients angry and confused—more likely to file suit

Good documentation improves your defense

Credibility is everything

Disparity makes Plaintiff's job easier!

Hospital policies can be used against you if not followed

DOCUMENTATION & COMMUNICATION

Plaintiff Strategies

- Plaintiffs' attorneys use what's in the record – and what's not – to make their case

- This includes:
  - defensive, accusatory or incomplete charting
  - inconsistent charting
  - charting that does not reflect effective communication between practitioners
  - charting using improper, out-of-date, or vague terminology
  - notes created outside of the medical record
  - charting that fails to document the techniques, maneuvers, interventions, communications and other actions taken by the team

Electronic evidence comes from variety of sources

EMR

Social Media

Records and log books of phone calls, texts, emails, and pagers

Frequent use of extraneous digital data in lawsuits:

- Audit trails
- Transponder data
- Key card use
- Parking garage records

ELECTRONIC DOCUMENTATION PROBLEMS

- Limited space to document
- Multiple menu choices
- Multiple places could document
- Flow sheets
- Key stroke documentation
- Failure to add free text (narrative)
- Overuse of copy/paste – results in duplicative data
- Auto population – can result in erroneous data
- Late entries
- FHT strip electronic documentation

DOCUMENTATION & COMMUNICATION

Defense Strategies

- Typical options for reconstructing the care at issue:
  - Independent recollection
  - Documentation
  - Custom and practice
- What's in the record, and what we develop outside the EMR, will be used to develop theories
- Good documentation in the EMR ***really*** helps to defend a lawsuit
- Effective communication reflected in the EMR helps us to defend a lawsuit
  - Education of patient
  - Communication among healthcare providers
  - Informed consent of patient

DOCUMENTATION & COMMUNICATION

Defense Questions

- Do we have the documentation in the EMR necessary to defend the care?
- Is the documentation – in or outside of the EMR – such that it will compromise the case?
- Will the client's "electronic trail" create problems?

OB Office Practice Case Study:
Prenatal Care of High-risk Patient

FACTS OF THE CASE

- 30 yo G1 P0
- 7/13/18 Began prenatal care at 10w2d
- 10/2/18 20w6d Second trimester ultrasound
  - Pericardial effusion
  - No signs of hydrops
- 10/10/18 Fetal echo done
  - Small pericardial effusion
- Referred to MFM
- TORCH titer, Parvovirus, and Coxsackie IgG and IgM

FACTS OF THE CASE

- 10/11/18 First visit with MFM
- TORCH: + for CMV IgG>10,000 and Parovirus IgG of 4.74
- 11/7/18 Repeat US--no changes of significance
- 11/27/18 Repeat echo done--no change in effusion
- Antenatal testing to begin at 32 weeks
- Serial growth US q4 weeks
- Recommendation: deliver by EDD of 2/6/19

FACTS OF THE CASE

12/18/18 OB Visit--31w6d

- Reviewed antenatal testing
- Patient aware of management requirements for fetal concerns
- Antenatal testing beginning at 32 weeks--ordered

Result Type: Obstetrics Note
Result Date: 12/18/2018 15:56 CST
Result Status: Auth (Verified)
Performed Information: 12/18/2018 16:01 CST)
Signed Information: 12/18/2018 16:01 CST)

ROB

Patient:
Age: **30 years** Sex: **FEMALE** DOB:
Associated Diagnoses: **None**
Author:

Basic Information
Gravida/Para:
Gravida Para Information:
Gravida: 1
Para Term: 0
Para Preterm: 0
Para Abortions: 0
Para Living: 0.

Chief Complaint
12/18/2018 3:26 PM **NORMAL PREGENCY**

denies danger signs, concerns.
seen by MFM recently--may return to CNM clinic
denies danger signs, concerns. reviewed ANT testing
discussed childbirth ed
aware of mgmt recs for fetal concerns
declined flu
24 hour diet recall--low veggies, heavy carbs. discussed modifying her diet and strategies to improve

Serial Growth ultrasounds every 4 weeks--scheduled next US--1/8/19
Follow up Echo--scheduled
Antenatal testing beginning at 32 weeks--ordered

breast/open to epidural/ condoms --wants another baby in 2 years

Electronically Signed on 12/18/18 04:01 PM

FACTS OF THE CASE

1/3/19 OB Visit--34w1d

- Reviewed importance of keeping all appts
- Antenatal testing done--BPP (8/8) and NST (reactive)

Follow up Echo--scheduled
Antenatal testing beginning at 32 weeks--ordered
reviewed importance of keeping all appts, fetal mov't awareness, danger signs, s/s preE, childbirth ed info, emergency contact info
spinning babies website, PT referral

Electronically Signed on 01/03/19 03:34 PM

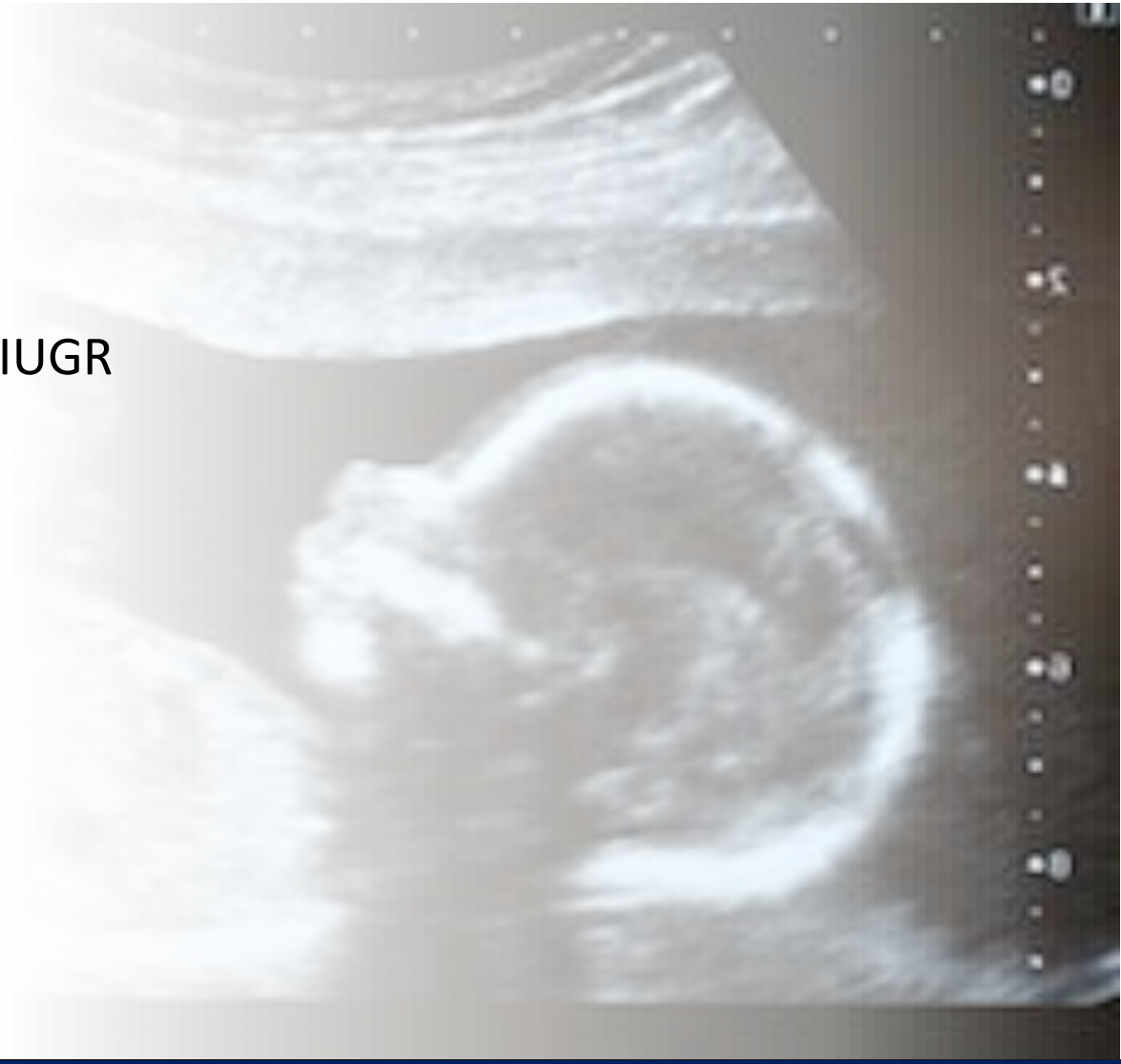
FACTS OF THE CASE

1/8/19 Antenatal Testing

- BPP (8/8) and NST (reactive)
- Follow Up Growth Ultrasound
  - Interval growth decelerated, consistent with IUGR (HC and AC <1%; overall 12%)
  - Normal AFI and UA Doppler
- Repeat fetal echo--cardiac effusion stable

1/15/18 OB Visit

- Twice weekly antenatal testing ordered
- BPP (8/8) and NST (reactive)



FACTS OF THE CASE

Next antenatal testing dates:

1/22/18--no show

- Patient contacted by antenatal testing nurse re missed appt.
- No note other than "no show“

1/25/18--late for appointment

- Patient claims she was turned away
- Providers claim she would have been referred to OBT
- No note of any kind re this day

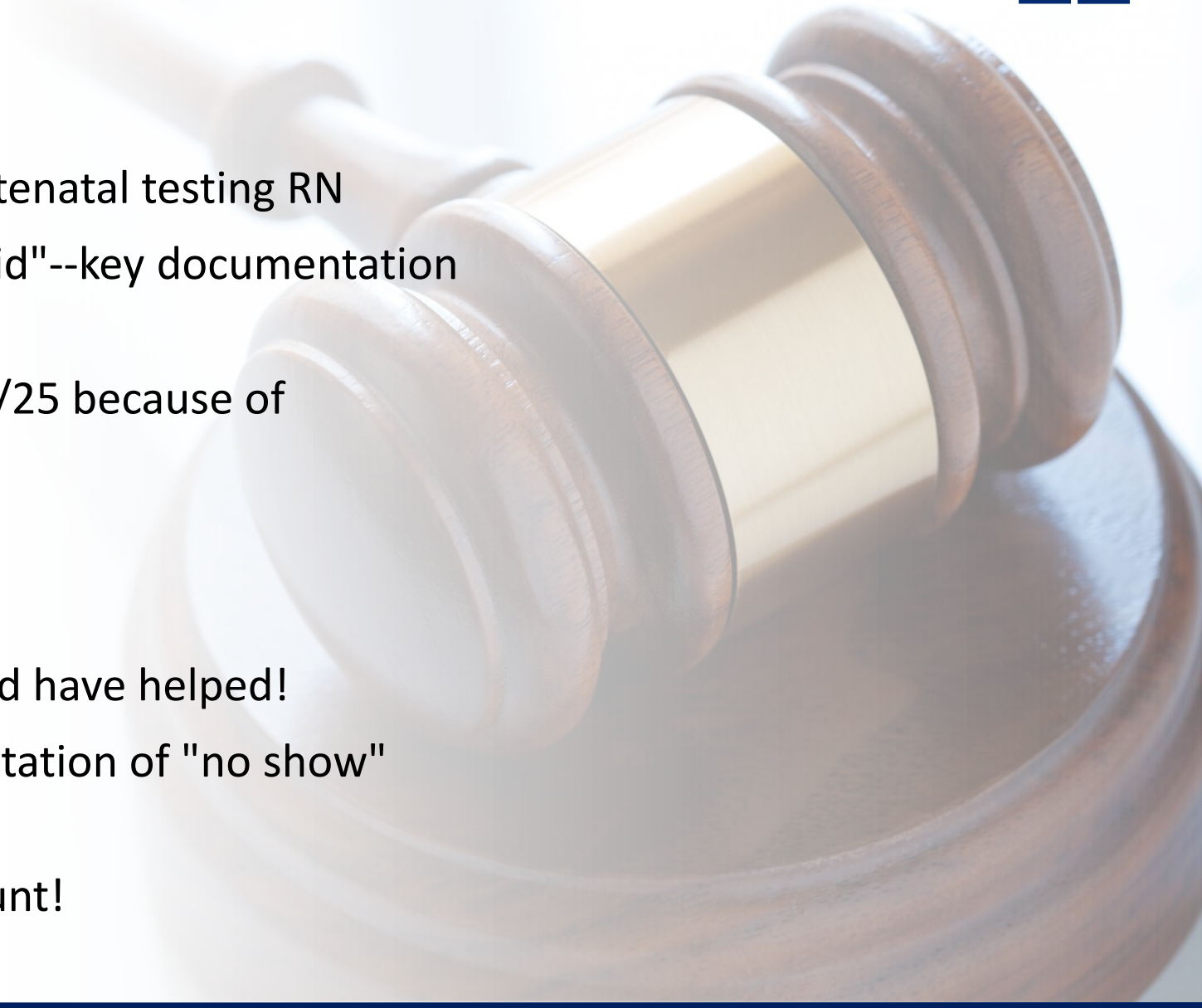
FACTS OF THE CASE

1/29/18

Patient To OB Triage

- 37w6d gestation
- Contractions
- No FHR detected
- Pitocin augmentation
- NSVD of IUFD
- No autopsy done
- Placental abnormalities
    - Small placenta
    - Chorioamnionitis

WHAT HAPPENED?



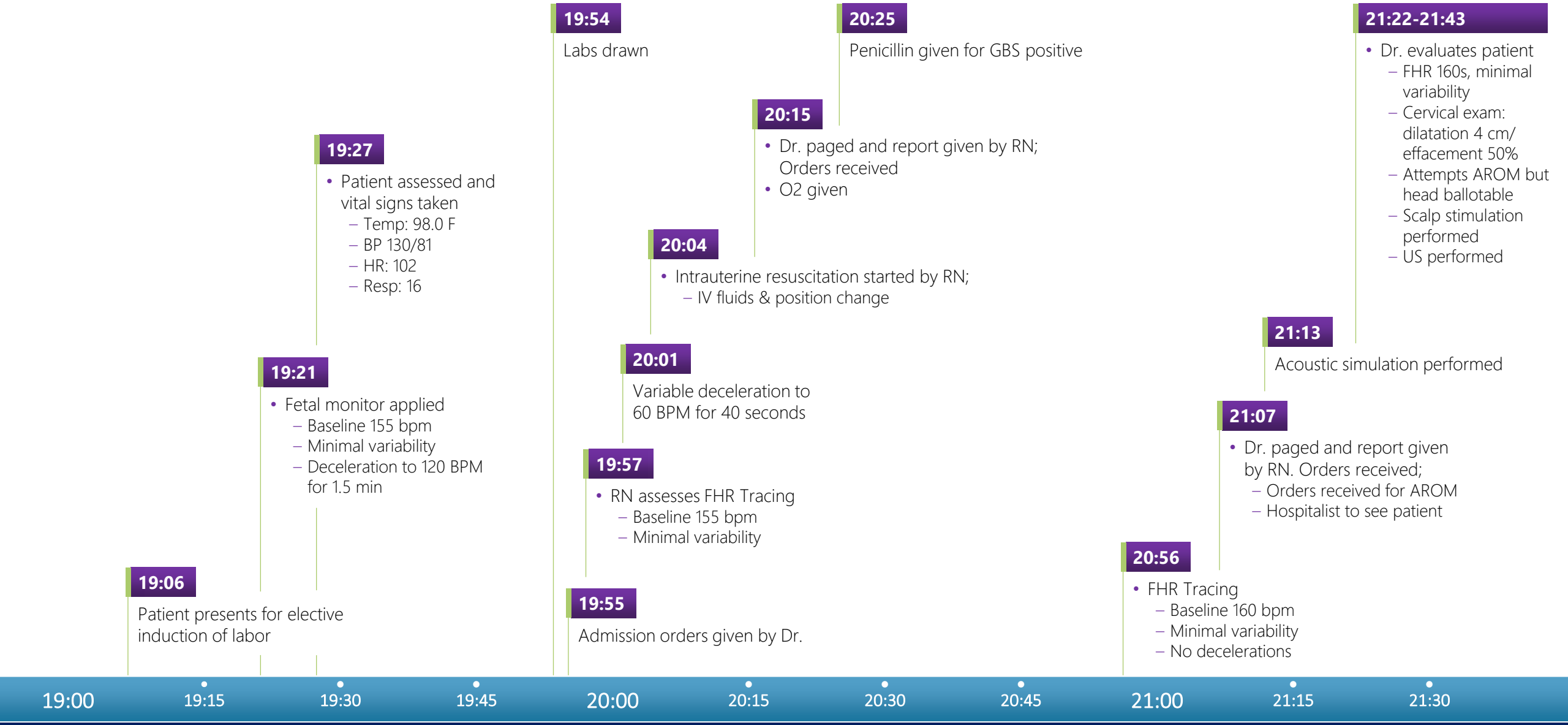
- Lawsuit filed against MFMs, OB, and Antenatal testing RN
- Case boiled down to a "she said--she said"--key documentation missing
- Had to rely on alternative evidence re 1/25 because of documentation problems
- Limited independent recollection
- “Custom and practice" evidence
- Well-written policy and procedure would have helped!
- Post-incident policy change re documentation of "no show" visits
- Settled for an exceedingly modest amount!

DOCUMENTATION LESSONS

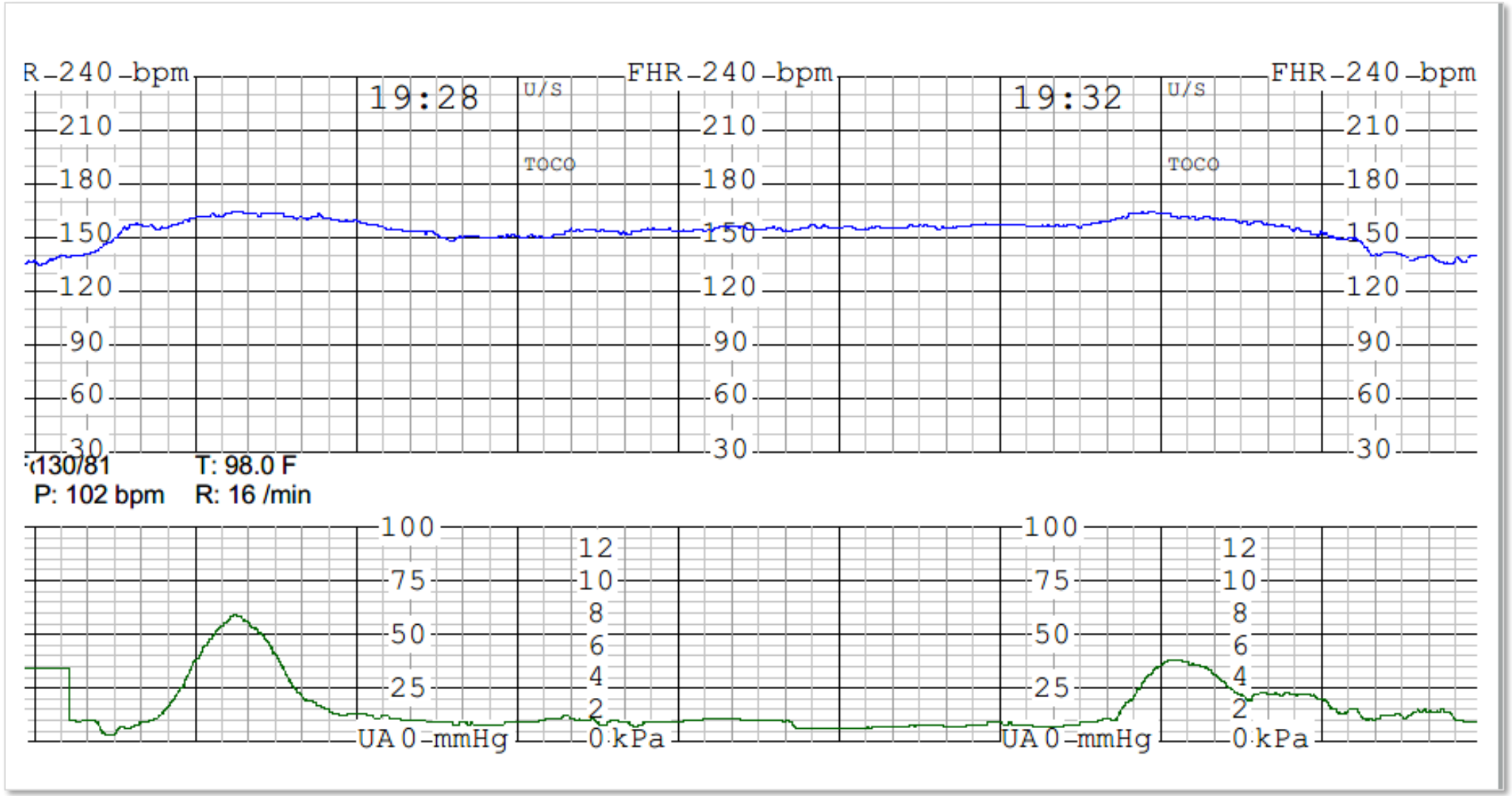
- When key documentation is missing, we have to fill the void with other evidence
- Doing so puts your credibility front and center
- Unnecessary duplication of prior entries creates confusion
- The lack of a clear hospital policy can create confusion re proper handling

Intrapartum Care Case Study

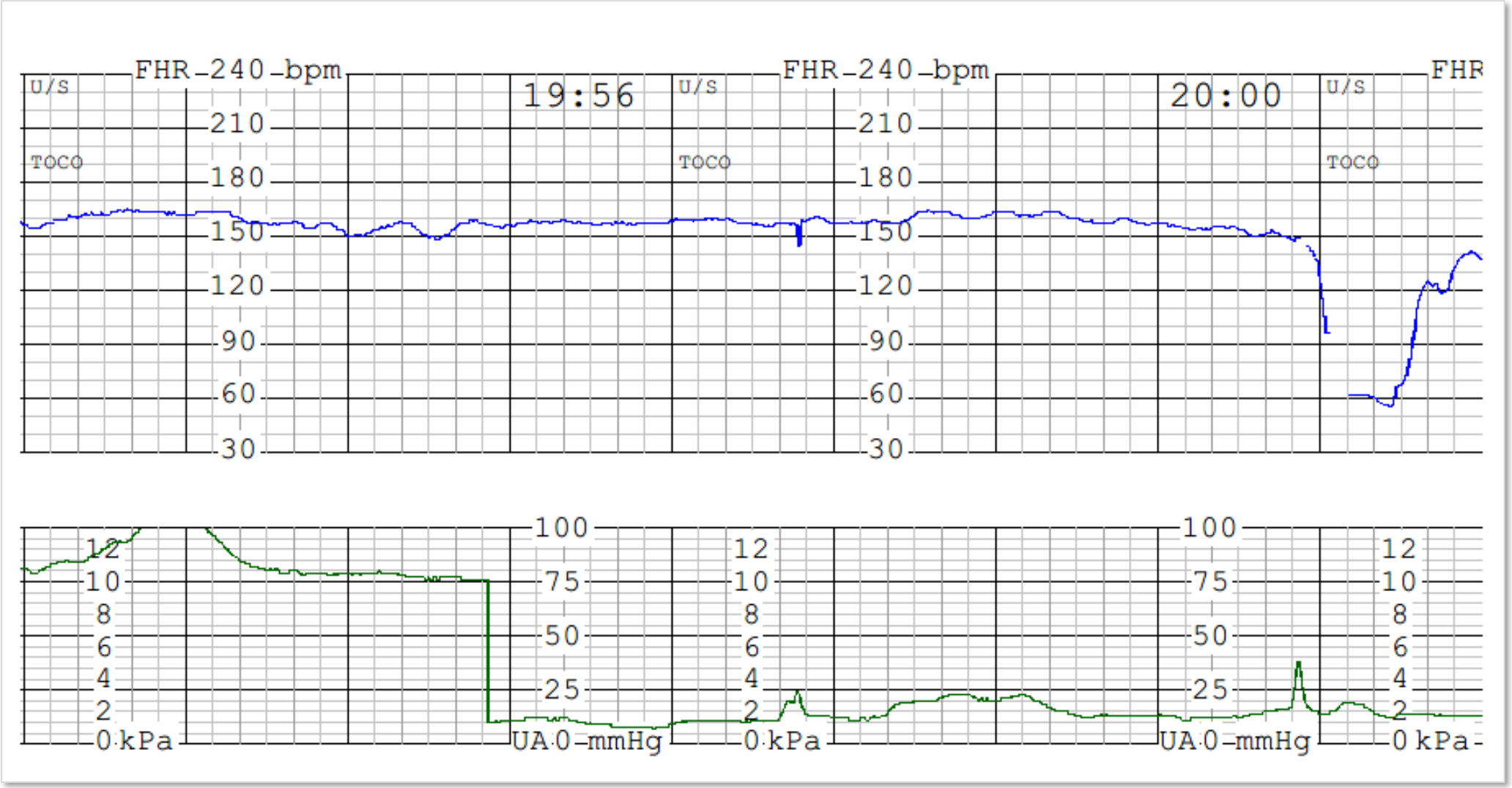
ADMISSION TIMELINE OF EVENTS



1926 - 1934


FHR 240 bpm
210
180
150
120
90
60
30
19:28
U/S
TOCO
19:32
U/S
TOCO
130/81
T: 98.0 F
P: 102 bpm
R: 16 /min
100
75
50
25
UA 0 mmHg
12
10
8
6
4
2
0 kPa

1952 - 2001


FHR
240
bpm
U/S
TOCO
19:56
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210
180
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100
75
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kPa
UA
mmHg

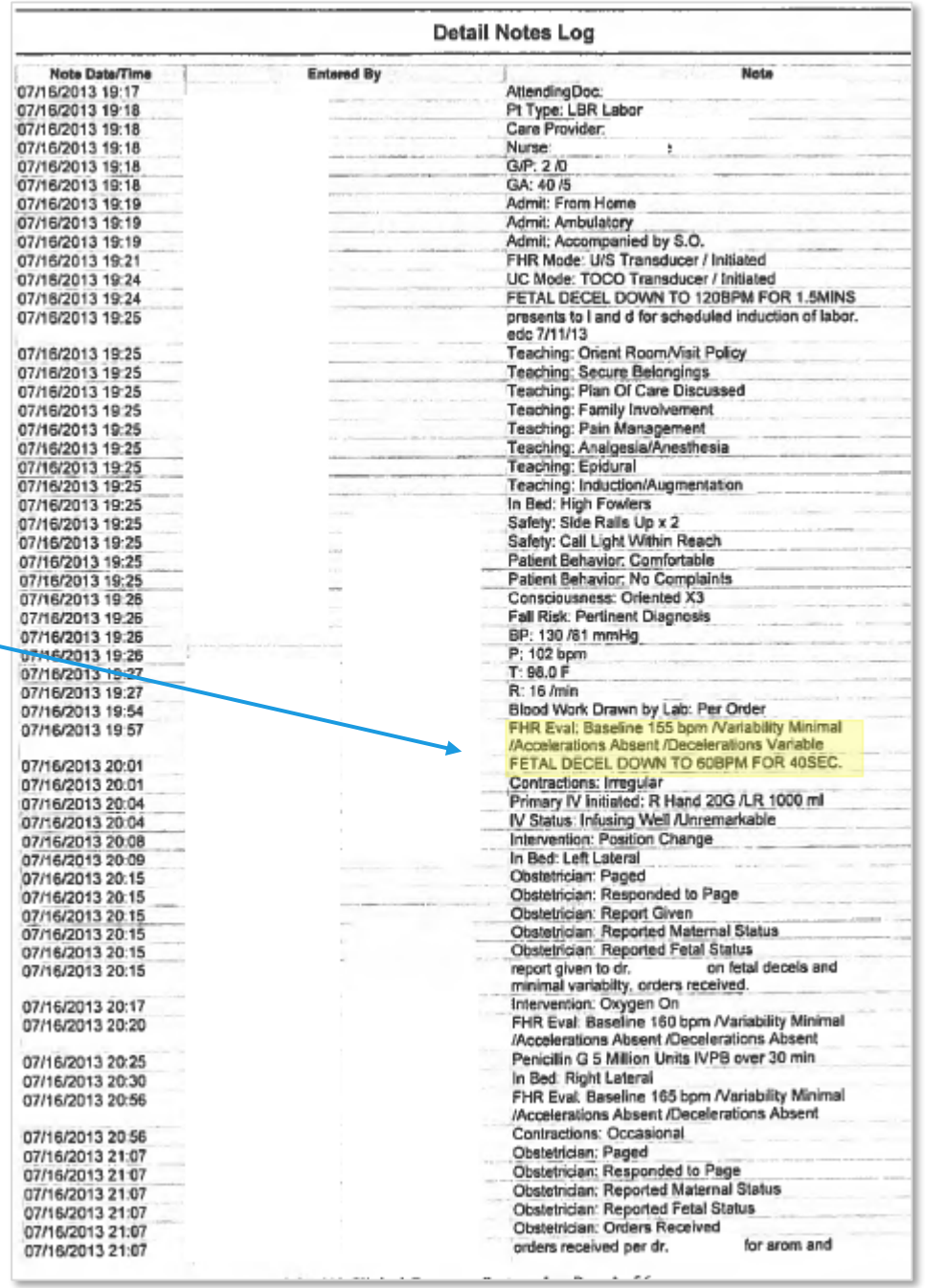
1957

FHR Eval: Baseline 155 bpm

Variability Minimal

Accelerations Absent

Decelerations Variable



Detail Notes Log

Note Date/Time	Entered By	Note
07/16/2013 19:17		AttendingDoc:
07/16/2013 19:18		Pt Type: LBR Labor
07/16/2013 19:18		Care Provider:
07/16/2013 19:18		Nurse:
07/16/2013 19:18		G/P: 2 /0
07/16/2013 19:18		GA: 40 /5
07/16/2013 19:19		Admit: From Home
07/16/2013 19:19		Admit: Ambulatory
07/16/2013 19:19		Admit: Accompanied by S.O.
07/16/2013 19:21		FHR Mode: U/S Transducer / Initiated
07/16/2013 19:24		UC Mode: TOCO Transducer / Initiated
07/16/2013 19:24		FETAL DECEL DOWN TO 120BPM FOR 1.5MINS
07/16/2013 19:25		presents to l and d for scheduled induction of labor. edc 7/11/13
07/16/2013 19:25		Teaching: Orient Room/Visit Policy
07/16/2013 19:25		Teaching: Secure Belongings
07/16/2013 19:25		Teaching: Plan Of Care Discussed
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07/16/2013 19:25		Teaching: Induction/Augmentation
07/16/2013 19:25		In Bed: High Fowlers
07/16/2013 19:25		Safety: Side Rails Up x 2
07/16/2013 19:25		Safety: Call Light Within Reach
07/16/2013 19:25		Patient Behavior: Comfortable
07/16/2013 19:25		Patient Behavior: No Complaints
07/16/2013 19:26		Consciousness: Oriented X3
07/16/2013 19:26		Fall Risk: Pertinent Diagnosis
07/16/2013 19:26		BP: 130 /81 mmHg
07/16/2013 19:26		P: 102 bpm
07/16/2013 19:27		T: 98.0 F
07/16/2013 19:27		R: 16 /min
07/16/2013 19:54		Blood Work Drawn by Lab: Per Order
07/16/2013 19:57		FHR Eval: Baseline 155 bpm /Variability Minimal /Accelerations Absent /Decelerations Variable
07/16/2013 20:01		FETAL DECEL DOWN TO 60BPM FOR 40SEC.
07/16/2013 20:01		Contractions: Irregular
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07/16/2013 20:09		In Bed: Left Lateral
07/16/2013 20:15		Obstetrician: Paged
07/16/2013 20:15		Obstetrician: Responded to Page
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2015

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Obstetrician: Responded to Page

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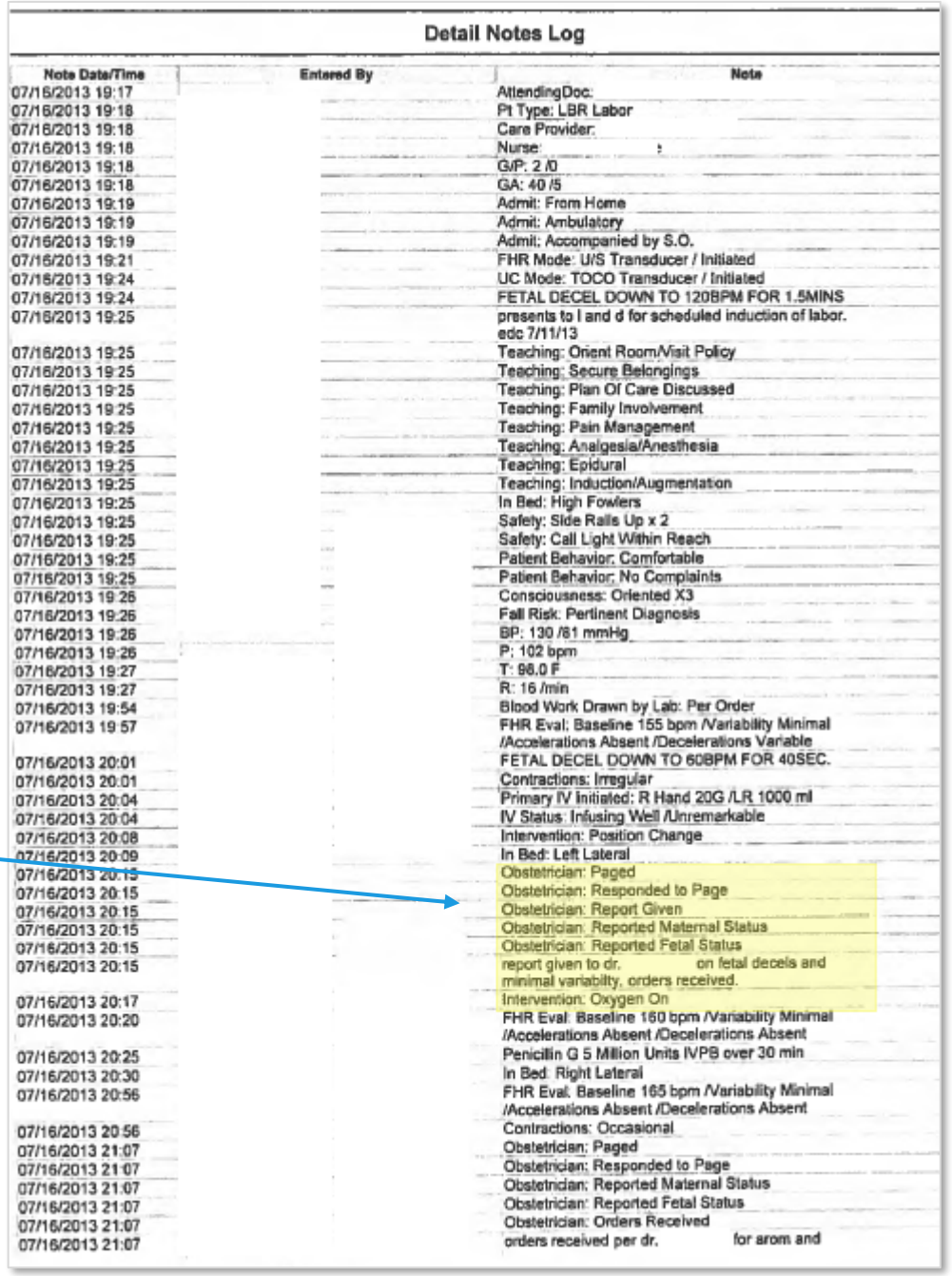
report given to Dr. on fetal decels and minimal variability.

Orders received.

Intervention: Oxygen On



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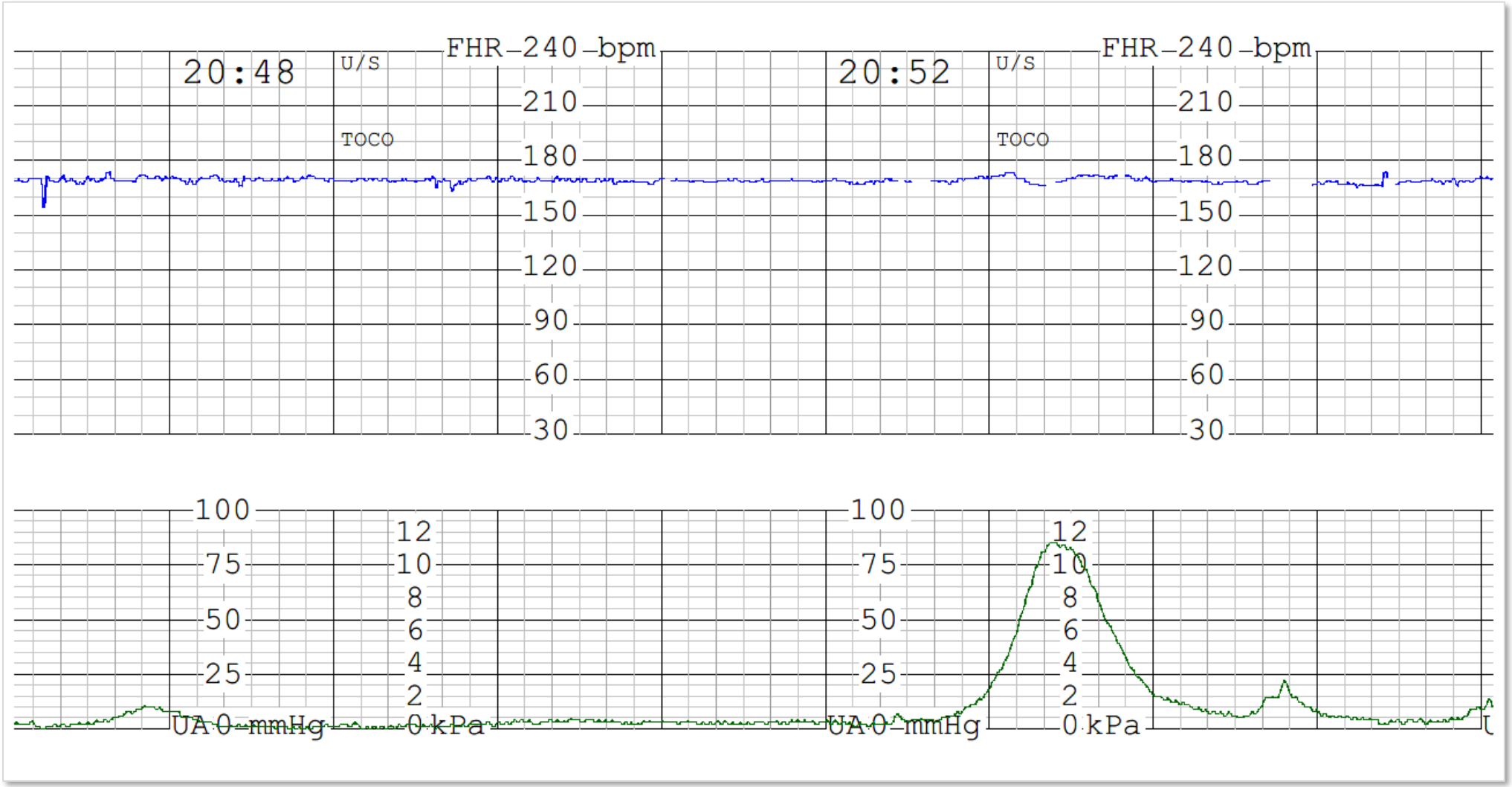
2047 - 2055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TOCO
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2107

Obstetrician: Paged

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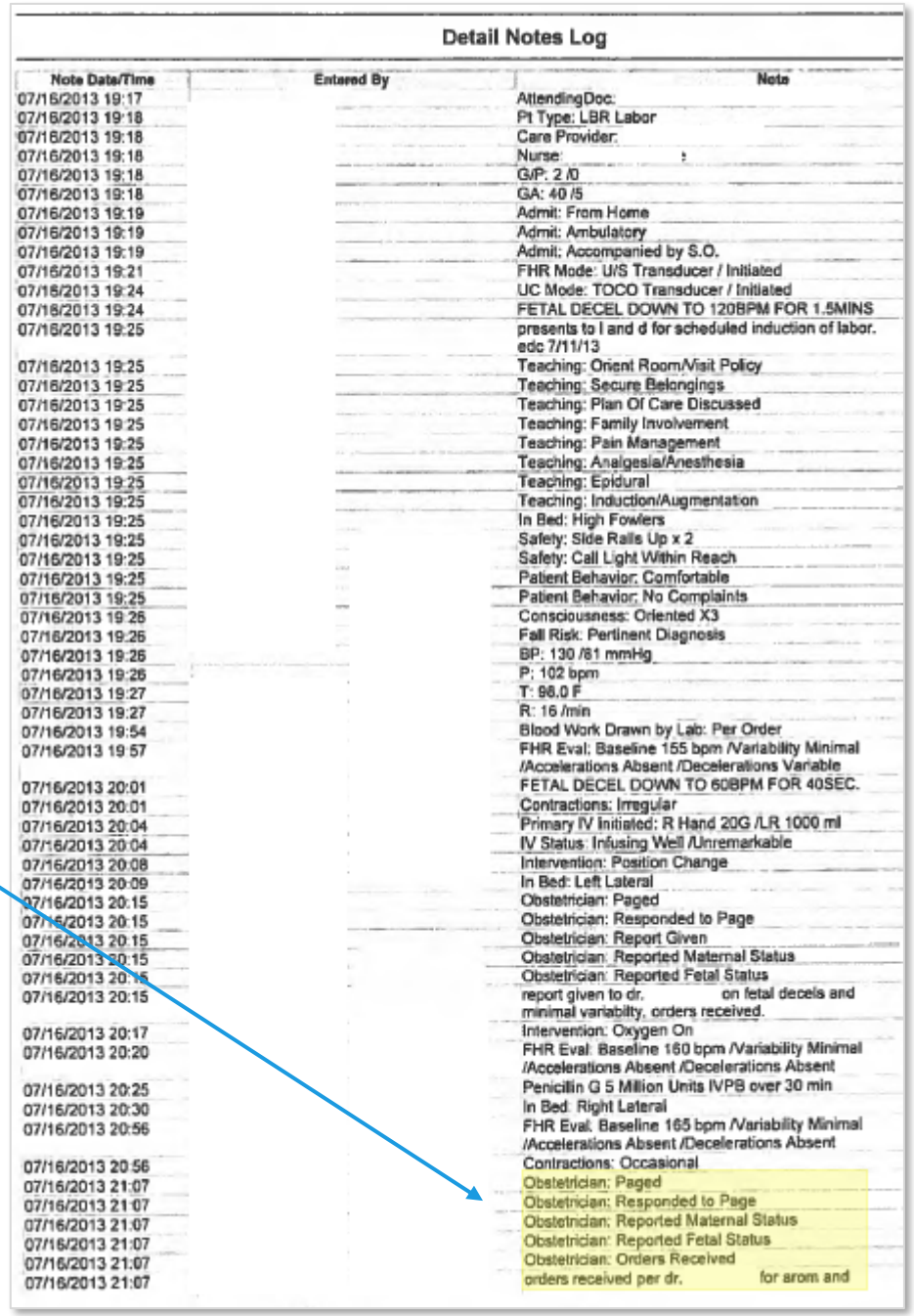
Obstetrician: Orders Received

Orders received per Dr. for AROM and internalize



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07/16/2013 21:07		orders received per dr. for arom and

2122 - 2143

2122

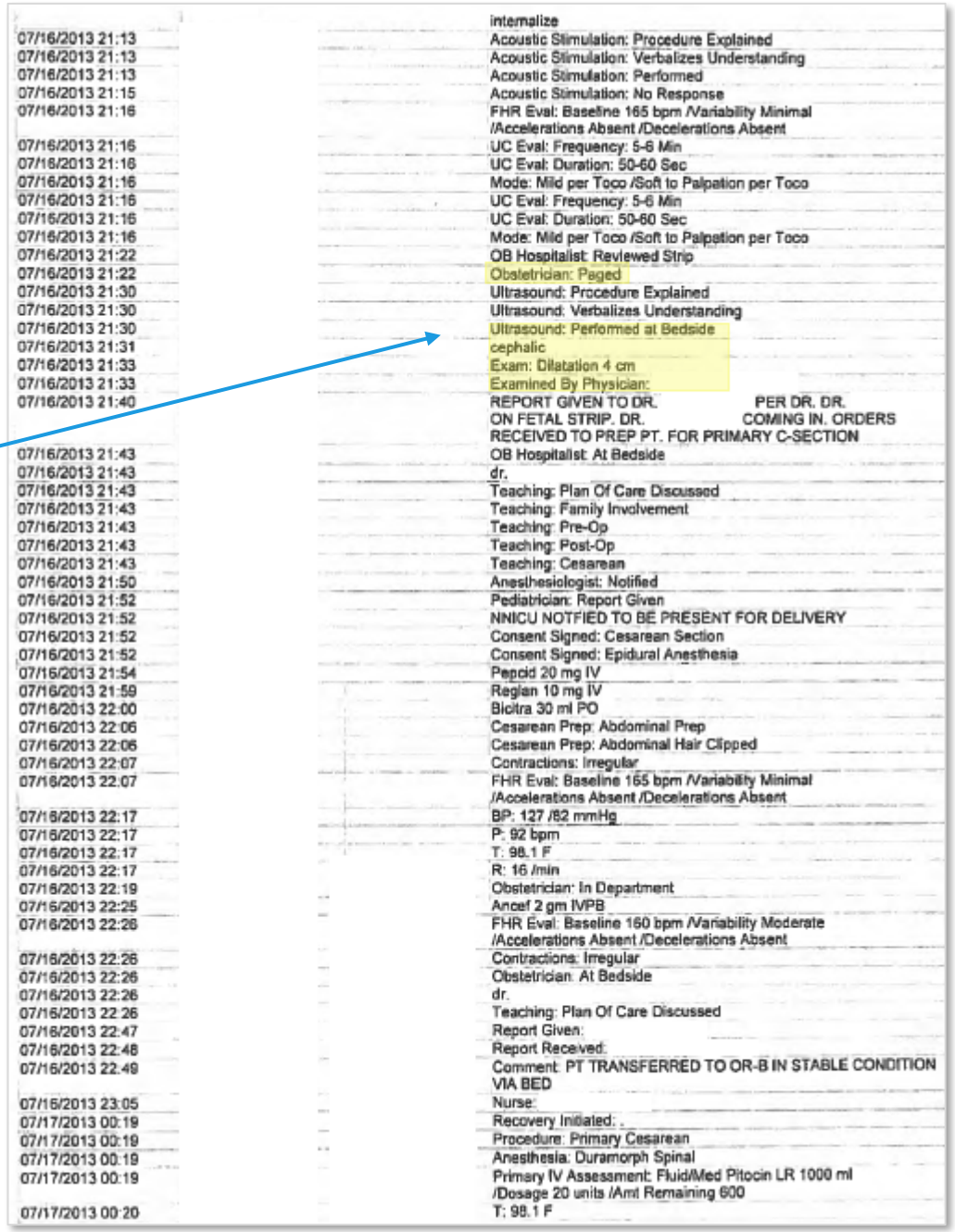
Obstetrician: Paged

2130

Ultrasound: Performed at bedside

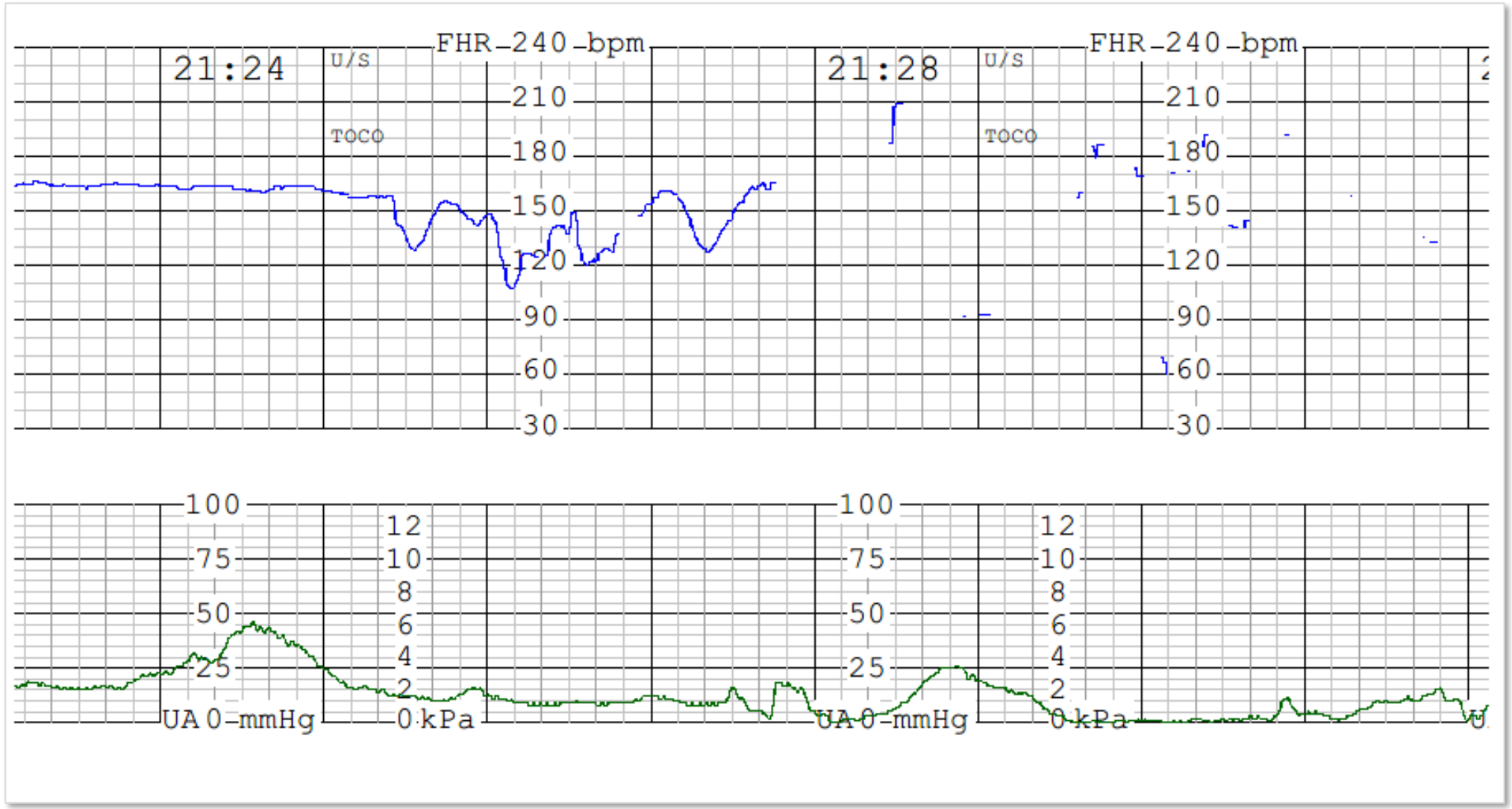
Exam: Dilation 4 cm

Examined By Physician:



	internalize
07/16/2013 21:13	Acoustic Stimulation: Procedure Explained
07/16/2013 21:13	Acoustic Stimulation: Verbalizes Understanding
07/16/2013 21:13	Acoustic Stimulation: Performed
07/16/2013 21:15	Acoustic Stimulation: No Response
07/16/2013 21:16	FHR Eval: Baseline 165 bpm /Variability Minimal /Accelerations Absent /Decelerations Absent
07/16/2013 21:16	UC Eval: Frequency: 5-6 Min
07/16/2013 21:16	UC Eval: Duration: 50-60 Sec
07/16/2013 21:16	Mode: Mild per Toco /Soft to Palpation per Toco
07/16/2013 21:16	UC Eval: Frequency: 5-6 Min
07/16/2013 21:16	UC Eval: Duration: 50-60 Sec
07/16/2013 21:16	Mode: Mild per Toco /Soft to Palpation per Toco
07/16/2013 21:22	OB Hospitalist: Reviewed Strip
07/16/2013 21:22	Obstetrician: Paged
07/16/2013 21:30	Ultrasound: Procedure Explained
07/16/2013 21:30	Ultrasound: Verbalizes Understanding
07/16/2013 21:30	Ultrasound: Performed at Bedside
07/16/2013 21:31	cephalic
07/16/2013 21:33	Exam: Dilatation 4 cm
07/16/2013 21:33	Examined By Physician:
07/16/2013 21:40	REPORT GIVEN TO DR. PER DR. DR. ON FETAL STRIP. DR. COMING IN. ORDERS RECEIVED TO PREP PT. FOR PRIMARY C-SECTION
07/16/2013 21:43	OB Hospitalist: At Bedside
07/16/2013 21:43	dr.
07/16/2013 21:43	Teaching: Plan Of Care Discussed
07/16/2013 21:43	Teaching: Family Involvement
07/16/2013 21:43	Teaching: Pre-Op
07/16/2013 21:43	Teaching: Post-Op
07/16/2013 21:43	Teaching: Cesarean
07/16/2013 21:50	Anesthesiologist: Notified
07/16/2013 21:52	Pediatrician: Report Given
07/16/2013 21:52	NNICU NOTFIED TO BE PRESENT FOR DELIVERY
07/16/2013 21:52	Consent Signed: Cesarean Section
07/16/2013 21:52	Consent Signed: Epidural Anesthesia
07/16/2013 21:54	Pepcid 20 mg IV
07/16/2013 21:59	Reglan 10 mg IV
07/16/2013 22:00	Bicitra 30 ml PO
07/16/2013 22:06	Cesarean Prep: Abdominal Prep
07/16/2013 22:06	Cesarean Prep: Abdominal Hair Clipped
07/16/2013 22:07	Contractions: Irregular
07/16/2013 22:07	FHR Eval: Baseline 165 bpm /Variability Minimal /Accelerations Absent /Decelerations Absent
07/16/2013 22:17	BP: 127 /82 mmHg
07/16/2013 22:17	P: 92 bpm
07/16/2013 22:17	T: 98.1 F
07/16/2013 22:17	R: 16 /min
07/16/2013 22:19	Obstetrician: In Department
07/16/2013 22:25	Ancef 2 gm IVPB
07/16/2013 22:26	FHR Eval: Baseline 160 bpm /Variability Moderate /Accelerations Absent /Decelerations Absent
07/16/2013 22:26	Contractions: Irregular
07/16/2013 22:26	Obstetrician: At Bedside
07/16/2013 22:26	dr.
07/16/2013 22:26	Teaching: Plan Of Care Discussed
07/16/2013 22:47	Report Given:
07/16/2013 22:48	Report Received:
07/16/2013 22:49	Comment: PT TRANSFERRED TO OR-B IN STABLE CONDITION VIA BED
07/16/2013 23:05	Nurse:
07/17/2013 00:19	Recovery Initiated: .
07/17/2013 00:19	Procedure: Primary Cesarean
07/17/2013 00:19	Anesthesia: Duramorph Spinal
07/17/2013 00:19	Primary IV Assessment: Fluid/Med Pitocin LR 1000 ml /Dosage 20 units /Amt Remaining 600
07/17/2013 00:20	T: 98.1 F

2123 - 2131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UA
0
mmHg
12
10
8
6
4
2
0
kPa
100
75
50
25
UA
0
mmHg
12
10
8
6
4
2
0
kPa

2140

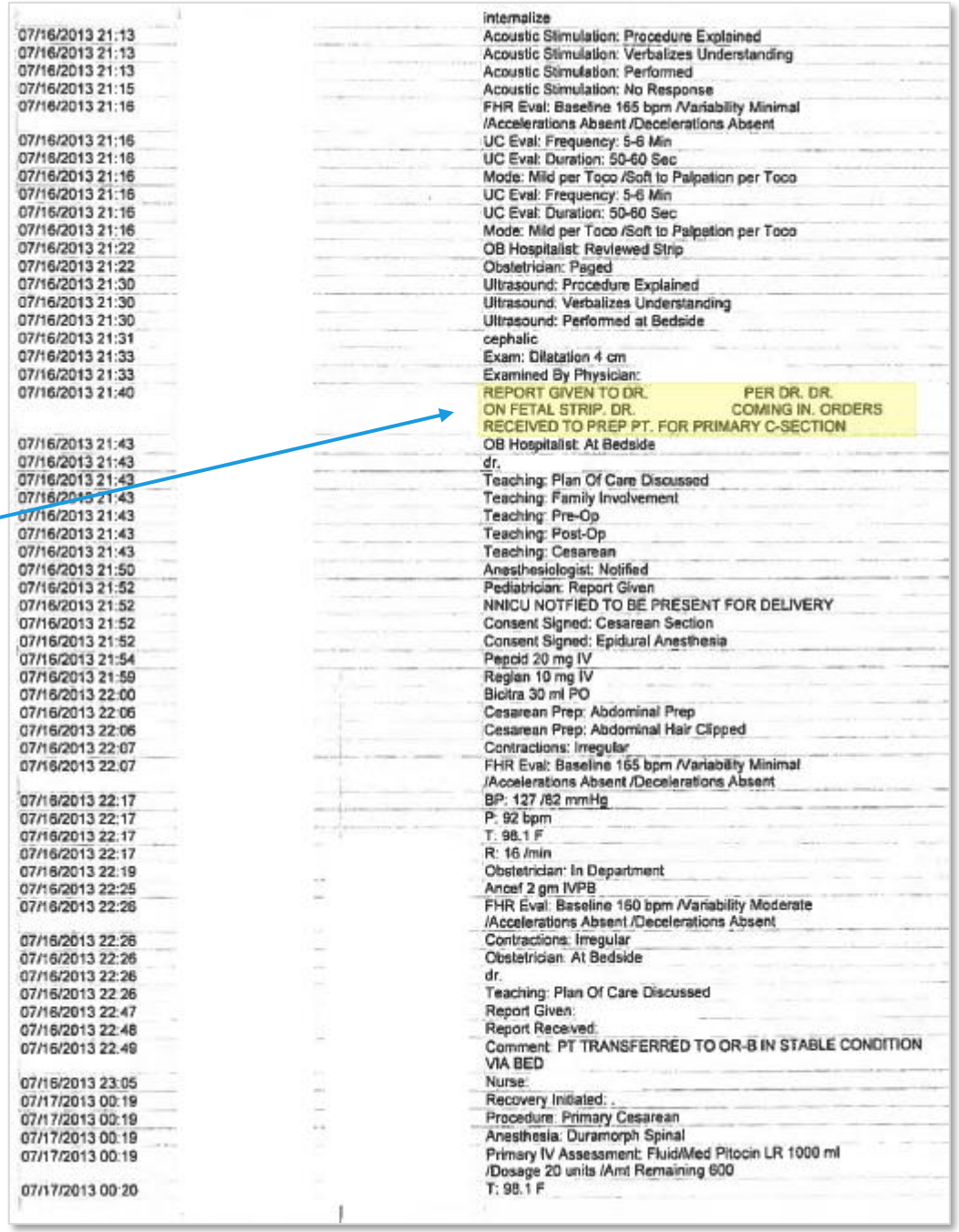
REPORT GIVEN TO DR. PER DR. ON

FETAL STRIP.

DR. COMING IN.

ORDERS RECEIVED TO PREP PT. FOR

PRIMARY C-SECTION



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07/16/2013 21:13	Acoustic Stimulation: Procedure Explained
07/16/2013 21:13	Acoustic Stimulation: Verbalizes Understanding
07/16/2013 21:13	Acoustic Stimulation: Performed
07/16/2013 21:15	Acoustic Stimulation: No Response
07/16/2013 21:16	FHR Eval: Baseline 165 bpm /Variability Minimal /Accelerations Absent /Decelerations Absent
07/16/2013 21:16	UC Eval: Frequency: 5-6 Min
07/16/2013 21:16	UC Eval: Duration: 50-60 Sec
07/16/2013 21:16	Mode: Mild per Toco /Soft to Palpation per Toco
07/16/2013 21:16	UC Eval: Frequency: 5-6 Min
07/16/2013 21:16	UC Eval: Duration: 50-60 Sec
07/16/2013 21:16	Mode: Mild per Toco /Soft to Palpation per Toco
07/16/2013 21:22	OB Hospitalist: Reviewed Strip
07/16/2013 21:22	Obstetrician: Paged
07/16/2013 21:30	Ultrasound: Procedure Explained
07/16/2013 21:30	Ultrasound: Verbalizes Understanding
07/16/2013 21:30	Ultrasound: Performed at Bedside
07/16/2013 21:31	cephalic
07/16/2013 21:33	Exam: Dilatation 4 cm
07/16/2013 21:33	Examined By Physician:
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07/17/2013 00:19	Anesthesia: Duramorph Spinal
07/17/2013 00:19	Primary IV Assessment: Fluid/Med Pitocin LR 1000 ml /Dosage 20 units /Amt Remaining 600
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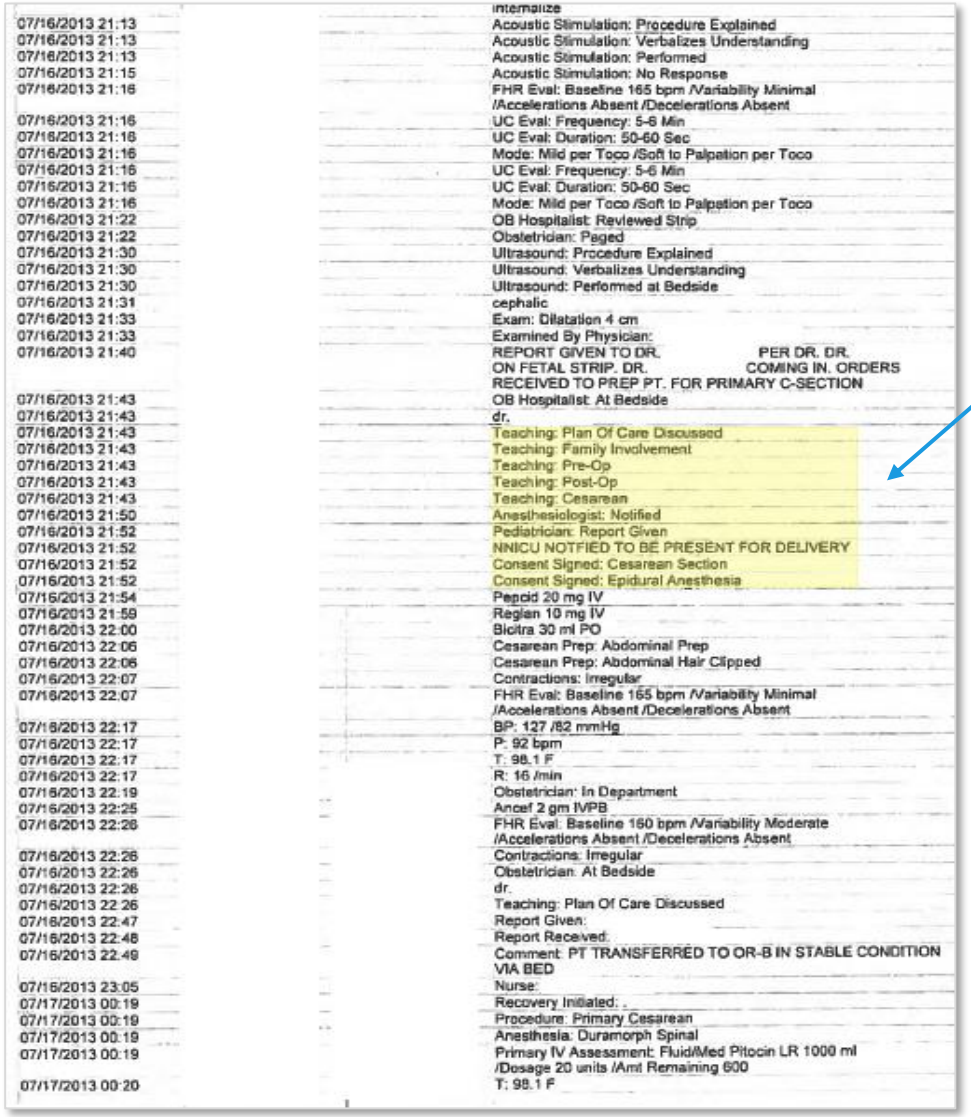
2143 - 2217



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07/17/2013 00:20	T: 98.1 F

2143

Teaching: Plan Of Care Discussed

Teaching: Family Involvement

Teaching: Pre-Op

Teaching: Post-Op

Teaching: Cesarean

2150

Anesthesiologist: Notified

2152

Pediatrician: Report Given

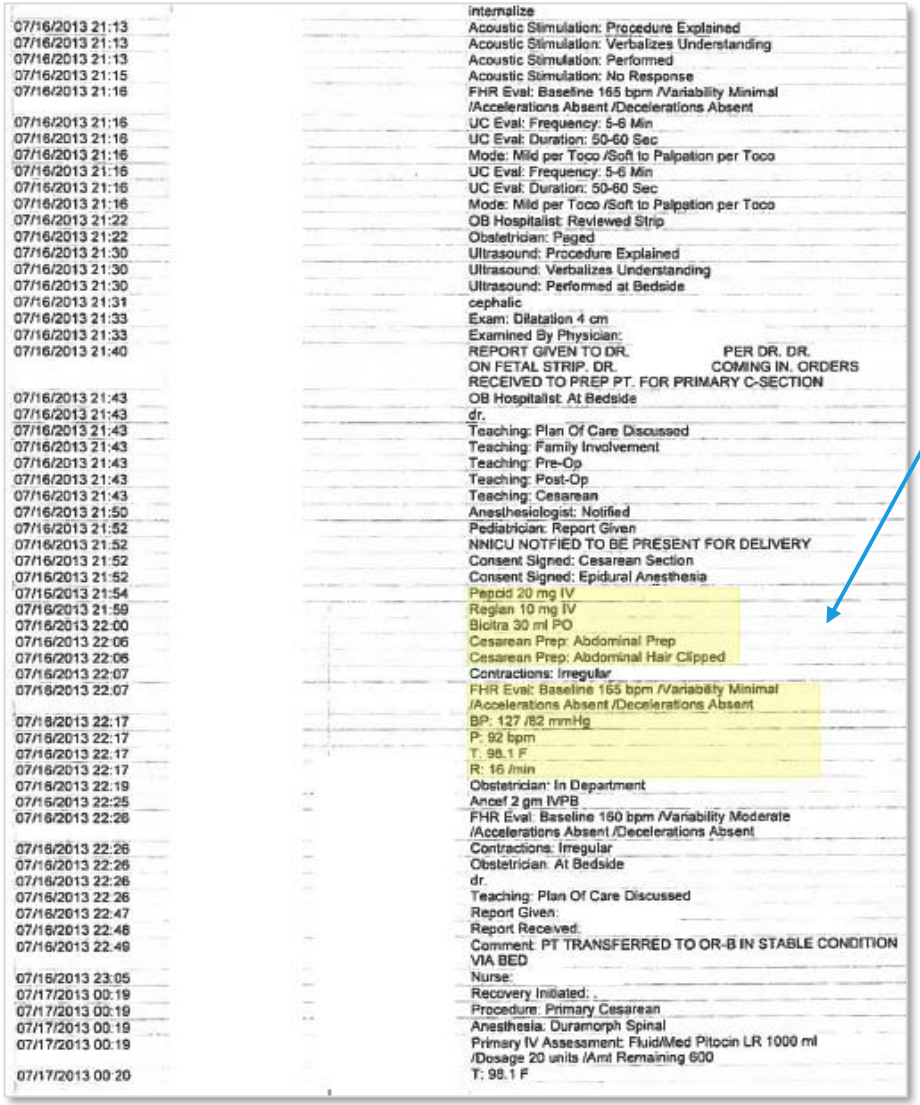
NNICU NOTIFIED TO BE PRESENT

FOR DELIVERY

Consent Signed: Cesarean Section

Consent Signed: Epidural Anesthesia

2143 - 2217



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07/16/2013 22:17	R: 16 /min
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07/16/2013 22:26	FHR Eval: Baseline 160 bpm /Variability Moderate /Accelerations Absent /Decelerations Absent
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07/16/2013 22:47	Report Given:
07/16/2013 22:48	Report Received:
07/16/2013 22:49	Comment: PT TRANSFERRED TO OR-B IN STABLE CONDITION VIA BED
07/16/2013 23:05	Nurse:
07/17/2013 00:19	Recovery Initiated:
07/17/2013 00:19	Procedure: Primary Cesarean
07/17/2013 00:19	Anesthesia: Duramorph Spinal
07/17/2013 00:19	Primary IV Assessment: Fluid/Med Pitocin LR 1000 ml /Dosage 20 units /Amt Remaining 600
07/17/2013 00:20	T: 98.1 F

21:54 Pepcid 20 mg IV

21:59 Reglan 10 mg IV

22:00 Bicitra 30 ml PO

22:06 Cesarean Prep: Abdominal Prep

22:07

FHR Eval: Baseline 165 bpm

Variability Minimal

Accelerations Absent /Decelerations

Absent

22:17

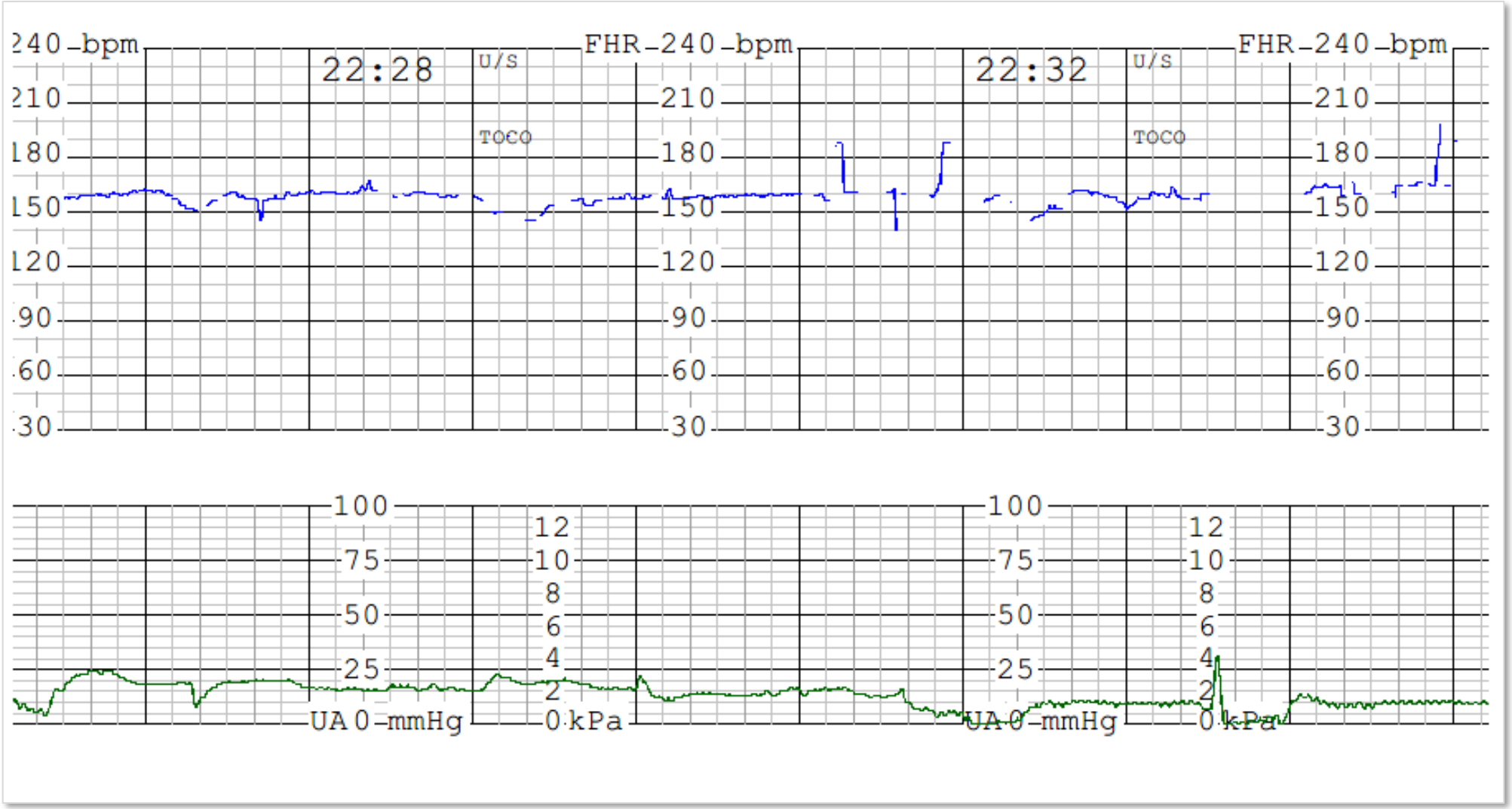
BP: 127 /82 mmHg

P: 92 bpm

T: 98.1 F

R: 16 /min

2226 - 2234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0 kPa
100
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4
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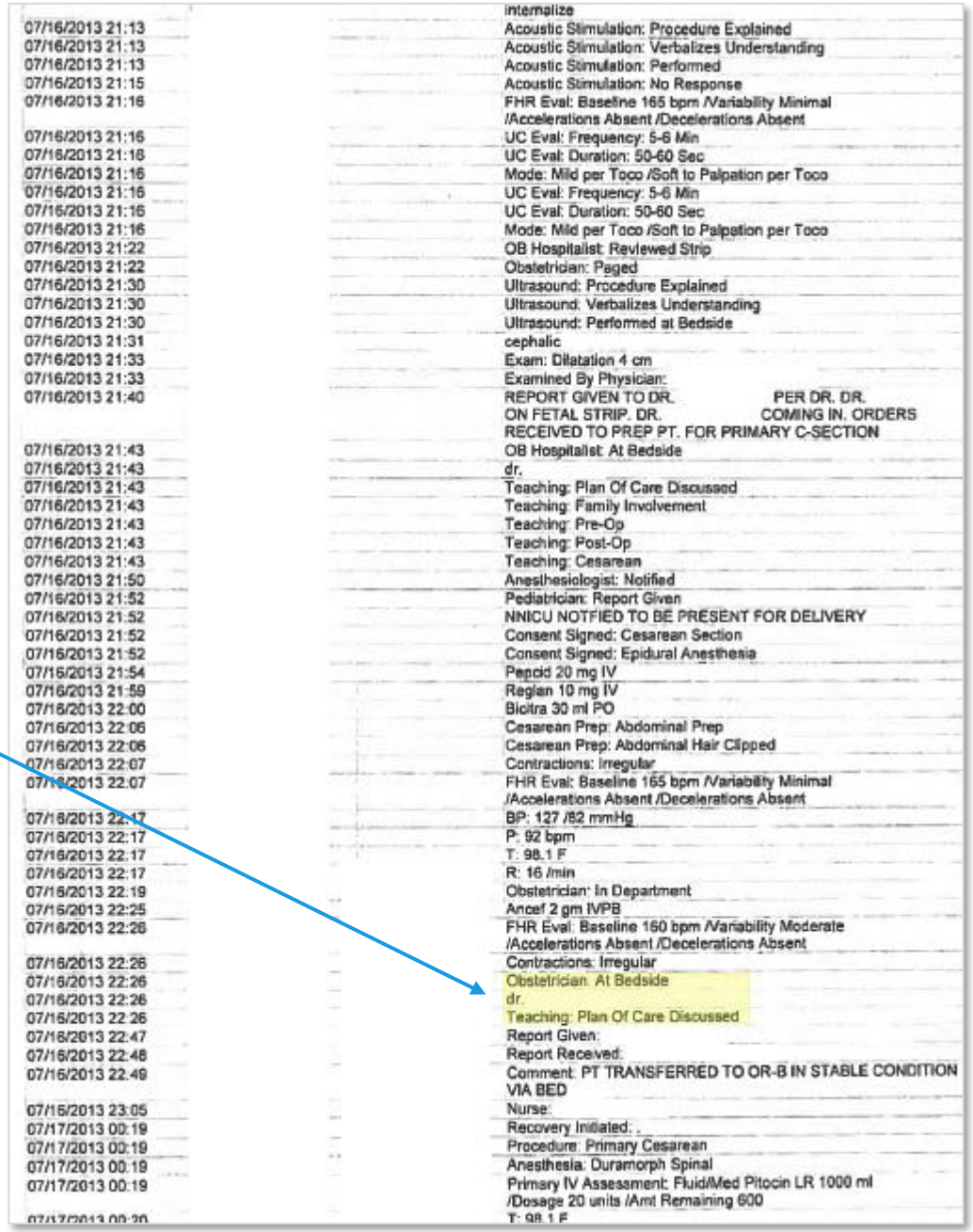
0 kPa

2226

Obstetrician: At Bedside

Teaching: Plan Of Care Discussed



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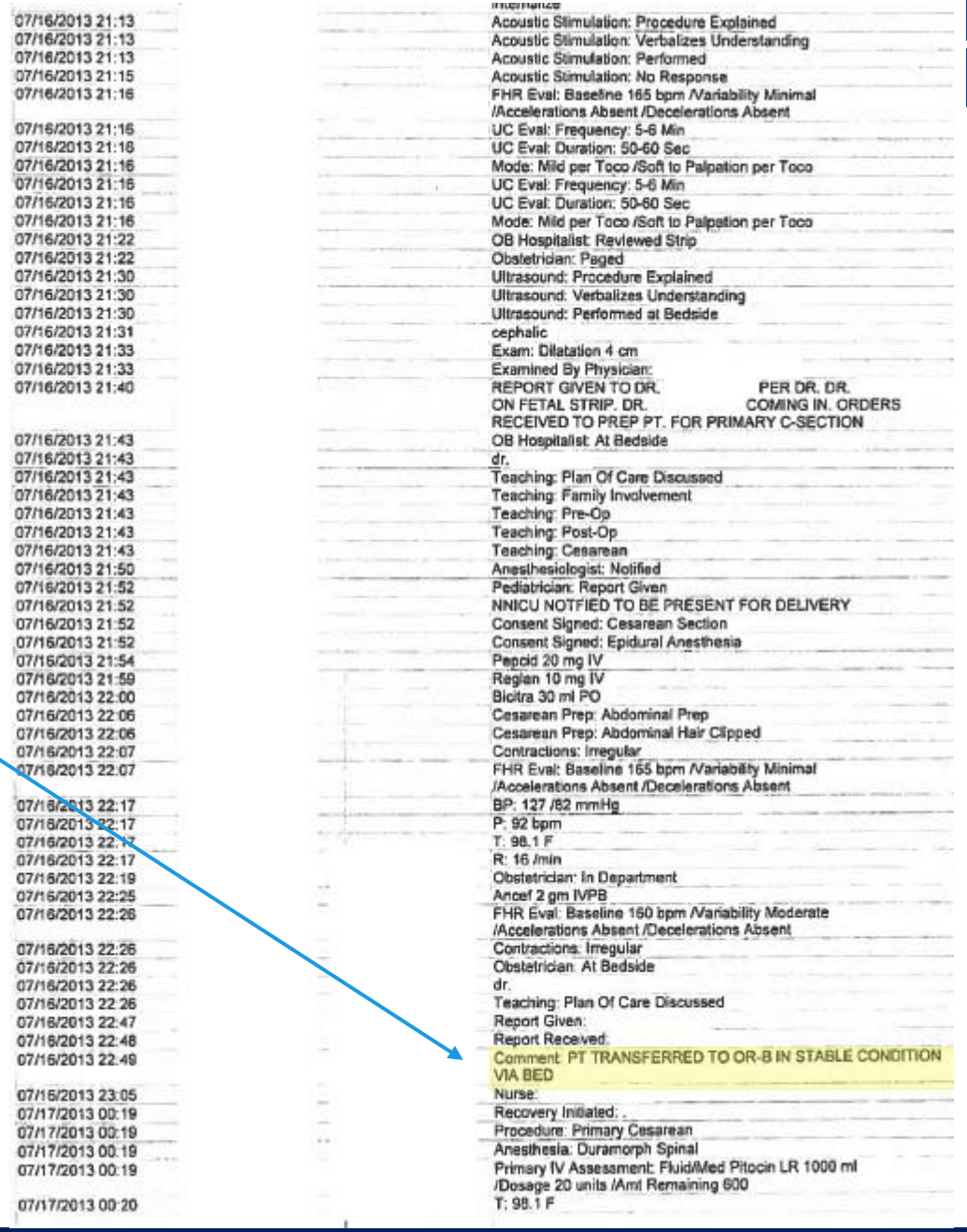
2249

Comment: PT TRANSFERRED TO OR-B IN STABLE CONDITION VIA BED



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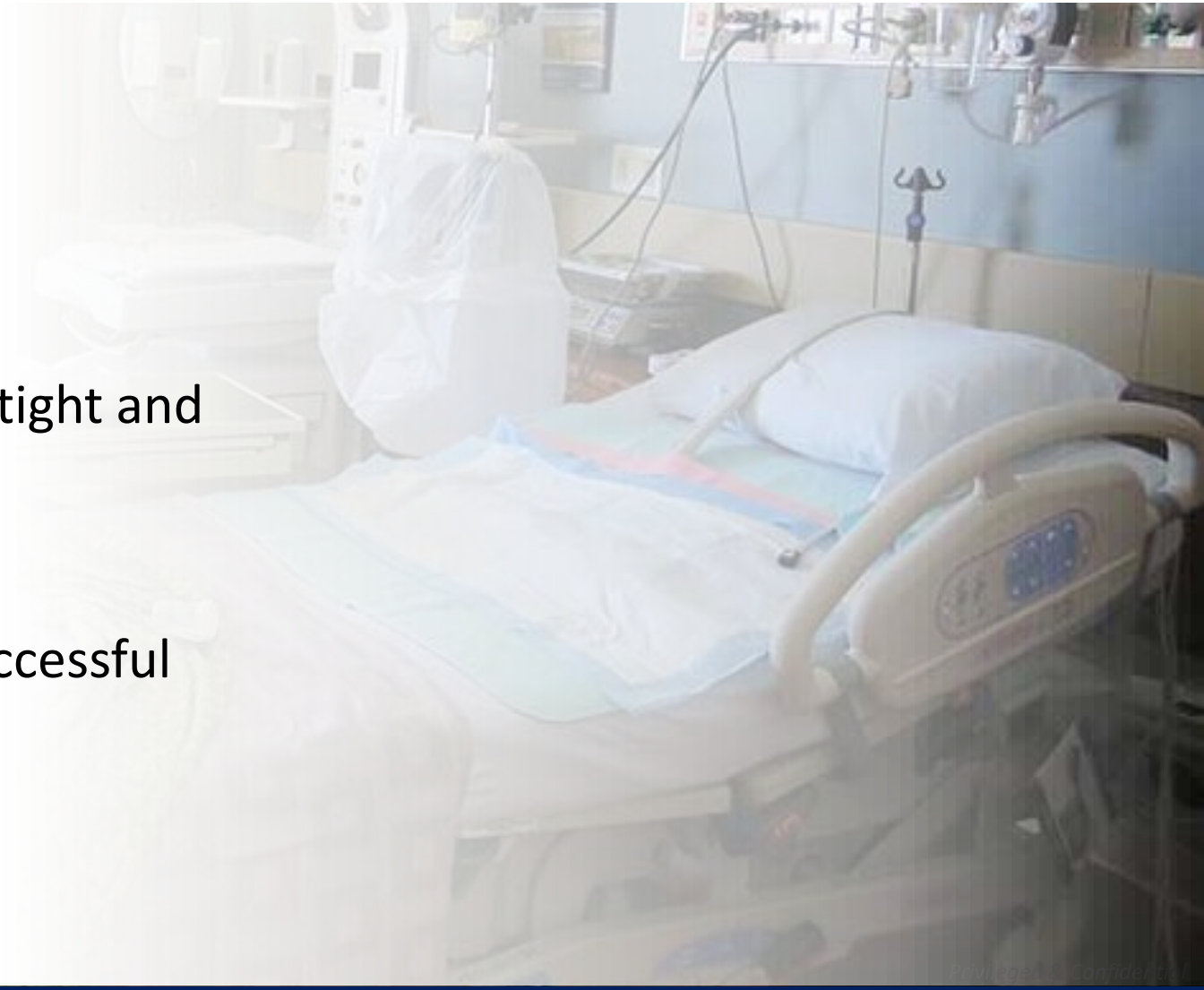
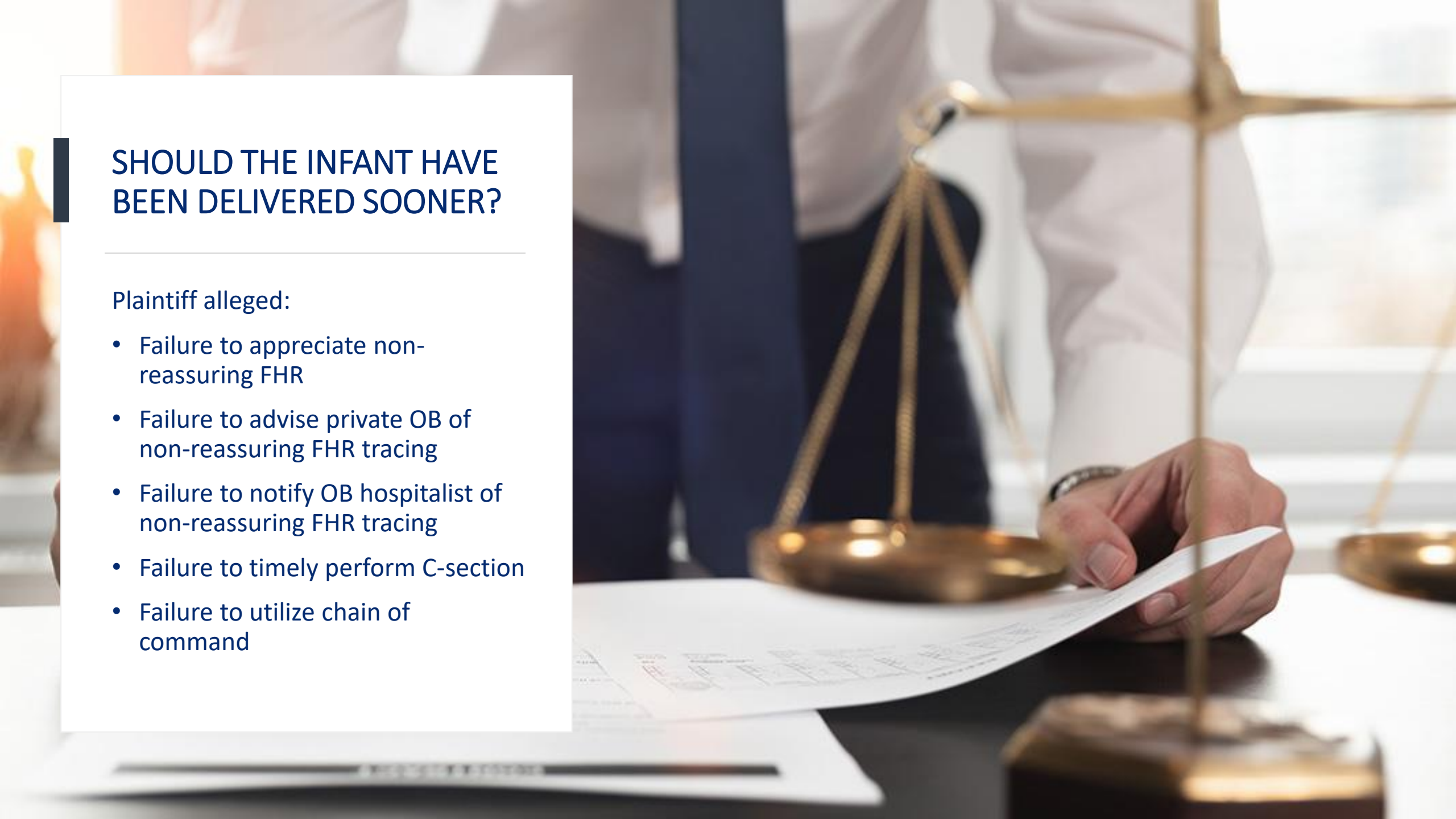
07/16/2013 22:47	Report Given:
07/16/2013 22:48	Report Received:
07/16/2013 22:49	Comment: PT TRANSFERRED TO OR-B IN STABLE CONDITION VIA BED
07/16/2013 23:05	Nurse:
07/17/2013 00:19	Recovery Initiated: .
07/17/2013 00:19	Procedure: Primary Cesarean
07/17/2013 00:19	Anesthesia: Duramorph Spinal
07/17/2013 00:19	Primary IV Assessment: Fluid/Med Pitocin LR 1000 ml /Dosage 20 units /Amt Remaining 600
07/17/2013 00:20	T: 98.1 F

FACTS OF THE CASE

- Incision at 2312
- Infant delivered at 2324
- Infant noted to have nuchal cord x3 tight and body cord
- Apgars 1,0,0, and 0
- Extensive resuscitation done – unsuccessful
- Infant pronounced





SHOULD THE INFANT HAVE BEEN DELIVERED SOONER?

Plaintiff alleged:

- Failure to appreciate non-reassuring FHR
- Failure to advise private OB of non-reassuring FHR tracing
- Failure to notify OB hospitalist of non-reassuring FHR tracing
- Failure to timely perform C-section
- Failure to utilize chain of command

WHAT WAS THE DECISION TO INCISION INTERVAL?

- Was the decision made at 2226 when private OB arrived at hospital and evaluated patient?
- Skin incision at 2312 means a 46-minute interval
- Evidence to support this:
  - Private OB recalled that she told nurse during the 2140 conversation that she would evaluate the patient upon arrival
  - Nurse recalled the same about the telephone conversation
  - Tracing remained Category II and was stable
  - Discussion of “plan of care” at 2226 prompted signing the C-section consent

- Was the decision made at 2140 when the OB hospitalist spoke to the private OB?
- Skin incision at 2312 means a 92-minute interval.
- Evidence to support this:
  - 2140 nursing note that patient was to be prepared for C-section
  - Immediate preparation of patient thereafter
  - FHR was “non-reassuring” per Op Report and Anesthesia Record
  - OB took patient to OR very shortly after arrival to hospital
  - Nurse’s documentation of interval!

FACTS OF THE CASE

DATE OF PROCEDURE:
07/16/2013

PREOPERATIVE DIAGNOSIS(ES):
1. Term intrauterine pregnancy at 40 weeks and 5 days gestational age.
2. Nonreassuring fetal heart tones.

POSTOPERATIVE DIAGNOSIS(ES):
1. Term intrauterine pregnancy at 40 weeks and 5 days gestational age.
2. Nonreassuring fetal heart tones.
3. Face presentation, mentum transverse, maternal right
4. Nuchal cord x3, tight.
5. Body cord x1.

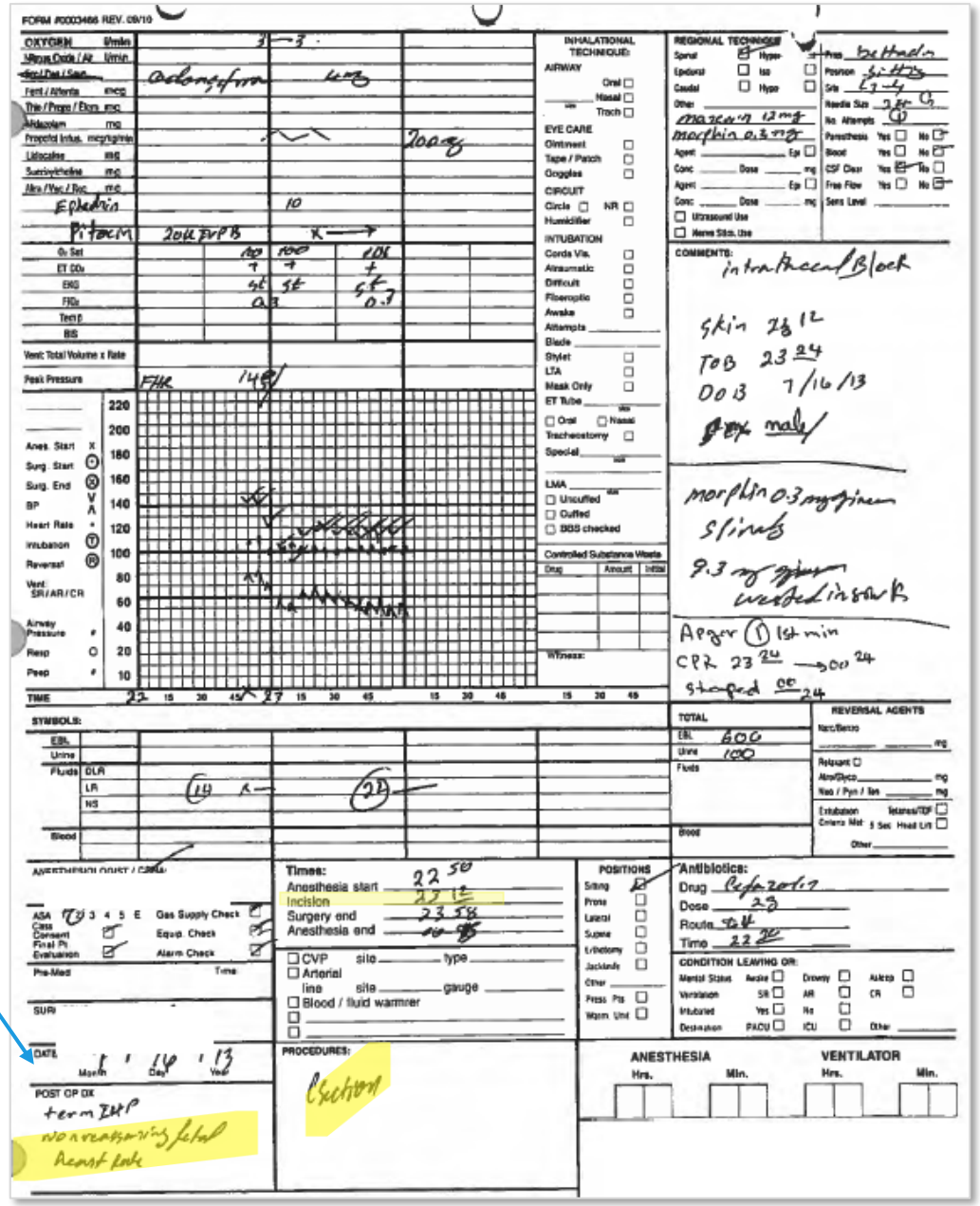
PROCEDURE(S):
Primary low transverse cesarean section via Pfannenstiel skin incision.

FACTS OF THE CASE

INDICATIONS:
The patient is a 30-year-old G2, P0-0-1-0 who presented to labor and delivery at 40 week and 5 days based on a first trimester ultrasound, for induction. When the patient was placed on the monitor, fetal heart tones demonstrated minimal variability as well as variable decelerations. Despite resuscitative efforts, fetal tracing remained Category II.
No accelerations were noted despite vibroacoustic stimulation or scalp stimulation. When in attempt to artificially rupture the patient's membranes and place internal monitors, the fetal head was noted to be ballottable and AROM was not performed. In light of the patient being remote from delivery, the decision was made to proceed with a primary low transverse cesarean section.

ANESTHESIA RECORD

C-section
non-reassuring
fetal heart rate

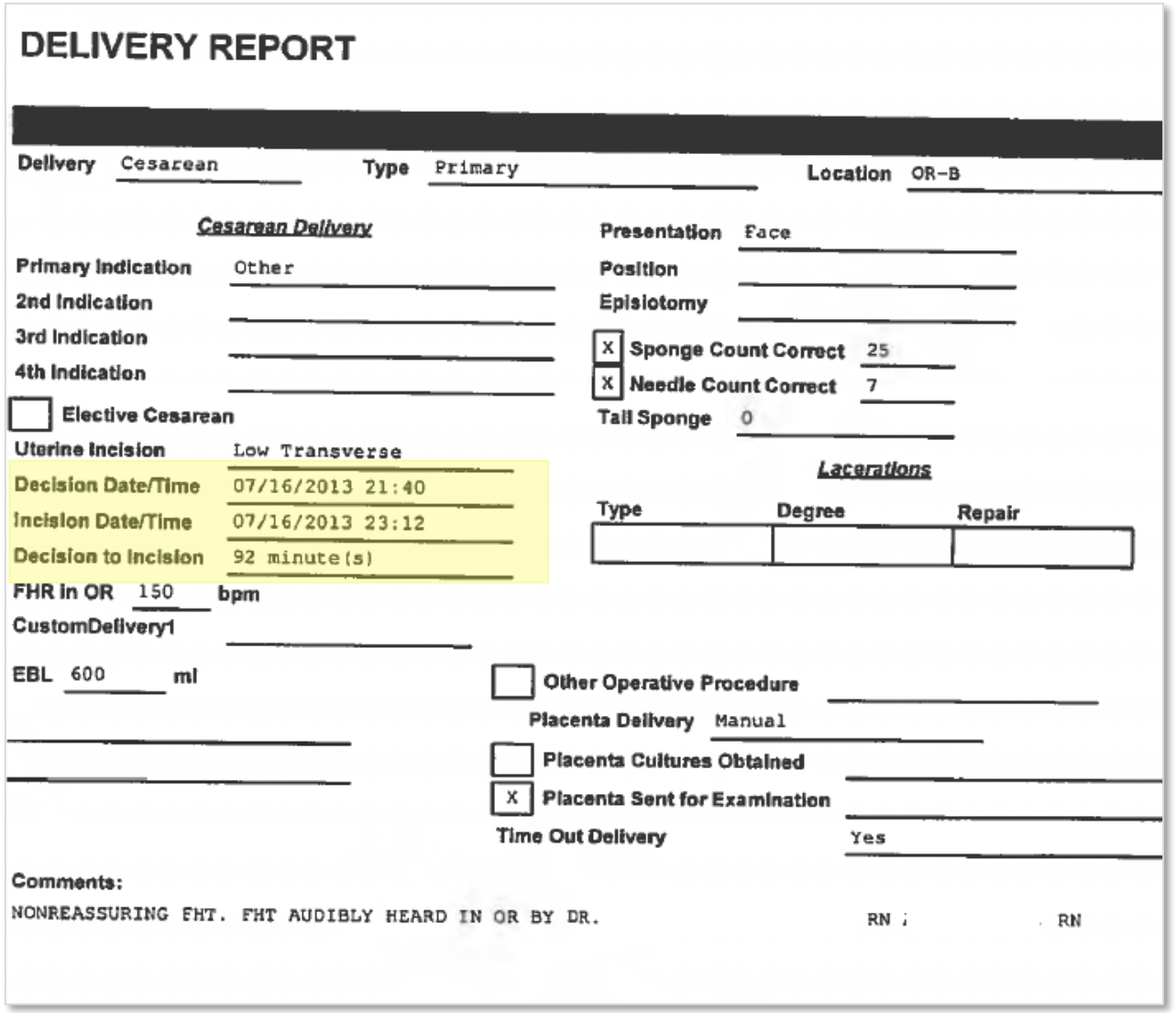


2251

Decision Time: 2140

Incision time: 2312

Decision to Incision: 92 min



DELIVERY REPORT

Delivery Cesarean Type Primary Location OR-B

Cesarean Delivery

Primary Indication Other
2nd Indication
3rd Indication
4th Indication
[ ] Elective Cesarean
Uterine Incision Low Transverse
Decision Date/Time 07/16/2013 21:40
Incision Date/Time 07/16/2013 23:12
Decision to Incision 92 minute(s)
FHR in OR 150 bpm
CustomDelivery1

Presentation Face
Position
Episiotomy
[X] Sponge Count Correct 25
[X] Needle Count Correct 7
Tail Sponge 0

Lacerations

Type	Degree	Repair

EBL 600 ml

[ ] Other Operative Procedure
Placenta Delivery Manual
[ ] Placenta Cultures Obtained
[X] Placenta Sent for Examination
Time Out Delivery Yes

Comments:
NONREASSURING FHT. FHT AUDIBLY HEARD IN OR BY DR.

RN RN

ADMISSION TIMELINE OF EVENTS

21:40
- Drs discuss plan of care
- Dr. instructs nurse to prepare patient for possible C-section
- Dr. heads to hospital

21:43-22:17
- RN prepares patient for possible C-section
  - Notifies anesthesia and NICU
  - Obtains consent for C-section and anesthesia
  - Performs abdominal prep

22:07
- FHR Tracing
  - Baseline 160 bpm
  - Moderate variability
  - No decelerations

22:19
Dr. arrives on unit and reviews FHR Tracing

22:26
- Dr. at bedside and evaluates patient
- **Dr. orders C-section**

22:40
Pre-op verification by Nurse

22:47
Patient transferred to Operating Room

Dr. performs pre-anesthesia assessment

22:51
FHR: 150 BPM

23:00
FHR: 140s BPM

23:12
- Incision made
- Membranes ruptured and thick meconium noted
- Infant noted in face presentation with head flexed

23:24
- Infant delivered
  - Tight nuchal cord x3
  - Body cord x1
  - Umbilical cord stained with meconium
  - HR 90 → 0 in 4 minutes
  - Apgar's 1, 0, 0 at 1, 5 10 minutes
  - 59 minute resuscitation is performed and unsuccessful

21:45 22:00 22:15 22:30 22:45 23:00 20:15 20:30 20:45 00:00

FHR IN THE DELIVERY ROOM

FHR in OR 150 bpm

DELIVERY REPORT

[redacted]

Delivery Cesarean Type Primary Location OR-B

Cesarean Delivery

Primary Indication Other
2nd Indication
3rd Indication
4th Indication
☐ Elective Cesarean
Uterine Incision Low Transverse
Decision Date/Time 07/16/2013 21:40
Incision Date/Time 07/16/2013 23:12
Decision to Incision 92 minute(s)
FHR in OR 150 bpm
CustomDelivery1

Presentation Face
Position
Episiotomy
☒ Sponge Count Correct 25
☒ Needle Count Correct 7
Tail Sponge 0

Lacerations

Type	Degree	Repair

EBL 600 ml

☐ Other Operative Procedure
Placenta Delivery Manual
☐ Placenta Cultures Obtained
☒ Placenta Sent for Examination
Time Out Delivery Yes

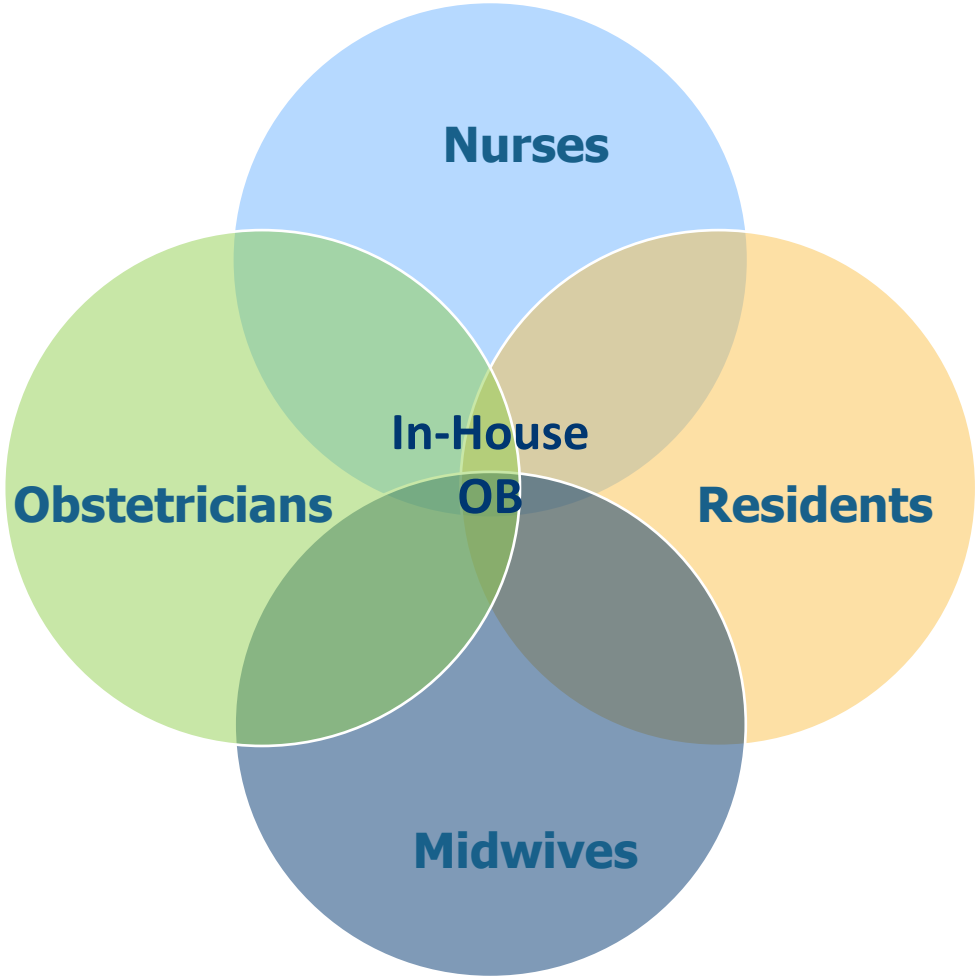
Comments:
NONREASSURING FHT. FHT AUDIBLY HEARD IN OR BY DR. RN ; RN

WHAT WAS THE JURY'S VERDICT?

DOCUMENTATION LESSONS

- Inadequate documentation of communications creates confusion
- Reconstruction of events years later is easier with clear documentation
- Independent recollection or custom and practice needs to fill the void
- Inaccurate documentation of times can complicate the defense
- Be careful how you label the C-section that is done
  - “Primary” C-section
  - “Urgent” C-section
  - “Emergent” C-section
  - “C-section for non-reassuring FHR”

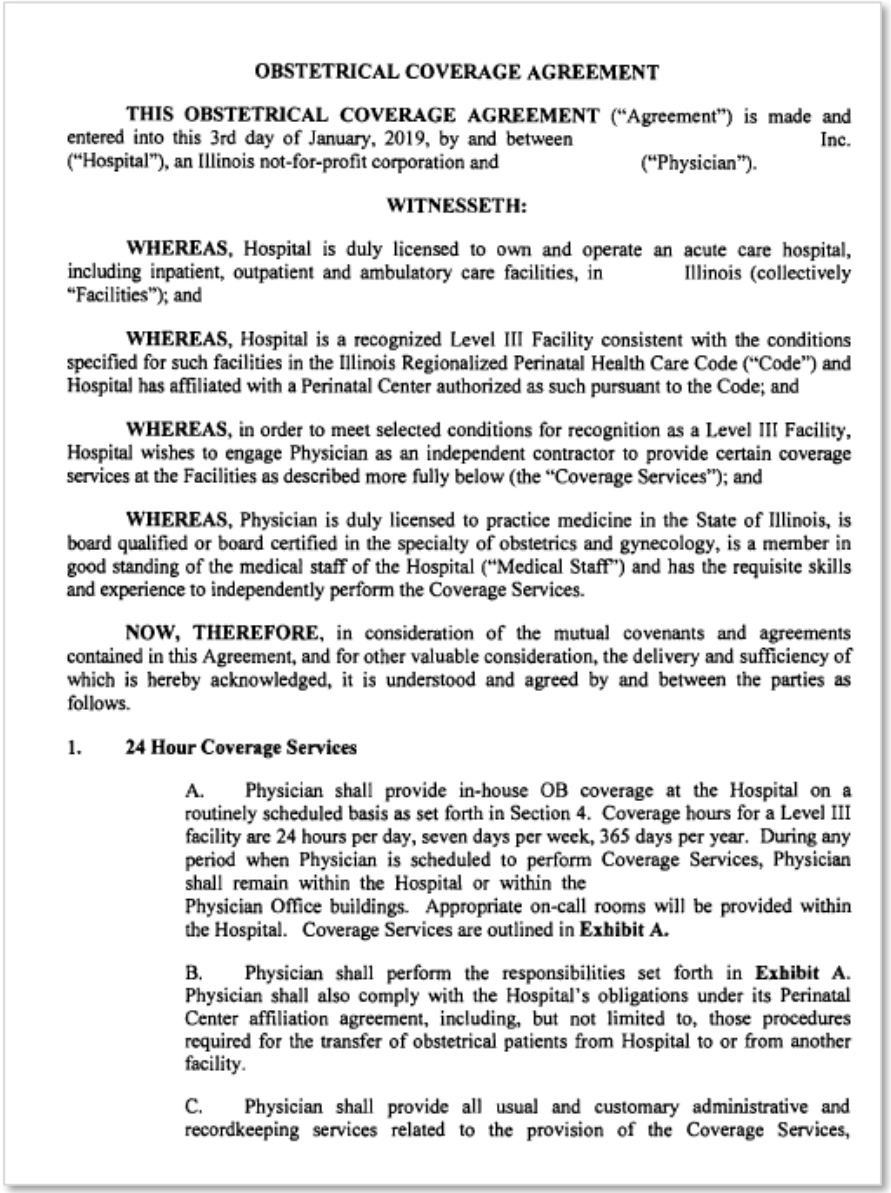
IN-HOUSE OB



OB HOSPITALIST COVERAGE AGREEMENT

Sample Policy and Responsibilities

- The primary responsibility of the Physician is to respond to and treat obstetrical emergencies!
  - Respond (to nurses and OB Providers!)
  - Evaluate the patient
  - Treat the patient
  - Deliver the patient as indicated
- Physician will evaluate high risk and low risk OB patients who are unassigned to a physician
- Physician will assist other physicians with emergency C-sections as needed
- Eyes and ears of attending in their absence



OBSTETRICAL COVERAGE AGREEMENT

THIS OBSTETRICAL COVERAGE AGREEMENT ("Agreement") is made and entered into this 3rd day of January, 2019, by and between Inc. ("Hospital"), an Illinois not-for-profit corporation and ("Physician").

WITNESSETH:

WHEREAS, Hospital is duly licensed to own and operate an acute care hospital, including inpatient, outpatient and ambulatory care facilities, in Illinois (collectively "Facilities"); and

WHEREAS, Hospital is a recognized Level III Facility consistent with the conditions specified for such facilities in the Illinois Regionalized Perinatal Health Care Code ("Code") and Hospital has affiliated with a Perinatal Center authorized as such pursuant to the Code; and

WHEREAS, in order to meet selected conditions for recognition as a Level III Facility, Hospital wishes to engage Physician as an independent contractor to provide certain coverage services at the Facilities as described more fully below (the "Coverage Services"); and

WHEREAS, Physician is duly licensed to practice medicine in the State of Illinois, is board qualified or board certified in the specialty of obstetrics and gynecology, is a member in good standing of the medical staff of the Hospital ("Medical Staff") and has the requisite skills and experience to independently perform the Coverage Services.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained in this Agreement, and for other valuable consideration, the delivery and sufficiency of which is hereby acknowledged, it is understood and agreed by and between the parties as follows.

1. **24 Hour Coverage Services**

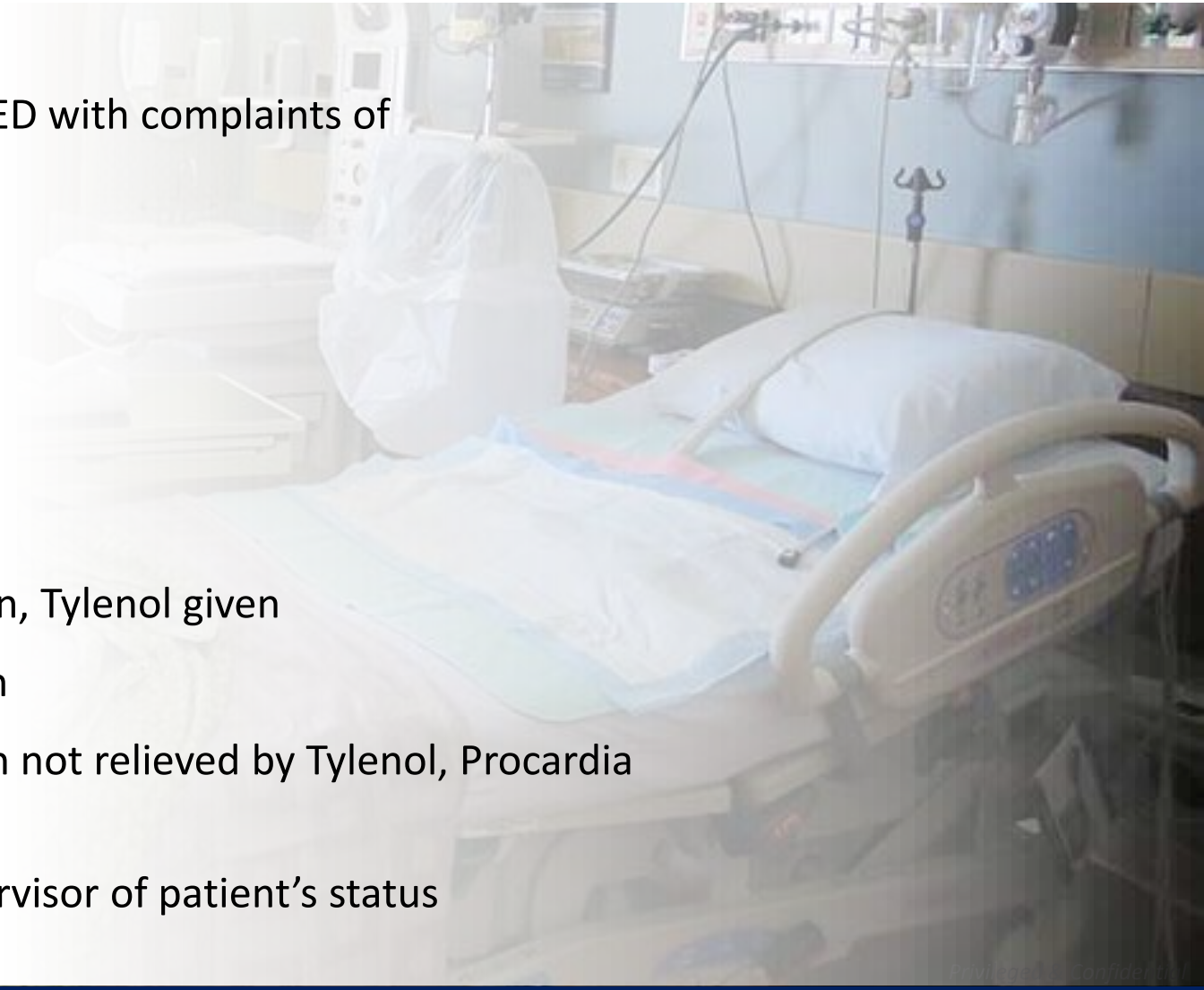
A. Physician shall provide in-house OB coverage at the Hospital on a routinely scheduled basis as set forth in Section 4. Coverage hours for a Level III facility are 24 hours per day, seven days per week, 365 days per year. During any period when Physician is scheduled to perform Coverage Services, Physician shall remain within the Hospital or within the Physician Office buildings. Appropriate on-call rooms will be provided within the Hospital. Coverage Services are outlined in **Exhibit A.**

B. Physician shall perform the responsibilities set forth in **Exhibit A.** Physician shall also comply with the Hospital's obligations under its Perinatal Center affiliation agreement, including, but not limited to, those procedures required for the transfer of obstetrical patients from Hospital to or from another facility.

C. Physician shall provide all usual and customary administrative and recordkeeping services related to the provision of the Coverage Services,

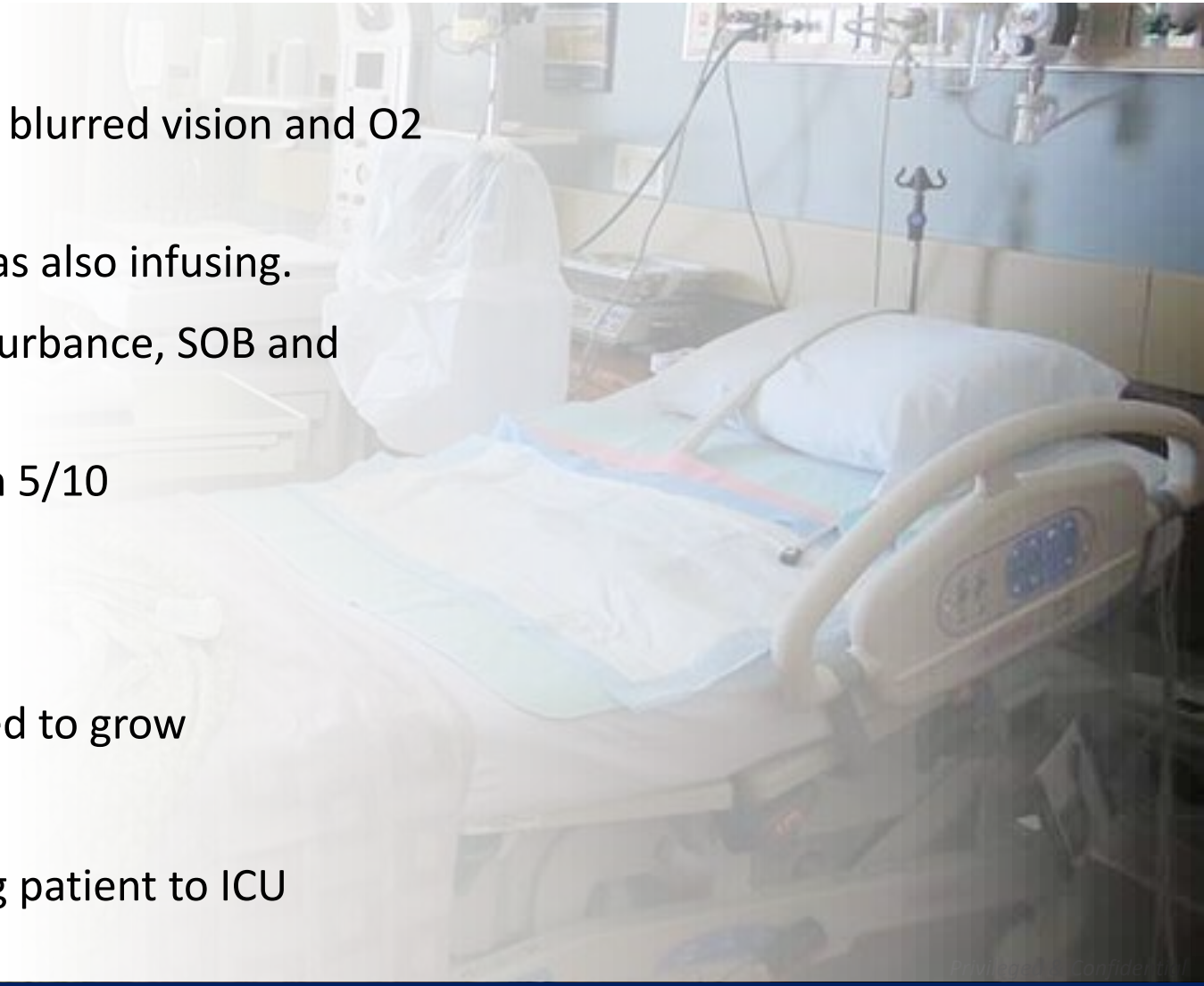
Healthcare Provider Frustration Case Study

FACTS OF THE CASE

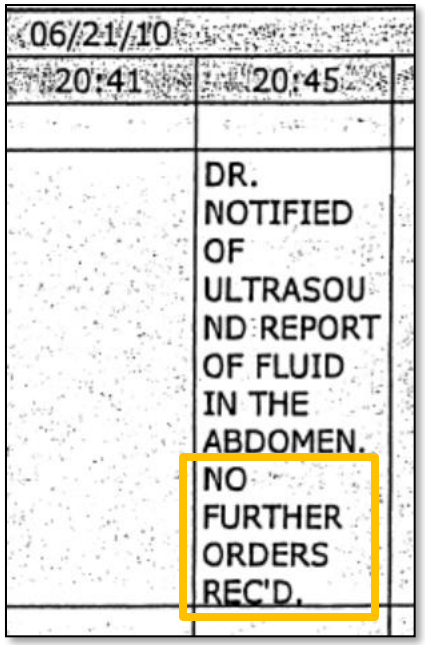


- 8:00 AM – 34 y/o G5 P4 @ 37weeks presented to ED with complaints of
  - Epigastric pain
  - BP 155/88
  - Patient admitted to L&D
  - HELLP syndrome diagnosed
  - MD ordered Pitocin IOL
- 3:12 PM - Infant delivered with Apgars 9, 9, 9
- 3:30 PM – Patient c/o headache and epigastric pain, Tylenol given
- 4:00 PM - Patient c/o headache and epigastric pain
- MD advised of platelet count @ 23, rising BPs, pain not relieved by Tylenol, Procardia ordered
- 4:30 PM – RN notified charge nurse and shift supervisor of patient's status

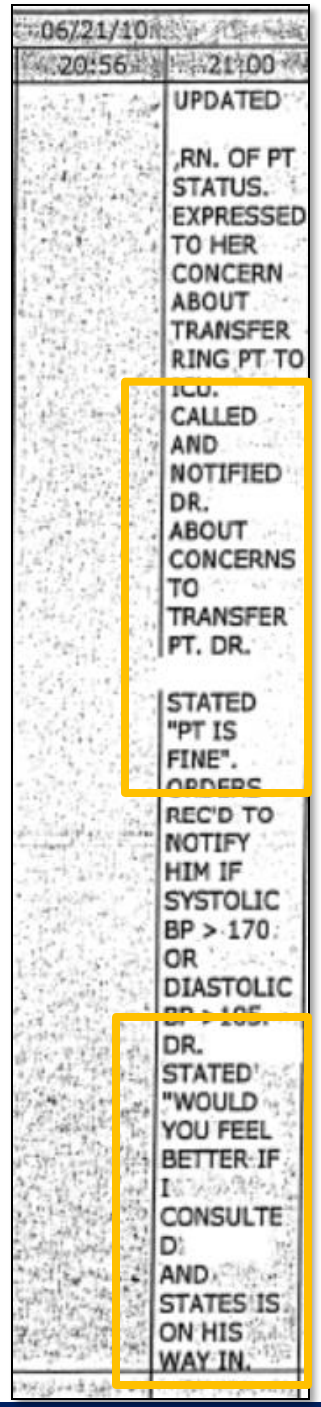
FACTS OF THE CASE



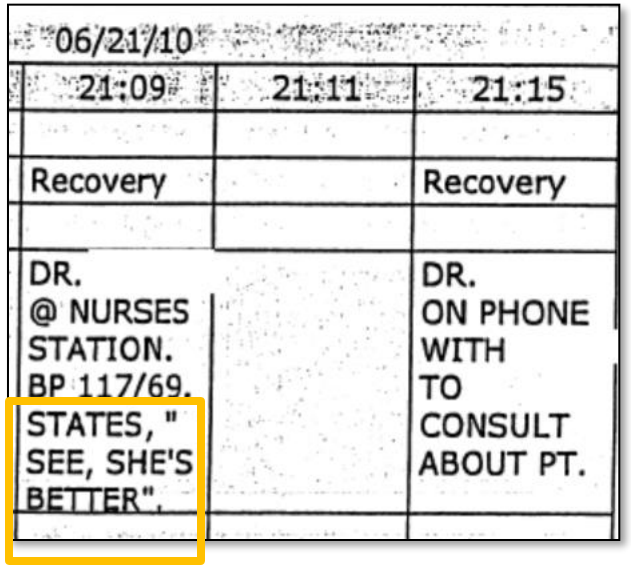
- 7:37 PM – MD at bedside, aware of BP 162/94, blurred vision and O2 sat 92%
- Hydralazine ordered and given. Mag sulfate was also infusing.
- 8:00 PM – Patient denied headache, visual disturbance, SOB and epigastric pain.
- 9:00 PM – Patient with constant headache pain 5/10
- Patient's BP persistently high, and rising
- Patient growing less alert and responsive
- Nurse's concern regarding the patient continued to grow
- Staff nurse tells Charge Nurse of her concerns
- Nurse calls MD with concern about transferring patient to ICU



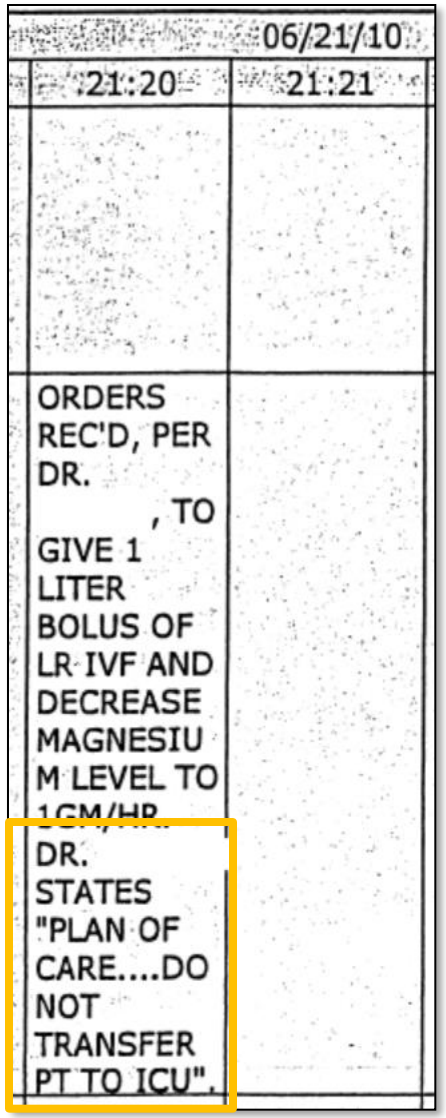
06/21/10	
20:41	20:45
	DR. NOTIFIED OF ULTRASOU ND REPORT OF FLUID IN THE ABDOMEN. NO FURTHER ORDERS REC'D.



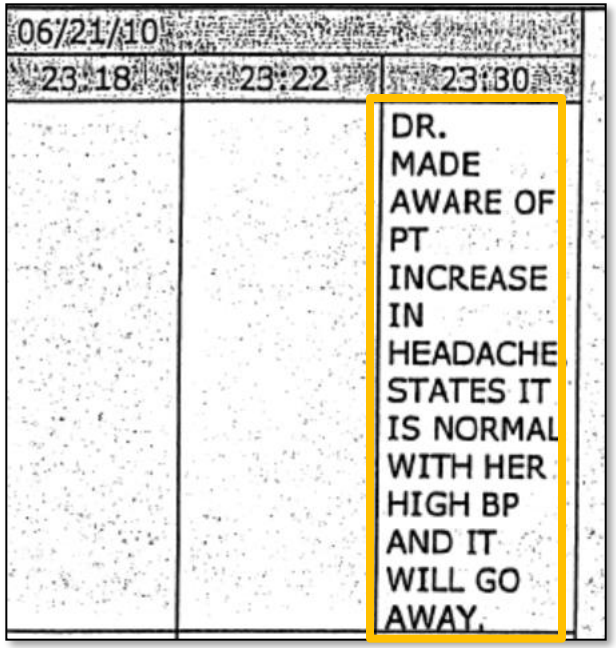
06/21/10	
20:56	21:00
	UPDATED ,RN. OF PT STATUS. EXPRESSED TO HER CONCERN ABOUT TRANSFER RING PT TO ICU. CALLED AND NOTIFIED DR. ABOUT CONCERNS TO TRANSFER PT. DR. STATED "PT IS FINE". ORDERS REC'D TO NOTIFY HIM IF SYSTOLIC BP > 170 OR DIASTOLIC BP > 105. DR. STATED "WOULD YOU FEEL BETTER IF I CONSULTE D AND STATES IS ON HIS WAY IN.



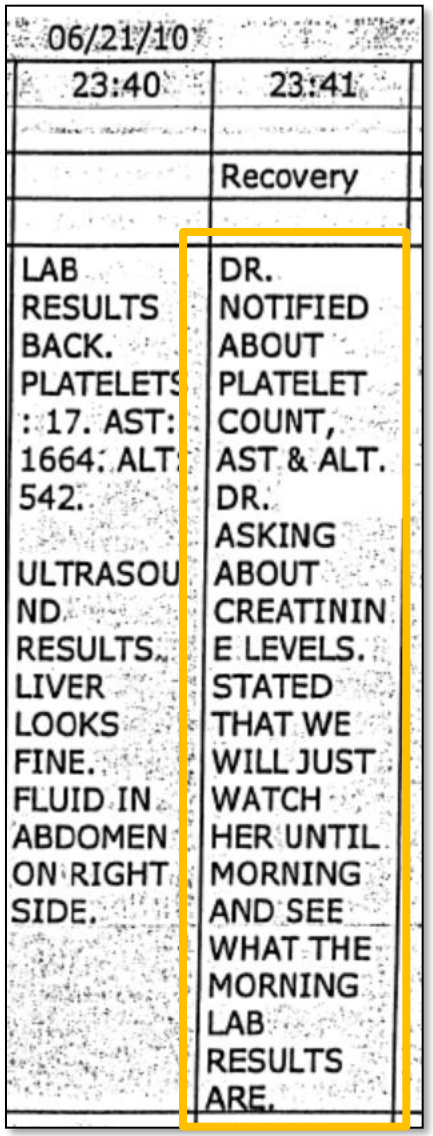
06/21/10		
21:09	21:11	21:15
Recovery		Recovery
DR. @ NURSES STATION. BP 117/69. STATES, " SEE, SHE'S BETTER".		DR. ON PHONE WITH TO CONSULT ABOUT PT.



06/21/10	
21:20	21:21
ORDERS REC'D, PER DR. , TO GIVE 1 LITER BOLUS OF LR IVF AND DECREASE MAGNESIUM LEVEL TO 1GM/HR.	
DR. STATES "PLAN OF CARE....DO NOT TRANSFER PT TO ICU".	

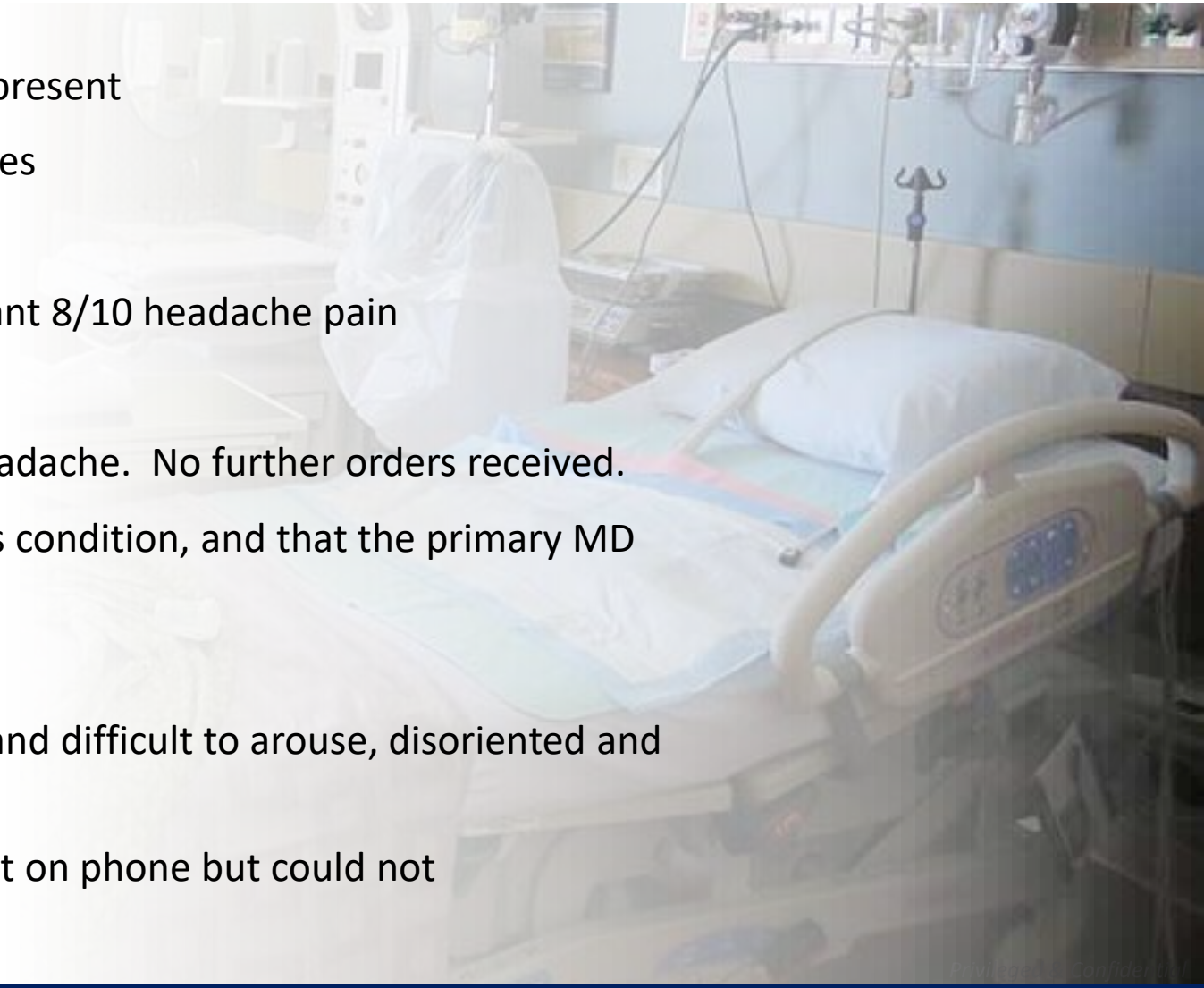


06/21/10		
23:18	23:22	23:30
		DR. MADE AWARE OF PT INCREASE IN HEADACHE STATES IT IS NORMAL WITH HER HIGH BP AND IT WILL GO AWAY.



06/21/10	
23:40	23:41
	Recovery
LAB RESULTS BACK. PLATELETS: 17. AST: 1664. ALT: 542. ULTRASOUND RESULTS. LIVER LOOKS FINE. FLUID IN ABDOMEN ON RIGHT SIDE.	DR. NOTIFIED ABOUT PLATELET COUNT, AST & ALT. DR. ASKING ABOUT CREATININE LEVELS. STATED THAT WE WILL JUST WATCH HER UNTIL MORNING AND SEE WHAT THE MORNING LAB RESULTS ARE.

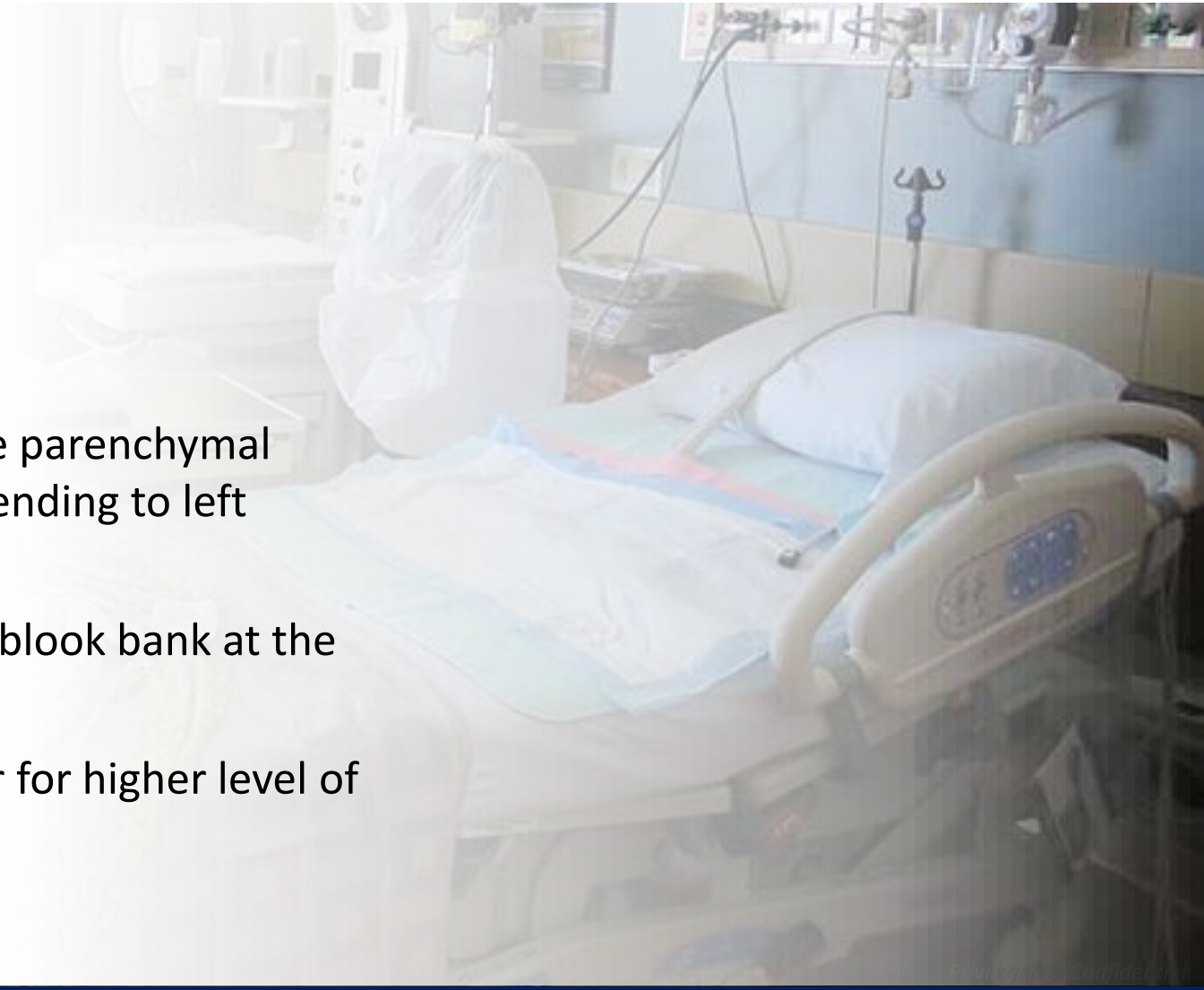
FACTS OF THE CASE



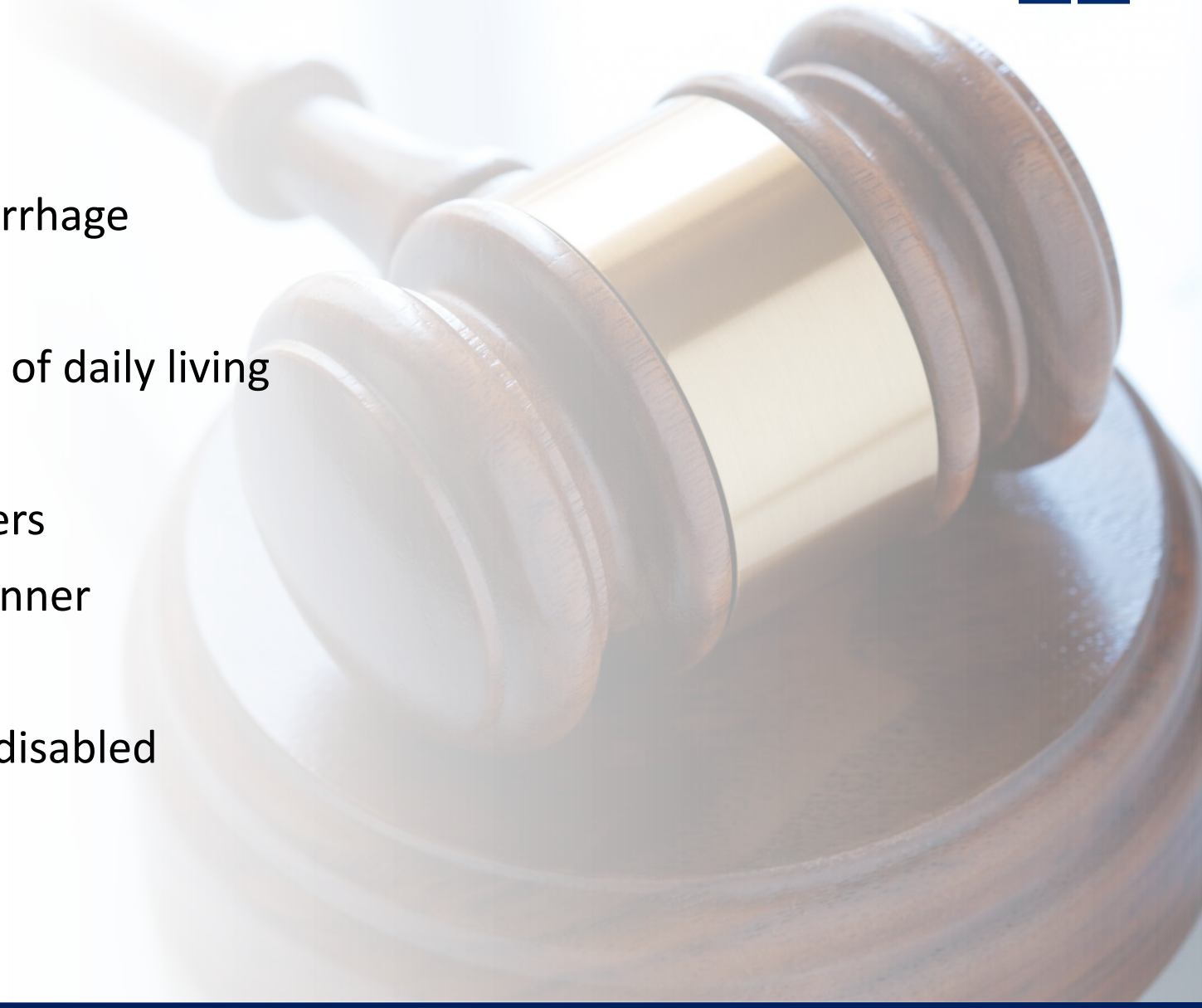
- 10:00 PM – headache increasing and epigastric pain present
- 11:00 PM – patient holding her head and covering eyes
- 11:30 PM – OB ordered Protonix
- 11:40 pm – OB notified of BP 154/90, labs and constant 8/10 headache pain
- OB stated plan was to watch until morning
- 1:30 AM – OB made aware of patient's continuing headache. No further orders received.
- 1:37 AM – RN notified Nursing Supervisor of patient's condition, and that the primary MD had been notified
- 2:00 AM –RN takes her 30-minute break
- 2:10 AM – Relief RN found patient holding her head and difficult to arouse, disoriented and non-responsive
- 2:15 AM – OB paged, attempted to speak with patient on phone but could not

FACTS OF THE CASE

- 2:31 AM – Rapid Response Team at bedside
- 2:39 AM – OB at bedside
- Patient still not responsive
- Patient intubated and transferred to ICU
- 3:10 AM – Heat CT confirmed a very large, acute parenchymal hematoma in much of the left parietal lobe, extending to left temporal lobe
- Platelet transfusion ordered, no platelets in the blook bank at the time
- 4:45 AM – Patient transferred to Medical Center for higher level of care



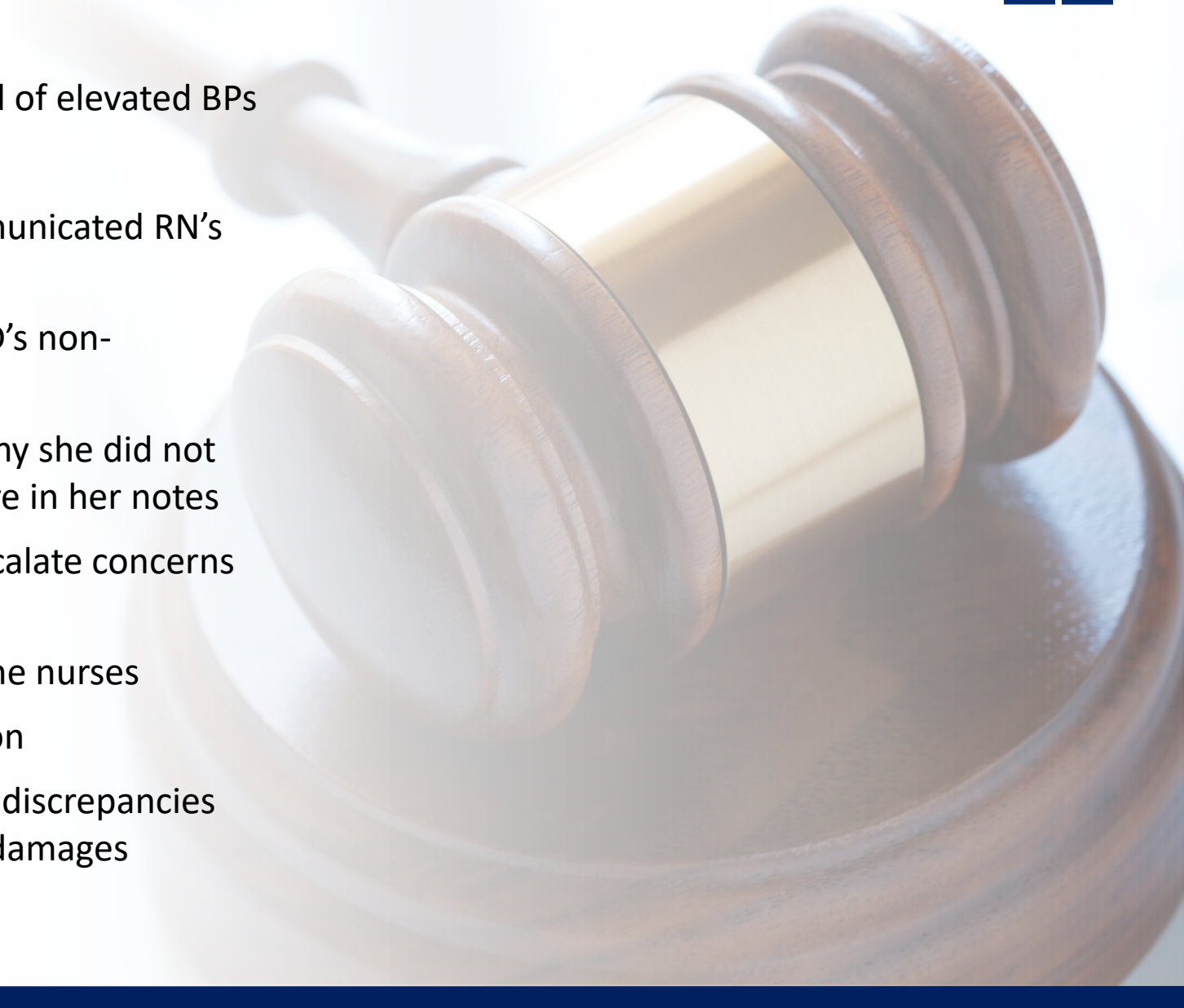
WHAT HAPPENED?



- Patient survived the intracranial hemorrhage
- Spastic quadriplegia
- Required 24-hour care for all activities of daily living
- Confined to hospital bed in home
- Feeding tube, trach, suction, O2, diapers
- Unable to move in any meaningful manner
- Unable to communicate
- Completely physically and cognitively disabled

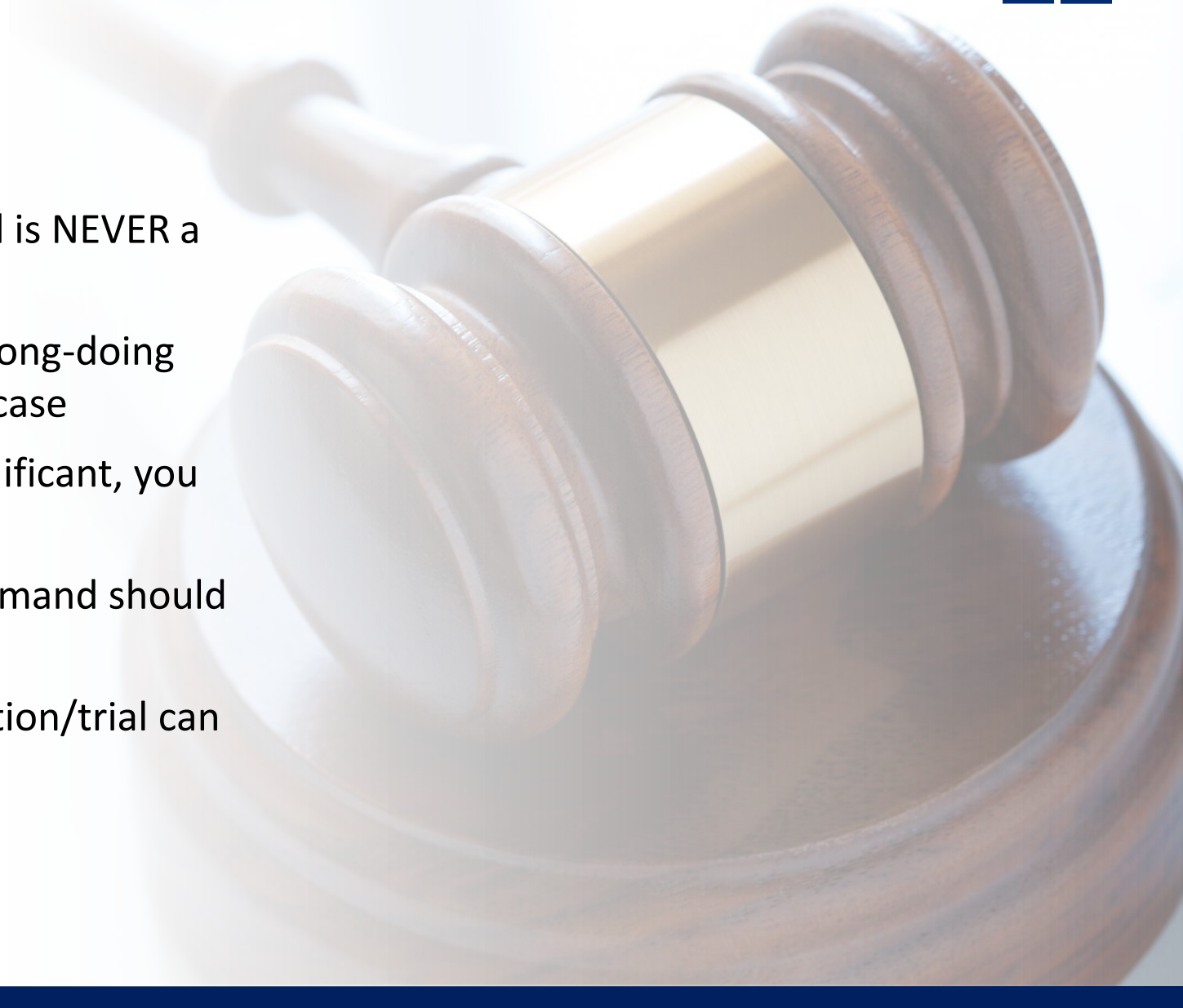
WHAT HAPPENED?

- At deposition, MD claimed had not been advised of elevated BPs
- Documentation indicated otherwise!
- Unfortunately, documentation also clearly communicated RN's frustration and displeasure
- RN used chain of command given concern of MD's non-responsiveness
- It was difficult for her to explain at deposition why she did not do more given the level of frustration/displeasure in her notes
- Charge Nurse and Nursing Supervisor did not escalate concerns beyond their levels
- Chain of Command Policy was not followed by the nurses
- Finger pointing persisted throughout the litigation
- Case had to be settled given the finger pointing, discrepancies between the OB and RN, and the magnitude of damages



LESSONS LEARNED

- Airing your frustration in the medical record is NEVER a good idea
- Expressly or implicitly accusing others of wrong-doing significantly compromises the defense of a case
- If your concerns regarding a patient are significant, you have a duty to use the chain of command
- Actions taken in activating the chain of command should be documented
- Disparity in the medical record or at deposition/trial can sink a case



STRATEGY TO IMPROVE DEFENSIBILITY

- Develop a culture of mutual respect
- Listen to your colleagues!
- They may have noticed something you missed
- They may have reasons you have not considered
- They may be doing the best they can under the circumstances
- Discuss the situation and work towards consensus – minimize disparity!
- Remember you are all on the same team
- Know and use your hospital's Chain of Command Policy effectively

KNOW YOUR INSTITUTIONAL POLICY

And Follow It

- Document who you spoke to
- Do not inject personal comments – keep it factual!
- Escalate up the chain of command as indicated

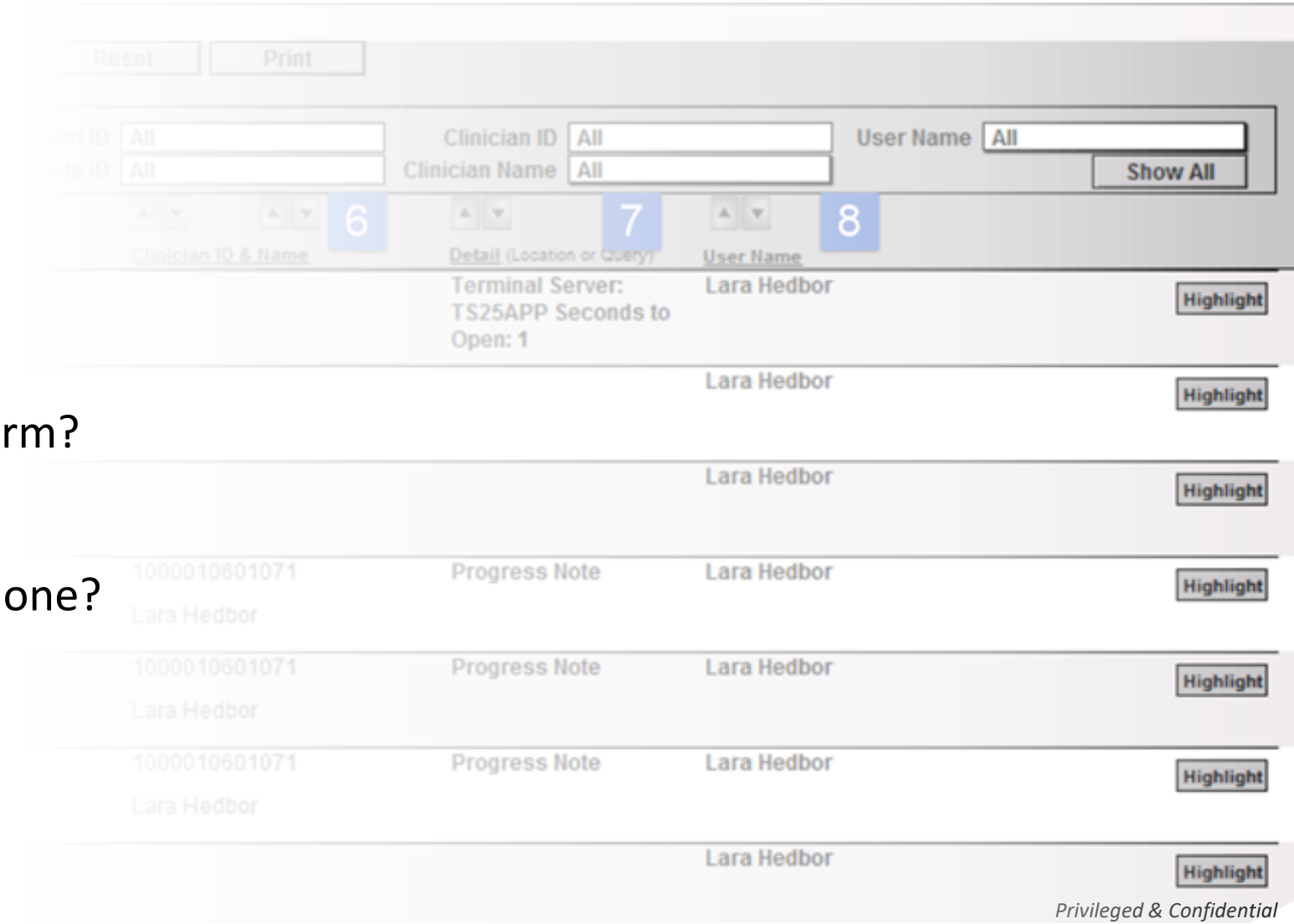
EMR – AUDIT TRAILS

- Who was in the EMR – and when?
  - Viewing
  - Signing-in
  - Documenting
- What time were entries made?
- What was added, when, and by whom?
- What was deleted or changed, when, and by whom?
- From what terminal and location?

FHR TRACINGS

What does the audit trail show?

- Who signed in/looked at the strip?
- Who acknowledged the alert or alarm?
- From what location?
- When was the acknowledgement done?



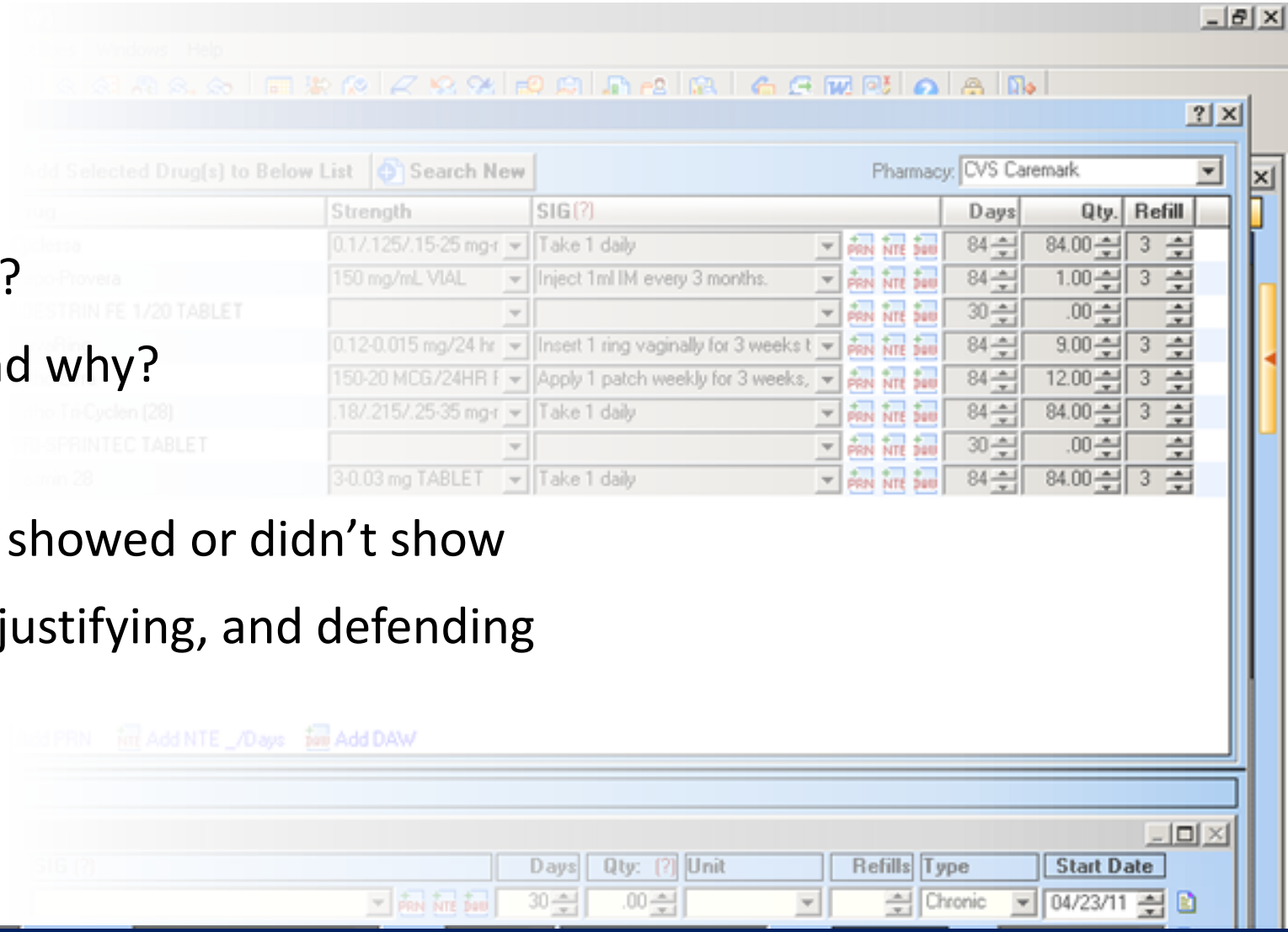
EMR CONSIDERATIONS

Cut & Paste Documentation

- Are you taking a short cut?
- Is what you're "cutting and pasting" still accurate?
- Did you actually reevaluate the patient?
- The likelihood of "cut and paste" does not escape us when record reviewed
- The ease of electronic documentation should not be abused!

Drop Down/Menu Choices

- What were the available choices?
- What was chosen/not chosen and why?
- Thought process revealed
- Better clarifies what assessment showed or didn’t show
- Can assist witness in explaining, justifying, and defending



ACCESS TO EMR SYSTEMS

- Plaintiff’s attorneys commonly demand an EMR inspection
- Courts have readily ordered them

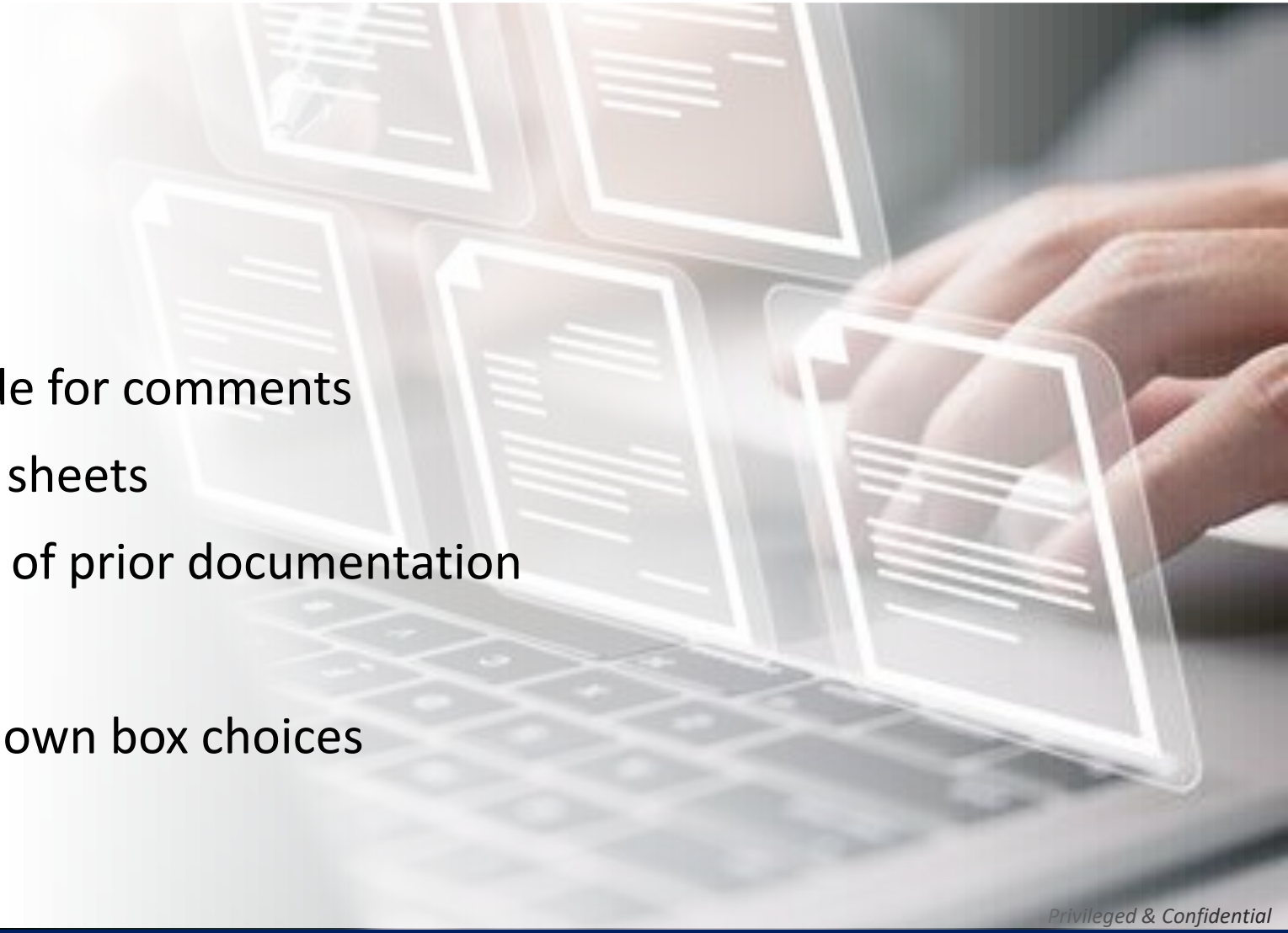
Personal Notes Outside the EMR- were they made and kept?

They Shouldn't Be

- Personal notes usually follow adverse outcomes
- Fear/conflict/hostility prompts them
- Suggests immediately that something out of the ordinary happened
- Personal notes on your computer, cell phone, diary, journal or blog can be used as evidence

EMR - UNIQUE ISSUES

Strategies to Improve Defensibility



- Clarity is key
- Expand the cell as needed
- Do a narrative comment
- Use other screens specially made for comments
- Use FHR tracing to adjunct flow sheets
- Avoid inappropriate duplication of prior documentation
- Don’t perpetuate inaccuracies
- Make appropriate menu/drop down box choices

TRADITIONAL DOCUMENTION ISSUES

Strategies to Improve Defensibility

- Include all key information in your notes
- Avoid accusatory charting
- Avoid defensive charting
- Be consistent
- Avoid disparity
- Avoid making personal notes
- NEVER alter a medical record

Questions?

Thank You!

MARILEE CLAUSING, Managing Partner
Hall Prangle LLC
mclausing@hallprangle.com
312.267.6340
www.hallprangle.com

HALL PRANGLE LLC