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

Effective Poor communication 60% - 70% of claims Effective communication with may leave patients occur because of communication angry and confused patients can prevent communication issues results in better care more likely to file suit lawsuits Good documentation Hospital policies can **Disparity makes** Credibility is be used against you if improves your everything Plaintiff's job easier! defense not followed



DOCUMENTATION E 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 - charting using improper, out-of-date, or vague terminology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





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



Frequent use of extraneous digital data in lawsuits:

Social Media

Transponder data

Audit trails

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 E COMMUNICATION

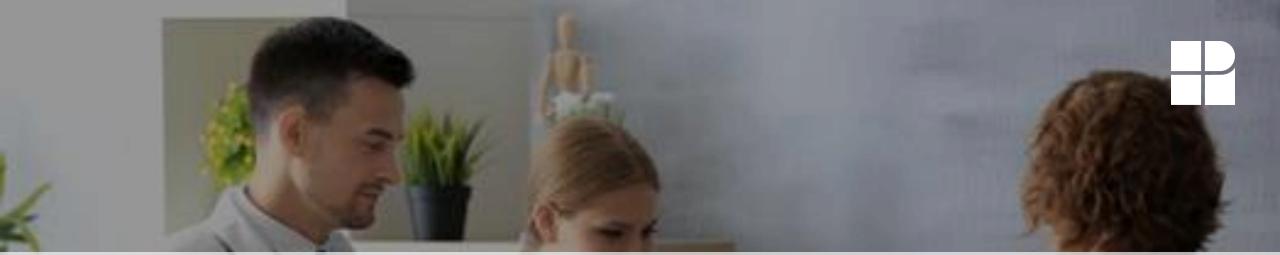
Defense Strategies

- 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 E 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



• 10/11/18 First visit with MFM

FACTS OF THE CASE

- 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: Result Date: Result Status: Performed Information: Signed Information:

ROB

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

Basic Information Gravid a/Para: <u>Gravid a Para Information:</u> 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

breast/open to epidural/ condoms --wants another baby in 2 years Electronically Signed on 12/18/18 04:01 PM

Obstetrics Note 12/18/2018 15:56 CST Auth (Verified)

> 12/18/2018 16:01 CST) 12/18/2018 16:01 CST)



1/3/19 OB Visit--34w1d

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

Foliow 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

1/8/19 Antenatal Testing

FACTS OF THE CASE

- 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)



- Next antenatal testing dates:
- 1/22/18--no show

FACTS OF THE CASE

- 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

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

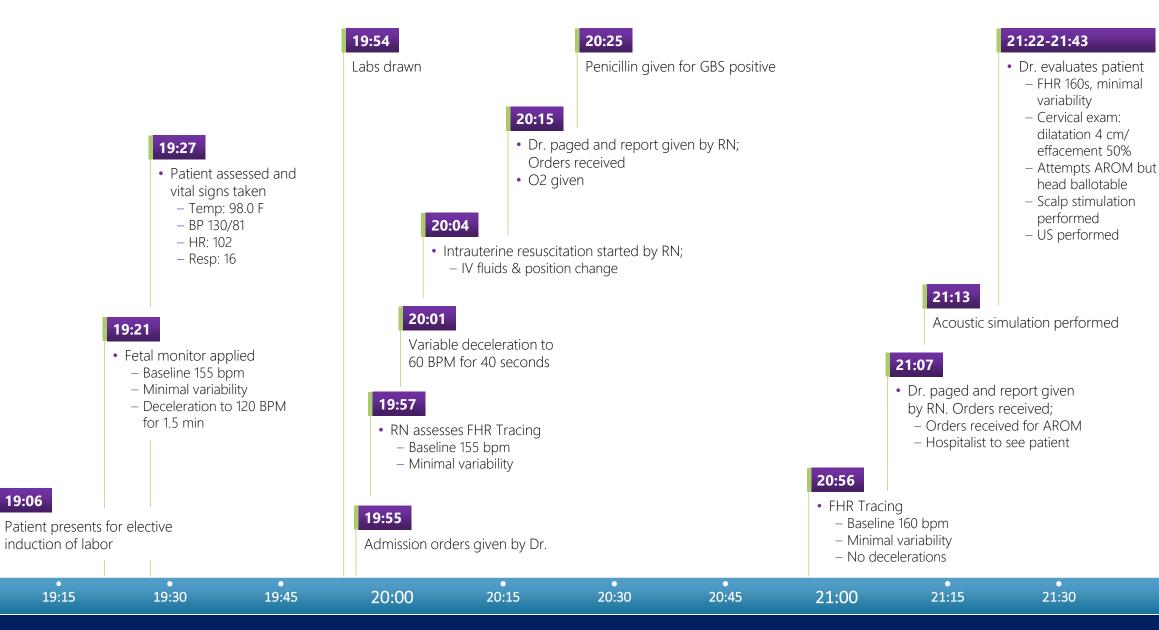


Intrapartum Care Case Study

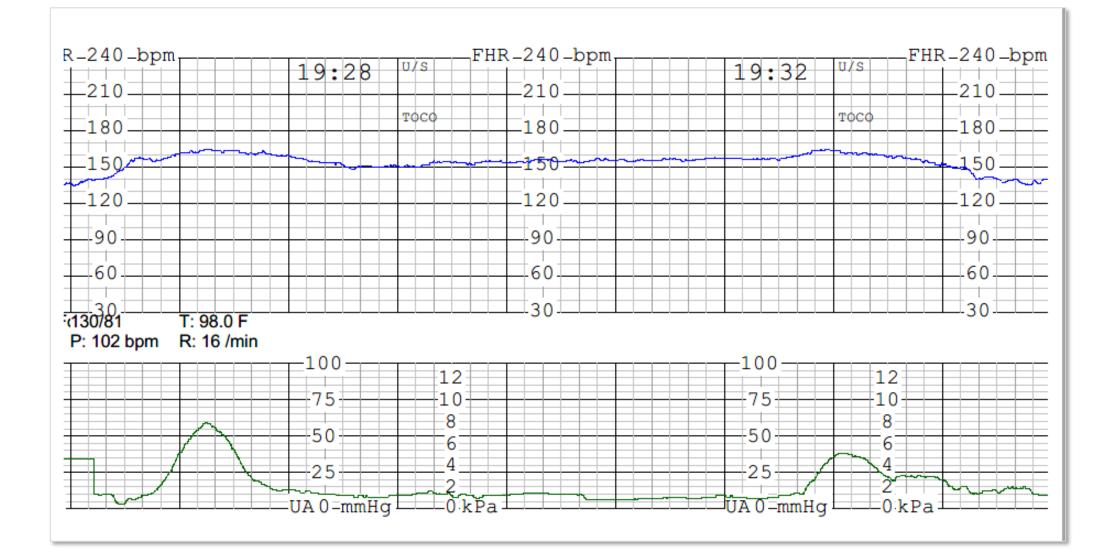


ADMISSION TIMELINE OF EVENTS

19:00

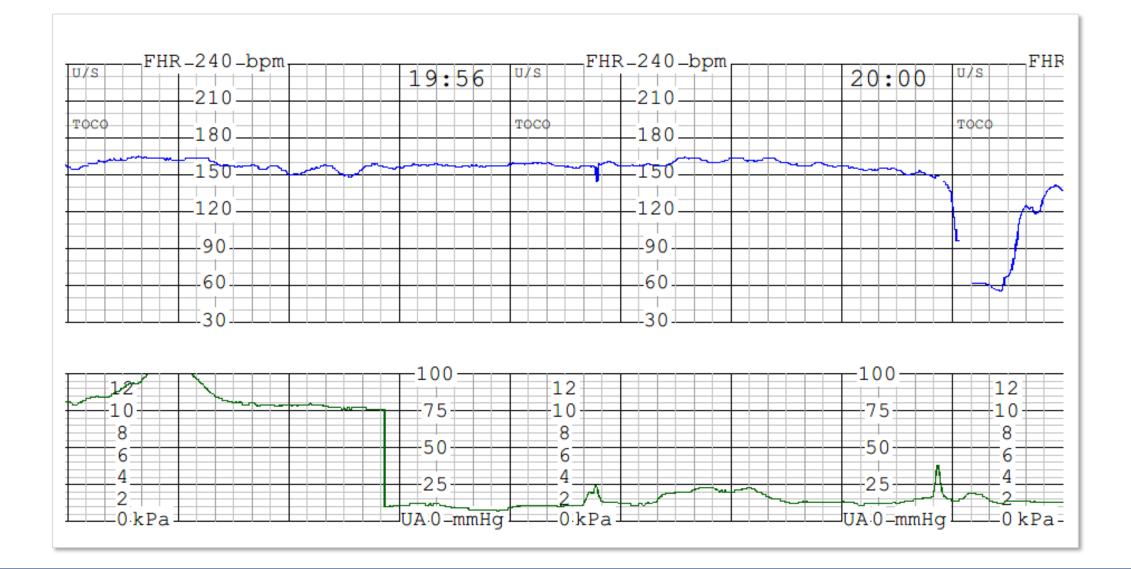












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FHR Eval: Baseline 155 bpm

Variability Minimal

Accelerations Absent

Decelerations Variable

	0	etail Notes Log
Note Date/Time	Entered By	Note
7/16/2013 19:17		AttendingDoc:
7/16/2013 19:18		Pt Type: LBR Labor
7/16/2013 19:18	a transmission of marks of their second structure	Care Provider:
7/16/2013 19:18	the second second second	Nurse: t
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7/16/2013 19:19		Admit: From Home
7/16/2013 19:19		Admit: Ambulatory
/16/2013 19:19		Admit: Accompanied by S.O.
7/16/2013 19:21		FHR Mode: U/S Transducer / Initiated
7/16/2013 19:24		UC Mode: TOCO Transducer / Initiated
//18/2013 19:24		FETAL DECEL DOWN TO 1208PM FOR 1.5MINS
7/16/2013 19:25		presents to I and d for scheduled induction of labor
16/2013 19:20		edc 7/11/13
/16/2013 19:25		Teaching: Orient Room/Visit Policy
/16/2013 19:25		Teaching: Secure Belongings
/16/2013 19:25		Teaching: Plan Of Care Discussed
/16/2013 19:25		Teaching: Family Involvement
//16/2013 19:25		Teaching: Pain Management
7/16/2013 19:25	1. J	Teaching: Analgesia/Anesthesia
		Teaching: Epidural
7/16/2013 19:25		
7/16/2013 19:25		Teaching: Induction/Augmentation
7/16/2013 19:25		In Bed: High Fowlers
7/16/2013 19:25		Safety: Side Rails Up x 2
/16/2013 19:25		Safety: Call Light Within Reach
//16/2013 19:25	1.00	Patient Behavior: Comfortable
7/16/2013 19:25		Patient Behavior: No Complaints
		Consciousness: Oriented X3
7/16/2013 19:28		
7/16/2013 19:26		Fall Risk: Pertinent Diagnosis
7/16/2013 19:26		BP: 130 /81 mmHg
7/16/2013 19:26		P: 102 bpm
7/16/2013 19:27		T: 98.0 F
7/16/2013 19:27		R: 16 /min
7/16/2013 19:54		Blood Work Drawn by Lab: Per Order
7/16/2013 19:57		FHR Eval: Baseline 155 bpm /Variability Minimal
//16/2013 19:5/		/Accelerations Absent /Decelerations Variable
		FETAL DECEL DOWN TO 608PM FOR 40SEC.
7/16/2013 20:01		
7/16/2013 20:01		Contractions: Irregular
7/16/2013 20:04		Primary IV Initiated: R Hand 20G /LR 1000 ml
7/16/2013 20:04		IV Status: Infusing Well /Unremarkable
7/16/2013 20:08		Intervention: Position Change
7/16/2013 20:09		In Bed: Left Lateral
		Obstetrician: Paged
7/16/2013 20:15		
7/16/2013 20:15		Obstetrician: Responded to Page
7/16/2013 20:15		Obstetrician: Report Given
7/16/2013 20:15		Obstetrician: Reported Maternal Status
7/16/2013 20:15		Obstetrician: Reported Fetal Status
7/16/2013 20:15	-	report given to dr. on fetal decels and
192013 20.13		minimal variability, orders received.
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7/16/2013 20:17		
7/16/2013 20:20		FHR Eval: Baseline 160 bpm /Variability Minimal
		Accelerations Absent /Decelerations Absent
//16/2013 20:25		Penicilin G 5 Million Units IVPB over 30 min
7/16/2013 20:30		In Bed: Right Lateral
7/16/2013 20:56		FHR Eval, Baseline 165 born /Variability Minimal
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		Contractions: Occasional
7/16/2013 20:56		
7/16/2013 21:07		Obstetrician: Paged
7/16/2013 21:07		Obstetrician: Responded to Page
7/16/2013 21:07		Obstetrician: Reported Maternal Status
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7/16/2013 21:07		Obstetrician: Orders Received
7/16/2013 21:07		orders received per dr. for arom and
7/16/2013 21:07		



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Obstetrician: Paged

Obstetrician: Responded to Page

Obstetrician: Reported Maternal Status

Obstetrician: Reported Fetal Status

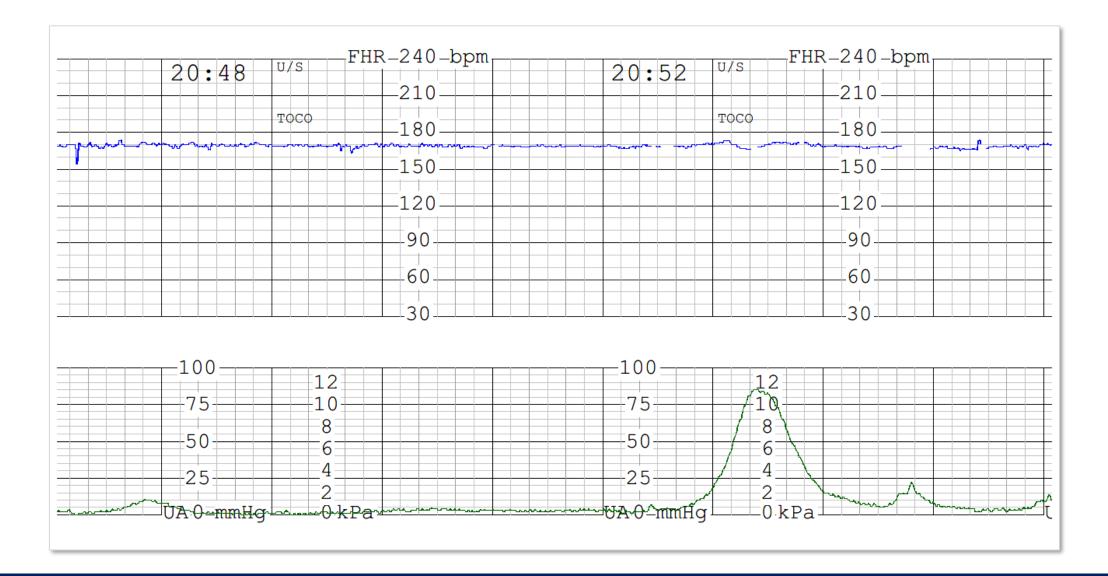
report given to Dr. on fetal decels and minimal variability.

Orders received.

Intervention: Oxygen On

	De	etail Notes Log
Note Date/Time	Entered By	Note
7/16/2013 19:17		AttendingDoc:
7/16/2013 19:18		Pt Type: LBR Labor
7/16/2013 19:18	a state of a sector of the sector in the	Care Provider:
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7/16/2013 19:18		G/P. 2/0
7/16/2013 19:18	Provide State Stat	GA: 40 /5
7/16/2013 19:19		Admit: From Home
7/16/2013 19:19		Admit: Ambulatory
7/16/2013 19:19		Admit: Accompanied by S.O.
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7/16/2013 19:25		Teaching: Induction/Augmentation
7/16/2013 19:25		In Bed: High Fowlers
7/16/2013 19:25		Safety: Side Rails Up x 2
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	1.00	
7/16/2013 19:25		Patient Behavior. Comfortable
7/16/2013 19:25		Patient Behavior: No Complaints
7/16/2013 19:26		Consciousness: Oriented X3
7/16/2013 19:26		Fall Risk: Pertinent Diagnosis
7/16/2013 19:26		BP: 130 /81 mmHg
7/16/2013 19:26		P: 102 bpm
7/16/2013 19:27		T: 98.0 F
7/16/2013 19:27		R: 16 /min
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07/16/2013 21:07		Analis i consistente presidente a consistente a consistent





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Obstetrician: Paged

- Obstetrician: Responded to Page
- **Obstetrician: Reported Maternal Status**
- **Obstetrician: Reported Fetal Status**
- **Obstetrician: Orders Received**
- Orders received per Dr. for AROM and
- internalize

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07/16/2013 21:07		Obstetrician: Orders Received
07/16/2013 21:07		orders received per dr. for arom and
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Obstetrician: Paged

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Ultrasound: Performed at

bedside

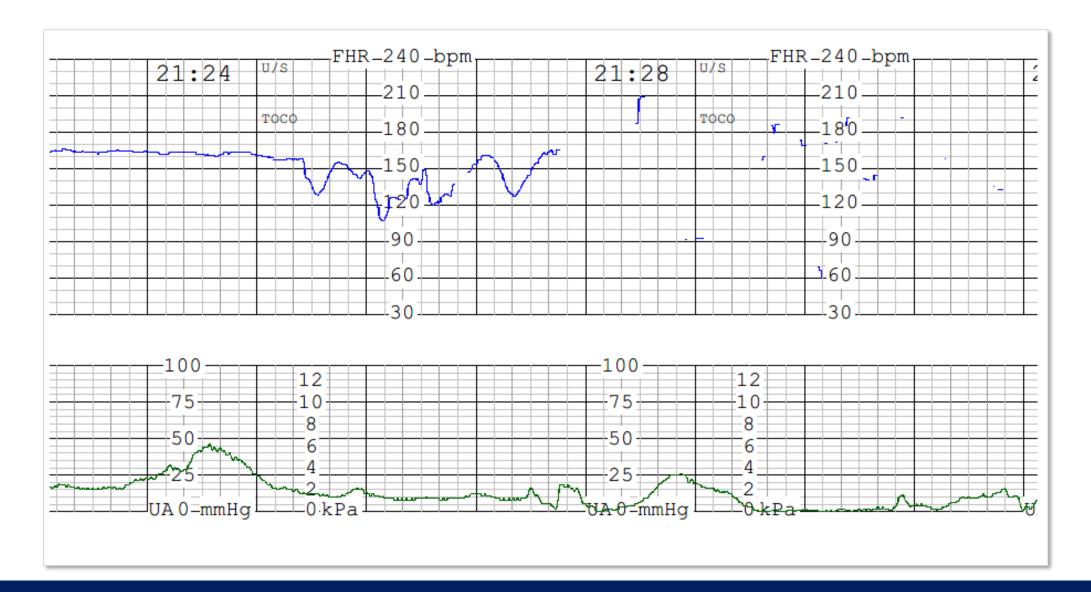
Exam: Dilation 4 cm

Examined By Physician:

4		internalize	
07/16/2013 21:13		Acoustic Slimulation: Procedure Exp	lained
07/16/2013 21:13	communication of the state of t	Acoustic Stimulation: Verbalizes Un	
07/16/2013 21:13	1	Acoustic Stimulation: Performed	activitationing
07/16/2013 21:15		Acoustic Stimulation: No Response	
	THE PARTY NAMES		
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07/16/2013 21:16		Mode: Mid per Toco /Soft to Palpati	on per 1000
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 Understandir	00
07/16/2013 21:30		Ultrasound: Performed at Bedside	-3
07/16/2013 21:31			tana di tanuna
		cephalic	and the second se
7/16/2013 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 PRI	
7/16/2013 21:43			and the dependent
	and the second sec	OB Hospitalist At Bedside	and the second second second second
7/16/2013 21:43		dr.	
7/16/2013 21:43		Teaching: Plan Of Care Discussed	
7/16/2013 21:43		Teaching: Family Involvement	
7/16/2013 21:43		Teaching: Pre-Op	
7/16/2013 21:43		Teaching: Post-Op	
7/16/2013 21:43	and a second provide the second		
		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	The second se	Consent Signed: Cesarean Section	
07/16/2013 21:52		Consent Signed: Epidural Anesthesi	
	and and an investor of the		
07/16/2013 21:54	International Advances of the second se	Pepcid 20 mg IV	
07/16/2013 21:59		Regian 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 Clip	bed
07/16/2013 22:07		Contractions: Irregular	
	and the same of second as another	FHR Eval: Baseline 165 bpm /Varial	All Linimal
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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	the second s
		Obstetrician: In Department	
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07/16/2013 22:25	_	Ancel 2 gm IVPB	
07/16/2013 22:26		FHR Eval: Baseline 160 bpm /Varial	bility Moderate
		/Accelerations Absent /Deceleration	s 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:	and have been seen to be a first
07/16/2013 22.49		Comment: PT TRANSFERRED TO VIA BED	OR-B IN STABLE CONDITION
07/16/2013 23:05		Nurse	
			and a second design of the second de-
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 1	Pitocin LR 1000 ml
211112013 00.10		/Dosage 20 units /Amt Remaining 6	
		T: 98.1 F	
07/17/2013 00:20			







2140

REPORT GIVEN TO DR. PER DR. ON

FETAL STRIP.

DR. COMING IN.

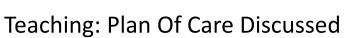
ORDERS RECEIVED TO PREP PT. FOR

PRIMARY C-SECTION

		internalize
7/16/2013 21:13		
	And and a second s	Acoustic Stimulation: Procedure Explained
7/16/2013 21:13		Acoustic Stimulation: Verbalizes Understanding
7/16/2013 21:13		Acoustic Stimulation: Performed
7/16/2013 21:15		Acoustic Stimulation: No Response
7/16/2013 21:16		FHR Eval: Baseline 165 bpm Mariability Minimal
		Accelerations Absent /Decelerations Absent
7/16/2013 21:16		UC Eval: Frequency: 5-6 Min
7/16/2013 21:16		UC Eval: Duration: 50-60 Sec
7/16/2013 21:16		Mode: Mild per Toco /Soft to Palpation per Toco
7/16/2013 21:16		UC Eval: Frequency: 5-6 Min
7/16/2013 21:16	part of the second s	
	and the second se	UC Eval: Duration: 50-60 Sec
7/16/2013 21:16		Mode: Mild per Toco /Soft to Palpation per Toco
7/16/2013 21:22		OB Hospitalist: Reviewed Strip
7/16/2013 21:22		Obstetrician: Paged
7/16/2013 21:30		Ultrasound: Procedure Explained
7/16/2013 21:30		Ultrasound: Verbalizes Understanding
7/16/2013 21:30		Ultrasound: Performed at Bedside
7/16/2013 21:31		cephalic
7/16/2013 21:33		Exam: Dilatation 4 cm
	a set and a second set	
7/16/2013 21:33		Examined By Physician:
7/16/2013 21:40		REPORT GIVEN TO DR. PER DR. DR.
		ON FETAL STRIP. DR. COMING IN. ORDERS
Statement Characteristic	-	RECEIVED TO PREP PT. FOR PRIMARY C-SECTION
7/16/2013 21:43		OB Hospitalist. At Bedside
7/16/2013 21:43		dr.
7/16/2013 21:43		Teaching: Plan Of Care Discussed
7/16/2013 21:43	terrative states and the second	Teaching: Family Involvement
//16/2013 21:43		Teaching: Pre-Op
7/16/2013 21:43		
		Teaching: Post-Op
7/16/2013 21:43		Teaching: Cesarean
7/16/2013 21:50		Anesthesiologist: Notified
7/16/2013 21:52		Pediatrician: Report Given
7/16/2013 21:52		NNICU NOTFIED TO BE PRESENT FOR DELIVERY
7/16/2013 21:52		Consent Signed: Cesarean Section
7/16/2013 21:52		Consent Signed: Epidural Anesthesia
7/16/2013 21:54	and and an inclusion of the second	Pepcid 20 mg IV
7/16/2013 21:59		Regian 10 mg IV
7/16/2013 22:00		Bicitra 30 ml PO
7/16/2013 22:06		Cesarean Prep: Abdominal Prep
7/16/2013 22:06		Cesarean Prep: Abdominal Hair Clipped
7/16/2013 22:07		Contractions: Irregular
7/16/2013 22:07	the second se	FHR Eval: Baseline 165 bpm /Variability Minimal
		/Accelerations Absent /Decelerations Absent
7/16/2013 22:17		BP: 127 /82 mmHg
7/16/2013 22:17	and the second s	P: 92 bpm
11.1.4.4.4.1.4.4.4.4.1.1.	A	T. 98.1 F
7/16/2013 22:17		
7/16/2013 22:17		R: 16 /min
7/16/2013 22:19		Obstetrician: In Department
7/16/2013 22:25	-	Ancel 2 gm IVPB
7/16/2013 22:26		FHR Eval: Baseline 160 bpm Manability Moderate
		/Accelerations Absent /Decelerations Absent
7/16/2013 22:26		Contractions: Irregular
7/16/2013 22:26	_	Obstetrician At Bedside
7/16/2013 22:26		dr.
7/16/2013 22.26		Teaching: Plan Of Care Discussed
7/16/2013 22:47		Report Given
7/16/2013 22:48	12	Report Received.
7/16/2013 22.49		Comment PT TRANSFERRED TO OR-B IN STABLE CONDITION
		VIA BED
7/16/2013 23:05		Nurse
		Recovery Initiated: .
747/0013 00:10	-	Procedure: Primary Cesarean
07/17/2013 00:19 07/17/2013 00:19	**	
7/17/2013 00:19 17/17/2013 00:19	**	Anesthesia: Duramorph Spinal
7/17/2013 00:19 7/17/2013 00:19		Anesthesia: Duramorph Spinal Primary IV Assessment: Fluid/Med Pitocin LR 1000 ml
7/17/2013 00:19 7/17/2013 00:19		Anesthesia: Duramorph Spinal
7/17/2013 00:19		Anesthesia: Duramorph Spinal Primary IV Assessment: Fluid/Med Pitocin LR 1000 ml

07/16/2013 21:13	and the second s	Internalize 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: 5-8 Min
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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	a 4.45	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
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07/16/2013 21:54	and a second sec	Pepcid 20 mg IV
07/16/2013 21:59		Regian 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
hours and a second second		/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		Ancel 2 gm IVPB
07/16/2013 22:26		FHR Eval: Baseline 160 bpm /Variability Moderate
07710/2013 22.20		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
07/18/2013 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

2143



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



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Acoustic Simulation: Procedure Explained Acoustic Simulation: Verbalizes Understanding Acoustic Simulation: No Response FHR Eval: Baseline 165 bpm /Variability Minimal /Accelerations Absent /Decelerations Absent UC Eval: Frequency: 5-6 Min UC Eval: Duration: 50-60 Sec Mode: Mid per Toco /Soft to Palpation per Toco UC Eval: Prequency: 5-6 Min UC Eval: Prequency: 5-6 Min UC Eval: Duration: 50-60 Sec Mode: Mid per Toco /Soft to Palpation per Toco OB Hospitalist Reviewed Stip Obstetrician: Paged Ultrasound: Procedure Explained Ultrasound: Procedure Explained Ultrasound: Procedure Explained Ultrasound: Procedure Explained Ultrasound: Procedure Explained Ultrasound: Procedure Explained Ultrasound: Procedure Explained Obstetrician: Paged Ultrasound: Procedure Explained Ultrasound: Performed at Bedside cephalic Exam: Diatation 4 cm Examined by Physician: REPORT GIVEN TO DR. PER DR. DR. ON FETAL STRIP. DR. COMING IN .ORDERS RECEIVED TO PREP PT. FOR PRIMARY C-SECTION OB Hospitalist At Bedside dr. Teaching: Paratify Involvement Teaching: Paratify Involvement Teaching: Cesarean Anesthesiologist. Notified Pediatbesiologist. Notified Pediatbesiologist. Notified Pediatbesiologist. Notified Pediatbesiologist. Notified Pediatbesiologist. Notified Pediatbesiologist. Notified Pediatbesiologist. Notified Pediatorian: Report Given NNICU NOTFIED TO BE PRESENT FOR DELIVERY Consent Signed: Epidural Angesthesia Peged 20 mg IV Bictra 30 ml PO Cesarean Prey: Abdominal Prep Cesarean Prep:		intermaline.	
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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

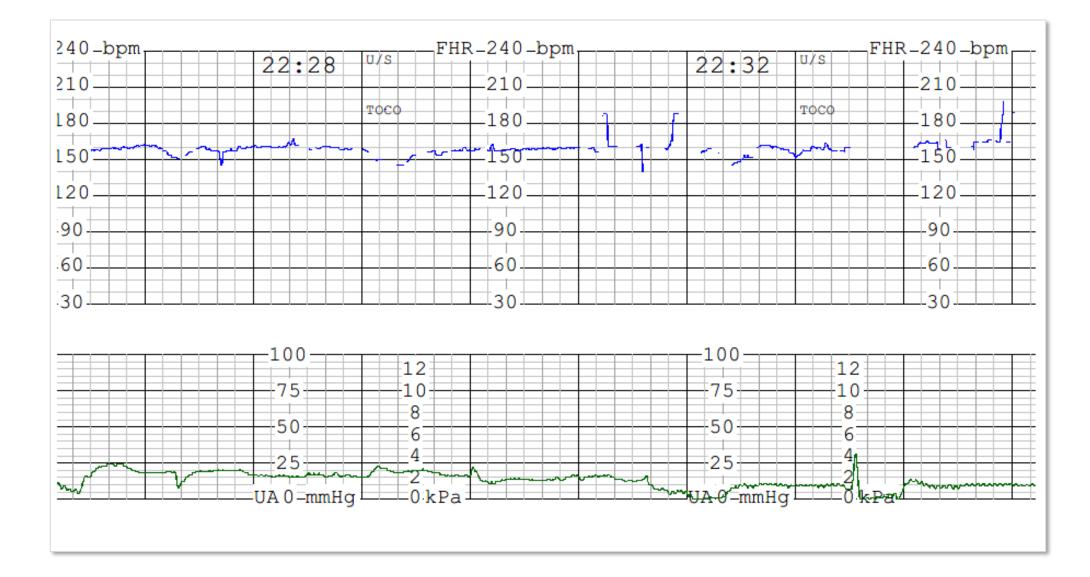
P: 92 bpm

T: 98.1 F

R: 16 /min







2226

Obstetrician: At Bedside

Teaching: Plan Of Care Discussed

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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
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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	the second	REPORT GIVEN TO DR. PER DR. DR.
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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
CONTRACTOR CONTRACTOR		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
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07/16/2013 21:52		Consent Signed; Epidural Anesthesia
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07/16/2013 22:06		Cesarean Prep: Abdominal Hair Clipped
07/16/2013 22:07		Contractions: Irregular
07/18/2013 22:07		FHR Eval: Baseline 165 bpm /Variability Minimal
		/Accelerations Absent /Decelerations Absent
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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 22:26		Obstetrician At Bedside
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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 nonreassuring 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





- 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) Term intrauterine pregnancy at 40 weeks and 5 days gestational age. Nonreassuring fetal heart tones. POSTOPERATIVE DIAGNOSIS(ES): Term intrauterine pregnancy at 40 weeks and 5 days gestational age; Nonreassuring fetal heart tones. 3. Face presentation, mentum transverse, maternal right Nuchal cord x3, tight. Body cord x1. PROCEDURE(S): Primary low transverse cesarean section via Pfannenstiel skin incision.

FACTS OF THE CASE

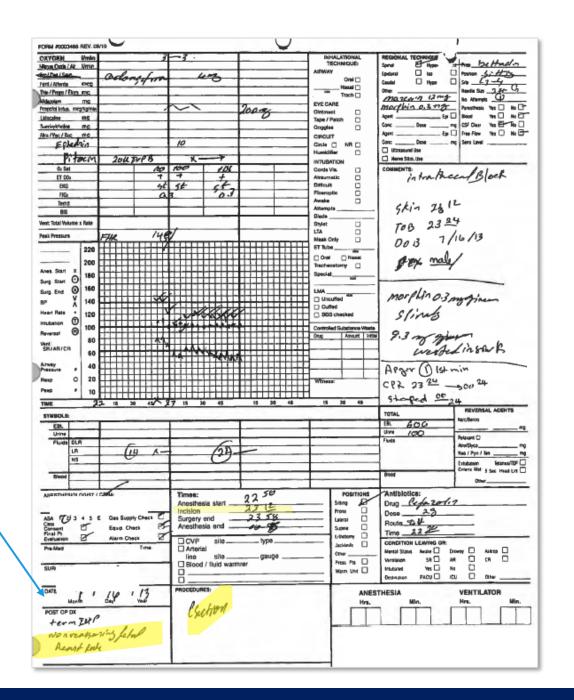


INDICATIONS: The patient is a 30-year-old G2, P0-0-1-0 who presented to labor and delivery at 40 week and 5 days based on a first trinester ultrasound; for induction. When the patient was placed on the monitor, fetal heart tones demonstrated minimal variability as well as variable decelerations. Despite 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

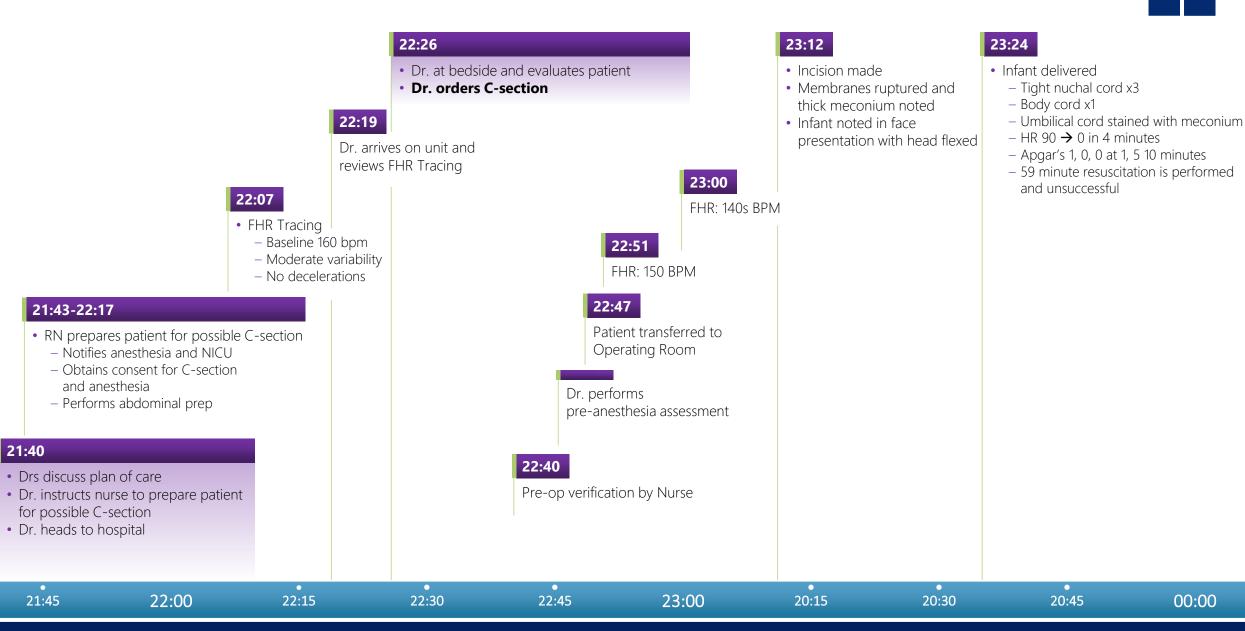
Incision time: 2312

Decision to Incision: 92 min

Delivery Cesarear	1 Type 1	rimary		Location	OR-B	
c	esarean Delivery		Presentation	Face		
Primary Indication	Other		Position			
and Indication			Episiotomy			
rd Indication			X Sponge Col	unt Correct 25		
th Indication			X Needle Cou			
Elective Cesare	an		-	0		
Uterine Incision	Low Transverse			Laceratic		
Decision Date/Time	07/16/2013 21:40		-			
ncision Date/Time	07/16/2013 23:12		Туре	Degree	Repair	
Decision to Incision	92 minute(s)					
HR in OR 150 SustomDelivery1	bpm					
BL 600 ml		_ •	ther Operative Proc	edure		
		Pla	centa Delivery Ma	nual		
		PI	lacenta Cultures Ot	stained		
		XP	acenta Sent for Exa	mination		
		Time C	Out Delivery	Yes		
Comments:						

DELIVERY REPORT

ADMISSION TIMELINE OF EVENTS





00:00

FHR IN THE DELIVERY ROOM



Delivery Cesarean	Type Pr	imary		Location	OR-B
C	asarean Delivery		Presentation #	-	
Primary Indication	Other		Position	a çe	
2nd Indication			Episiotomy		
3rd Indication				_	
4th Indication			X Sponge Cou		
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Decision Date/Time	07/16/2013 21:40			Lacerat	llons
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		Place	nta Delivery Man	ual	
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		Time Out	Dallara	Yes	

FHR in OR 150 bpm

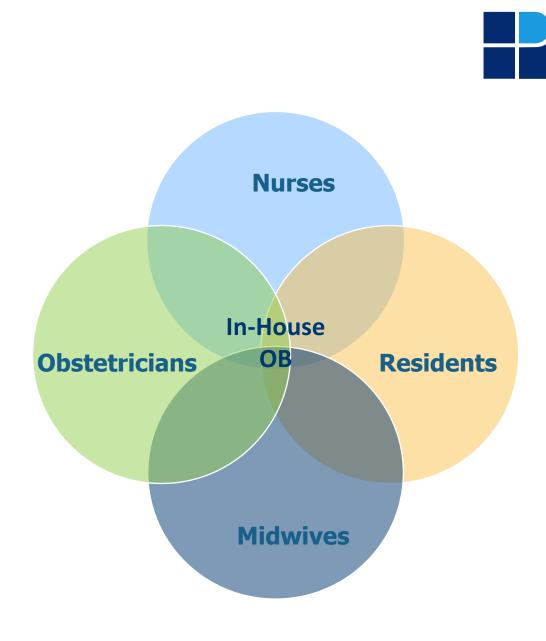
WHAT WAS THE JURY'S VERDICT?

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

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

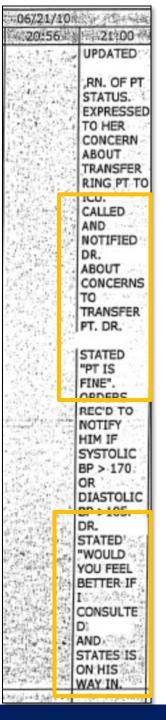


- 8:00 AM 34 y/o G5 P4 @ 37weeks presented to ED with complaints of
 - Epigastric pain
 - BP 155/88
 - Patient admitted to L&D
 - HELLP syndrome diagnosed
 - MD ordered Pitocin IOL
- 3:12 PM Infant delivered with Apgars 9, 9, 9
- 3:30 PM Patient c/o headache and epigastric pain, Tylenol given
- 4:00 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

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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 nonresponsiveness
- 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

KNOWYOUR 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

• Who was in the EMR – and when?

- Viewing
- Signing-in
- Documenting

EMR – AUDIT TRAILS

- 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?



Privileged & Confidential

		Clinician ID All Clinician Name All	User Name All	Show All
		▲ ▼ 7 Detail (Location or Query)	User Name	
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- 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 						_ 8
 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 		333886 880 28	xionin eini e d	5 m ® a a	ព្រ	?×
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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





Thank You!

MARILEE CLAUSING, Managing Partner

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HALL PRANGLE LLC