



Miscommunication in Labor and Delivery

Collaboration and communication form the cornerstone of effective care. Obstetrical nursing exemplifies this principle. The involvement and interaction of OB personnel has a critical impact on the outcome of mother and baby. The outcome is influenced by the degree of interaction and communication between nurses and physicians. OB nursing and team communication are – critical!

I'm Pat Iyer with Iyer's Insights, one of the twice weekly shows of Legal Nurse Podcast.

Consider this Michigan case. A high-risk mother in labor was managed by a midwife. The private attending physician collaborated with the defendant midwife. Although the fetal monitor strips were not reassuring, the physician left the hospital to attend to a patient at the ER of another nearby hospital.

When the midwife saw the worsening fetal monitoring strips, she did not call the staff physicians. Despite numerous calls, the defendant private physician did not return to the defendant hospital until after delivery. As a result, the infant was born with significant respiratory depression, sustained hypoxic brain injury and ultimately was diagnosed with cerebral palsy.

The parties reached a \$3.5 million settlement.

Obstetrical nursing and team communication – perfect together

Communication and collaboration are responsibilities of not only the nurses, but also of the physicians. The team must mutually update each other on information from the fetal monitor, assessments of the mother, and physiological and psychosocial parameters affecting the patient or family.

End-of-shift reporting, and timely and appropriate telephone calls combine to maintain an environment essential in a setting where a patient's condition changes rapidly and often. Patients in labor and delivery need a highly functional and communicative team.

Several studies have shown that the implementation of an integrated medical record, clinical pathways and protocols, and other products of a more collaborative arrangement may improve patient outcomes.

Unit-based protocols and standing orders

Unit-based protocols and standing orders are frequently used in the labor and delivery unit. These documents serve as a guide for the obstetrical nurse, permitting rapid intervention when signs of fetal distress are present. Protocols and standing orders should be dated and signed by the physician, and periodically updated as changes in medical and nursing practice mandate.

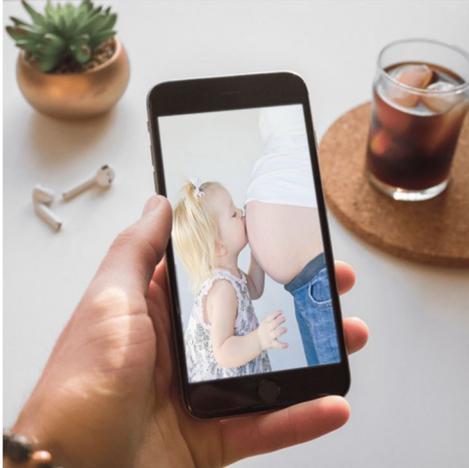
These documents often reveal what the labor and delivery staff should do when faced with complication. They not only guide the clinical staff; they also guide the expert witnesses and attorneys involved after the fact.

As a legal nurse consultant, you can be invaluable in helping the attorney by suggesting which documents to obtain.

Interdependence of the Team

The labor and delivery nurse is often required to perform critical and frequent assessments of the laboring mother without the direct and immediate supervision of a physician or nurse midwife. These activities must be based on established protocols created by medical and nursing departments of the hospital. The protocols should be reviewed frequently so healthcare professionals can determine if they reflect current medical and nursing standards of care. Unit protocols and procedures serve as evidence to assist with the establishment of the applicable standard of care.

The legal responsibility of OB nurses is the same as that of other nurses, i.e., they are responsible for their own conduct, including any negligence or tort. However, the complexity of patient problems, their rapidly changing condition, and ongoing technological innovations place a higher demand on the OB nurse. Obstetrical nursing and team communication – whether effective or dysfunctional – profoundly affects care.



Obstetrical nursing practice is intertwined with high risk for patient injury. The signs of fetal distress must be quickly detected and acted upon in labor and delivery suites. Listen to my audio training called, *When the Dream is Shattered: Legal Risks of Labor and Delivery*. Joanna McGrath, an experienced OB nurse educator and expert witness who shares tips about this highly litigated area.

You will learn to identify the most common sources of obstetrical nursing malpractice, including fetal distress and shoulder dystocia. And is it *enough* for the staff nurse to tell the obstetrician there is a problem? In this audio training, we explore issues surrounding the chain of command.

Order this training at the show notes for this podcast on podcast.legalnursebusiness.com. Don't forget to use the code "listened" in the coupon box to get a 25% discount off the training.

Consider this Georgia case: The plaintiff mother was a poorly controlled diabetic whose pregnancy had an increased risk for potential fetal complications. On the day of delivery, there were three and a half hours of consistent and persistent late decelerations, which were not addressed by the labor and delivery staff. The plaintiff claimed in the lawsuit that the staff should have performed a C Section. Instead, she continued to labor even though there were repeated and worsening fetal heart monitoring abnormalities – for another 10 hours.

At birth, the infant was profoundly depressed and acidotic. The baby required intensive resuscitation and total body cooling to minimize her hypoxic ischemic event injury. The infant sustained permanent neurological injuries that required ongoing care.

Guess what the defense argued? They said there was *no* hypoxic ischemic event injury. They attributed the baby's condition to an injury that took place before labor and delivery – and said it was her mother's diabetes.

Here's where the medical experts came in. They pointed to the medical records and fetal monitor tracings, which were abnormal. An MRI of the child's head after birth showed clear evidence of hypoxic ischemic event injury and placed the timing of the injury around the time of birth. The case settled for \$1.5 million.

I can think of several services an LNC could offer in this case: locating well-qualified experts, creating a timeline of care, summarizing the medical record, preparing questions to ask experts and defendants during deposition, summarizing depositions, performing an analysis of liability, preparing a summary of the damages to this infant, and assisting in a day in the life video.

Be sure to listen to Legal Nurse Podcast 340 to discover how technology takes the guess work out of interpreting fetal monitoring strips.

How about one more case? This took place in Florida. The mother had been diagnosed with placenta previa. Let me remind you of what this condition is. In placenta previa, the placenta lies low in the uterus and partially or completely covers the cervix. The placenta may separate from the uterine wall as the cervix begins to dilate during labor. The Florida mother had the most severe form: placenta accreta. Placenta accreta is a serious pregnancy condition that occurs when the placenta grows too deeply into the uterine wall. Typically, the placenta detaches from the uterine wall after childbirth. With placenta accreta, part or all the placenta remains attached. This can cause severe blood loss after delivery.

The defendant obstetrician failed to prepare for a delivery that involved this condition and mentioned the placenta accreta only once in her medical records. The plaintiff contended a cesarean section should have been scheduled at 34 to 36 weeks. Instead the defendant obstetrician did not schedule it until the mother was 39 weeks and performed it in the middle of the night when no other physicians were available to help in a difficult delivery.

The defendant obstetrician who performed the delivery relied on the notes of another doctor, who did not note the placenta accreta during his preop exam. When the defendant made the incision to perform the c section, he cut into the attached placenta and caused massive bleeding. He tried to manually extract the placenta, and made the condition worse, when he should have removed both the uterus and

placenta at the same time. *The mother died*. Eventually the defendants admitted liability and causation. The jury returned a \$24.5 million dollar verdict.

Damages can be enormous in obstetrical cases. And the need for effective and ongoing communication is essential. You can see that miscommunication is a common thread throughout these cases.

Join Joanna McGrath and me by listening to the audio training called *When the Dream is Shattered: Legal Risks of Labor and Delivery*. You'll receive a wealth of information to use in deciphering the issues of a labor and delivery case.

We have all kinds of resources for you at legalnursebusiness.com. Build your skills, get new ideas for your business. Check out the webinars, teleseminars, courses and books at legalnursebusiness.com.

Would having an experienced LNC business coach help you achieve your goals faster? Explore coaching with Pat Iyer at LNCAcademy.com to get more clients, make more money and avoid expensive mistakes.

Deepen your LNC knowledge and skills through the convenience of online learning. Each month we bring you two or more hours on online training covering two LNC topics. Invest in the monthly webinars at LNCEU.com. Watch the programs on your computer or mobile phone using our bizedu app. Get the app at legalnursebusiness.com/bizedu.