Risk Mgmt & Legal Perspectives for Obstetrics

SEMCME Fetal Assessment Course
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Session Content

- Introduction to Risk Management/Medical Error
- Case Study
  - Occurrence of Event
  - Root Cause Analysis
  - Litigation process

Healthcare Risk Management

What is it?
- Identifies, evaluates, and undertakes activities to reduce
- Risk of injury to patient in the healthcare setting
- Risk of loss to the organization itself

Medical Error/Adverse Event

Medical Error:
- Failure of a planned action to be completed as intended or
- Use of a wrong plan to achieve an aim

Adverse Event:
- An injury caused
  - by medical management
  - not by the underlying disease or condition of the patient

Causes of Medical Errors

- Communication problems
- Inadequate processes
- Human-related problems (e.g. distraction, fatigue)
- Patient-related issues
- Inadequate information flow
- Technical failure

Swiss Cheese Model

- Barriers to slips or accidents reaching the patient
- Layers of protection
- Prevention of errors through multiple layers
OB Events of Potential Harm

- Mismanagement of shoulder dystocia
- Inappropriate use of forceps/vacuum
- Delay in diagnosis of fetal distress or maternal complication resulting delayed delivery
- High spinal resulting in maternal cardiac arrest
- Infection due to inadequate sterile conditions leading to hysterectomy, sepsis, and/or death
- Delay in dx or inadequate treatment of post-partum complications, e.g. hemorrhage, pulmonary embolism

Result of Adverse Events

- Patients/families suffer injury, physical, emotional and financial loss
- Caregivers suffer emotionally, financially, professionally
- Lawsuits
- Reputation
- Clinical Privileges
- Possible inability to continue practicing

Result of Adverse Events

- Hospital/facility negatively impacted by:
  - Media coverage
  - Loss of reimbursement of care
  - Lawsuits
  - Financial loss in legal fees and settlements
  - Employee/staff productivity
  - Reputation

Root Cause Analysis

- A systematic analysis of an event or near miss that has occurred within the health care setting
- Answers the following questions:
  - What happened?
  - Why did it happen?
  - How can the system be redesigned so it does not reoccur?

Case Study

- 23yo ♀ with well-controlled IDDM
- Reassuring antenatal testing
- Admitted for induction at 39.1 wks on Sun. 5/6/18
- On-call Attending is in house/also covering resident clinic during the day in Office Bldg.
- 1st and 3rd year residents covering L&D

Case Study

- On Mon. 5/7 0730 attending examines pt
  - AROM with clear amniotic fluid
  - Category 1 strip: FHR 150; moderate variability; ctx q 2-3 minutes
  - Posterior position
  - Asynclitic head
- 0800 Attending leaves for clinic until approx 1200
- Computer access to fetal monitor tracings
- 0830 FHM not working properly – nurse changes out for new monitor
0850 On restart of monitor, HR 100. RN calls 1st yr resident to see patient
0900 1st yr examines 7/90%-

Notes prolonged deceleration

Resident does not report to senior
Prolonged decels at 1100 & 1115
1120 1st & 3rd yr examine together 10/100%/0
Expect delivery at anytime

Attempted pushing at 1130; allowed to labor down; prolonged decel x3 minutes
1145 FHR 160; moderate variability; variables
1200 FHR 175; minimal variability; temp 99.1; pushing
1230 FHR 150; minimal variability; variables

Category 2

Attending returns at 1240 – residents report what has been occurring with patient. Does VE
10 cm at +1 station; 2 cm caput
Fetal position: L occiput posterior; asynclitic
Attending diagnoses arrest of descent

1300 FHR 180 with variable/late decels
Attending discusses need to expedite delivery with patient due to nonreassuring Category 2:

Risks of vacuum/forceps
FHR elevation could be due to decreasing oxygenation
Pt refused C-Section and desired operative vaginal delivery. 1320 fetus at +2 station
Attending applied forceps but couldn’t lock blades

1330 Attending attempts vacuum extraction
4 pulls and 2 popoffs (pull x2; popoff x2; pull x2)
No descent
1340 Attending discusses C/Section with patient
Patient agrees
1345 C/Section called
1420 Delivery occurs

Newborn condition
Apgars 6/8; cord art pH 7.08; BE -14
Caput; molding, scalp bruising
Seizures at 10 hours of life
EEG: moderately abnormal; diffuse encephalopathy
CT on Day 3
Subdural hemorrhages L and R
Subarachnoid hemorrhage
Cerebral edema
Questionable skull fracture R occipital bone
Case Study

- Event is reported to Risk Manager due to unexpected poor outcome.
- Root Cause Analysis is planned.

What questions do you have about this scenario?

Root Cause Analysis

During interviews, Risk Manager learns the following:

- **Nurse**
  - Reason for 20 minute lapse in FHM strip
  - When FHM stopped working; left room to obtain another monitor
  - Was interrupted by another nurse re schedule
  - Concentration redirected to schedule
  - Temporarily lost resolve to get another monitor
  - Got back on track and obtained and connected new monitor

Root Cause Analysis

- **Nurse (cont.)**
  - Upon restart of monitor and calling 1st year
  - Not comfortable with resident's lack of action
  - 3rd year was busy and didn't want to contact attending due to her being in clinic – attending known to be "difficult"
  - During attempted vaginal delivery, noted 4 vacuum applications – policy is to only do 2
    - Didn't speak up as she has been "reamed out" in the past by this attending

Root Cause Analysis

- **1st-year resident**
  - After 0900 prolonged decel, he did not contact 3rd year because thought it was just an anomaly and didn't want to appear incompetent.

Root Cause Analysis

- **3rd-year resident**
  - At 1100 he felt the patient would deliver at anytime and did not notify the attending because she is a tyrant and he did not want to interrupt her in the clinic.

Root Cause Analysis

- **3rd year (cont.)**
  - When the attending returned at 1240 and learned what had occurred in her absence, she lit into the residents for not notifying her.
  - During the attending's initial consent discussion with patient for C-Section, she noted that she did not explain that decreasing oxygenation could lead to neurologic injury, but just didn't speak up about it.
Root Cause Analysis

- Attending
- Does not recall if she checked the fetal monitor tracings on the computer while in the clinic
- Was not notified by the residents of changes that occurred while she was in clinic
- Expected that nurse or residents would have called her for any change in dilatation, progress or any development that made a nurse or resident feel uncomfortable.
  - Has not communicated this expectation, but they should just know that they should do this.
  - This particular nurse is not that good anyway and guessed she can't trust the residents.

Root Cause Analysis

Based on these interviews, what process issues can be identified?

Litigation

Two years down the road, a Notice of Intent and Lawsuit have been filed.

Litigation

Who is named in the suit? Why?

- Standard of care of a reasonable & prudent:
  - Physician
  - Nurse
Definition of Malpractice

"Professional negligence" and "malpractice" are the same. They mean the failure to do something that a [name profession] of ordinary learning, judgment and skill would do, under the same or similar circumstances as in this case. Professional negligence, or malpractice, can also mean doing something that a [name profession / name particular specialty] of ordinary learning, judgment and skill would not do, under the same or similar circumstances as in this case.

What are the management issues?

Plaintiff’s Theories of Liability

* Failure to timely evaluate high risk patient
  * No exam by attending until patient is complete
  * No evidence that attending checked computer in clinic
  * Failure of RN/resident to timely notify attending of NRFHTs
  * No notification of attending of significant changes on strips

Plaintiff’s Theories of Liability (cont.)

* Failure to timely perform C/section due to intolerance of labor
  * Commit to expeditious delivery
  * If vacuum attempt fails, indication for expeditious delivery usually remains
  * Excessive delay in going to OR after abandoning vacuum

Plaintiff’s Theories of Liability (cont.)

* Failure to avoid excessive trauma during operative vaginal delivery attempt
  * Posterior position; Asylnclitic
  * Slow descent; +1 station with caput
  * Appropriate candidate for operative vag delivery?
    * i.e. Was it reasonable to expect a vag delivery?
    * How do you explain the hemorrhages/skull fracture?

Plaintiff’s Theories of Liability (cont.)

* Failure to invoke Chain of Command
  * When to invoke?
    * If the physician is unresponsive to calls
    * If the physician appears incapable of clinical performance (“the impaired provider”)
    * If the physician is clearly operating below the standard of care
Litigation

Plaintiff’s Theories of Liability (cont.)

* Failure to invoke Chain of Command (cont.)
  * Excessive attempts at use of forceps/vacuum
  * Deviated from policy/standard of practice of abandoning vacuum after 2 popoffs?
  * Deterioration of tracings warranted C/section rather than vacuum
  * Mere disagreement over strip interpretation?
  * Not an indication to invoke COC but requires communication of concerns

* Failure to provide proper informed consent
  * Did not inform of risk of brain damage (delay) or skull fracture (trauma) from use of vacuum
  * Given posterior position/asynclitism, should physicians have discussed possible C/section earlier in labor?

Litigation

Managing Conflict in L&D

* The clash of personalities
* Listen to the voice in your head
* Remember that duty supersedes ego, embarrassment, reluctance to act, etc.
* Create an environment of teamwork & open communication
* Know your limitations and seek assistance
* Professionalism at all times
* Respect the patient and your colleagues

What happens if I’m sued?

Don’t procrastinate!
Notify ins carrier/risk mgmt/attorney immediately
Must respond timely to complaint

Don’t release records without authorization
Need signed HIPAA release/valid subpoena/Court order

Don’t discuss case with plaintiff’s counsel or investigator without representation

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THANK YOU!
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