OB Claims Data and Risk Reduction Strategies

Ann Whitehead, RN, JD
Vice President, Risk Management & Patient Safety

We all know that expectant parents wish and hope for a “perfect” baby and smooth delivery. When those expectations are not realized, automatically the assumption is something must have gone wrong or someone must have done something wrong during delivery. But those of us who work in health care know that in the world of obstetrics, often there is no single factor, act, or omission for an untoward event, but rather a combination of factors that may have occurred.

Data can help reveal vulnerabilities and developing trends in liability and risk. Data also holds the key to risk reduction and supports the design of risk strategies and solutions. To be successful in the design of risk reduction strategies, leaders must revisit the data often and listen to their staff regarding safety improvements and commitment to change. It is important for hospitals and health systems to evaluate their own obstetrical risk. An analysis of professional liability (malpractice) claims data, adverse events, incident reports, and high-risk procedures will assist the organization to develop proactive targeted interventions that could dramatically reduce medical error, prevent patient injury, and minimize financial loss. For those facilities that do not have enough data, the 2010 CRICO Benchmarking Report, “Malpractice Risks in Obstetrics,” is a good place to start. CRICO Strategies found that “clinical judgement errors” and “infrequency or inexperience” are at the root of the majority of OB malpractice cases. These issues are often common to cases involving improper management of an assisted vaginal delivery, shoulder dystocia, and maternal hemorrhage. Thus, a targeted assessment of your systems and staff training in the above areas can mitigate risk and improve patient outcomes.

Continued on Page 2
Proactive, innovative risk mitigation strategies are borne from targeted assessments and continuous improvement opportunities. For your hospital or medical facility, OB risk mitigation strategies might include implementing an electronic fetal monitoring bundle, staff and physician credentialing in fetal monitor strip interpretation, a strong escalation policy, or establishment of an OB rapid response team. Perhaps it includes intervention, such as simulation training to help staff perfect the communication and technical skills needed to optimize situational awareness and ensure a swift and coordinated response to obstetrical emergencies. Change begins with collaboration between hospitals, health systems, physicians, and insurers. This newsletter is devoted to addressing proactive education and training for obstetric health care providers. I encourage you to carefully read all articles in this issue of The Patient Safety Advocate — each addresses specific obstetric risks and offers innovative, time-tested ways to reduce those risks and improve patient safety.

* CRICO Strategies is a division of the Risk Management Foundation of the Harvard Medical Institutions, Inc., a CRICO Company. CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard Medical Community. CRICO’s Comparative Benchmarking System (CBS) is a national database exceeding 300,000 medical professional liability (MPL) claims from more than 400 hospitals and 165,000 physicians.

**Shouldering Brachial Plexus Litigation**

Joann Hofmann, RN, BS
CAP Senior Claims Specialist, Obstetrics

*Brachial plexus injury as a result of shoulder dystocia is traumatizing to the involved clinicians and may generate liability exposure. The most difficult challenge with a shoulder dystocia case is impressing upon the trier of fact (the jury), that it is not just the shoulder, but the entire baby that is impacted, which at some point, if not resolved, may require increased efforts to release the shoulder.*

In professional forums, physicians often ask, “What could I have done differently?” and “How could I have better prepared myself and my patient for this potential outcome?” Understanding the potential allegations is a good place to start.

**Common Allegations**

When birth injury results in allegations of professional negligence, the medical record becomes a primary piece of evidence. To the “trier of fact,” what is not documented speaks as loudly as what is documented. When the medical record is “silent” regarding the physician’s discussion with the patient and only includes “suspected large baby, schedule induction,” it becomes anyone’s guess as to what was actually discussed with the patient. Plaintiffs often testify, “No one told me the baby was large” or “I was never offered a Cesarean section... I would have had a C-section if I had been told my baby could be injured.” The absence of documentation leaves the physician vulnerable to allegations that the discussion never happened. Thorough documentation showing that fetal and maternal risk factors were identified

---

**Risk Factors Associated with Shoulder Dystocia**

**Maternal**
- Abnormal pelvic anatomy
- Gestational or pre-gestational diabetes
- Post-term pregnancy
- Previous shoulder dystocia
- Short stature (less than 5 feet tall)
- Obesity >200 lbs
- Previous large infant >4000 grams

**Fetal**
- Suspected macrosomia

**Labor Related**
- Operative vaginal delivery
- Protracted active phase
- Prolonged second stage
- Precipitous delivery

and addressed with the patient in the antepartum and intrapartum periods will reflect favorably before a jury.

Common allegations brought by plaintiffs include:

- Failure to identify and manage risk factors in the antepartum period, such as diabetes and macrosomia
- Failure to sufficiently inform or obtain consent from the patient
- Failure to document the risks and options provided to the patient regarding the choice between vaginal delivery and Cesarean section
- Failure to offer Cesarean section
- Failure to properly manage the dystocia through the use of instrumentation or excessive force or traction during delivery
- Failure to recognize potential macrosomia or document and estimate of fetal weight

### Risk Factors and Risk Reduction Strategies

Current evidence suggests that shoulder dystocia is neither predictable nor preventable. In fact, about half of all shoulder dystocia cases occur with no identifiable risk factors. Nevertheless, obtaining and documenting a thorough prenatal history and identifying and managing factors associated with increased risk is essential. The American Congress of Obstetricians and Gynecologists (ACOG) lists a number of risk factors associated with shoulder dystocia (see chart on page 2).

### Documenting Fetal Weights

High birth weight is regarded as a major risk factor for shoulder dystocia. Unfortunately, current diagnostic methods for assessing fetal weight remain imprecise. Two conventional methods for estimating fetal weight are Leopold’s maneuvers and ultrasound. Although many consider ultrasonography to be no more accurate than palpation, obtaining a late third trimester ultrasound can support a decision to opt for a trial of labor. When the actual weight at birth is considerably larger than the ultrasound estimate and a shoulder dystocia occurs, the ultrasound discrepancy attests to the limitations of available technology and the difficulty of diagnosing macrosomia.

Documenting both an estimated fetal weight by Leopold’s and a third trimester ultrasound in the prenatal record provides strong evidence of efforts to rule out macrosomia, and may be beneficial to the defense. Additionally, the inclusion of an estimated fetal weight in the labor progress note demonstrates conscientious evaluation of risk factors through delivery. These steps provide valuable evidence that, at the time the decision was made to proceed with vaginal delivery, all available technology was utilized.

### Informed Consent and Informed Refusal

When a large baby is suspected, thoroughly discuss with the patient the specific fetal and maternal risks associated with vaginal delivery, as well as the risks and benefits of available alternatives. In the informed consent discussion, the clinician should describe in layperson’s terms the complication of shoulder dystocia and the specific risks of injury to the baby. Specifically, discuss the risk of brachial plexus injury, severe neurological damage, and death. Then, most importantly, document it in detail!

Detailed documentation of the discussion may seem onerous at the time, but it is negligible when compared to litigation that can extend for years and a trial that lasts for weeks. It’s the caliber of evidence that can deter litigation and greatly aid the defense. Without it, the case can easily devolve into a “he said, she said” dispute between plaintiff and defendant.

Continued on Page 4
When a large baby is suspected, consider using a progress note or consent form to enumerate the details of the discussion, including the specific risks associated with vaginal delivery versus Cesarean section. Also note the patient’s informed decision to proceed with a trial of labor or her informed refusal of recommendation for Cesarean section. Finally, the patient should be asked to sign the note, indicating that she has been fully informed and agrees with the plan of care.

**Prenatal Record**

Prenatal records are forwarded to labor and delivery at approximately 36 weeks gestation, often before macrosomia becomes a concern, leaving labor and delivery staff unaware of the potential for shoulder dystocia. I recommend practitioners establish a process to notify the labor and delivery unit of potential shoulder dystocia once the risk is suspected and a process for flagging the chart for the unsuspecting on-call physician. Communication with staff and covering physicians can reduce liability in the event of a dystocia. A large number of brachial plexus cases involved the unsuspecting on-call physician who has no knowledge of the patient’s history and may not have met the patient prior to being called for the delivery. The on-call physician is all too often presented with this emergency and finds himself or herself in litigation. A lack of prior relationship with the patient who delivered the baby coupled with birth injury is an excellent recipe for litigation.

**Plan of Care**

If a trial of labor is deemed appropriate, discuss and document the plan of care, making certain the patient is in agreement. Explain the plan is for her to progress normally without instrumentation and, if there is any arrest in dilation or descent, the plan will be to convert to Cesarean section. Prolonged second stage with suspected macrosomia is not recommended. Nor is the commonly known “laboring down.” If at any point, there is the need to change the initial plan, document well in the progress note what changed and the rationale for the change. Many physicians facing litigation regret having “second guessed” themselves by allowing the patient “a little more time” to deliver vaginally or assisting with instrumentation. Unfortunately, deviating from the plan may produce the very outcome one is trying to avoid. Generosity in allowing the patient to push longer will be quickly forgotten in the presence of a poor outcome.

**Labor and Delivery**

Having the right people in the room to assist with maneuvers or timely resuscitation is optimal. A well trained and prepared staff is essential for this emergent situation. Staff training through mock drills is important to raise team situational awareness and comfort level when confronted with shoulder dystocia. However, at times, staff may not be available, and sometimes family is the only available help. Having a family member available to assist with McRoberts positioning is suboptimal, but certainly may be used if absolutely necessary. Be sure to document who assisted with what maneuvers. In this emergency situation, it is important to document the time the head was delivered to indicate how long the dystocia lasts. This can be done by simply making a mark on the fetal tracing when the head delivers and again when the body delivers. This will assist with critical decision making during the dystocia and with neonatal evaluation of the baby after delivery, and helps to memorialize the event in real-time.

**The Delivery Note**

In addition to the above concurrent documentation of when the dystocia occurred, the delivering physician’s note should identify the baby’s head position, maneuvers used, and timing. The head position at delivery is critical since the anterior shoulder is the most commonly injured shoulder. It is important to document the baby’s head position, maneuvers used, and timing. The head position at delivery is critical since the anterior shoulder is the most commonly injured shoulder. It is important to identify and document the baby’s head position, maneuvers used, and timing. The head position at delivery is critical since the anterior shoulder is the most commonly injured shoulder. It is important to identify and document the baby’s head position, maneuvers used, and timing.
contractions during the dystocia and estimated time of the dystocia. In the event the baby is injured, document the location of the injury, right or left arm, and the extent to which movement is decreased, i.e., moving fingers versus no movement. Inform the patient as soon as you have completed delivery and document your discussion.

**Empathy and Support**

In the aftermath of a shoulder dystocia, patients have a strong desire for information about what happened. Do not hesitate to inquire as to the baby’s well-being during the hospitalization and at the post-partum visits. Always be available to answer questions. Reference earlier discussions about risks and recount the extensive efforts made by the team. Don’t place blame or avoid the patient. Document all your discussions.

**Conclusion**

Shoulder dystocia is an obstetrical emergency. It is not always predictable, but certainly critical when it is encountered. It is essential to prepare for shoulder dystocia at the beginning of the pregnancy. Obtaining and documenting a thorough prenatal history and identifying and managing factors associated with increased risk is important. Good documentation, communication, and team work are essential to reducing risk, improving patient outcomes, and limiting liability.

Joann Hofmann, RN, BS, is a Senior Claims Specialist in obstetrics at the Cooperative of American Physicians. She has 26 years’ experience as a registered nurse in labor and delivery and has worked as a clinical educator in obstetrics, teaching both basic and advanced fetal monitoring and as director of obstetrics. For the past 10 years she has managed high-value obstetrical claims at CAP.

**Take Away Tips**

1. Eliminate the “he said, she said” by thoroughly documenting discussions with the patient.
2. Identify the risk factors and notify support staff and physicians who may also be involved in the delivery.
3. Slow down. Use gentle traction, move through maneuvers slowly and allow time for them to work.
4. Document the position of the head at delivery, the maneuvers utilized to relieve the dystocia, the number of attempts with gentle downward traction, and length of time the dystocia lasted.
5. Document any injury observed and document your discussion with the parents regarding the injury.

For more information about shoulder dystocia and to view related photos, visit [http://www.shoulderdystociainfo.com/shoulder_dystocia.htm](http://www.shoulderdystociainfo.com/shoulder_dystocia.htm)

The Importance of Fetal Monitoring Certification and Owning the Strip

An interview with Paul R. Weber, MD, PhD

Dr. Weber is the current Chairman of CAP’s OB Claims Review Committee. Additionally, as a Teaching Professor of Obstetrics and Gynecology at UC Irvine School of Medicine, Dr. Weber instructs residents and medical students how to interpret fetal monitor strips.

With over two decades’ experience and insight into birth injuries, what advice would give about fetal monitoring?

That’s easy. It would definitely be “Own... The... Strip!” It’s yours and it’s really nothing to be casual about. It’s not a footnote or some ancillary bit of information: It’s a crucial piece of diagnostic information that helps to tell the story of what’s happening with the baby. If something goes wrong, it’s the evidence you’ll need to defend your decisions. Given its significance, it’s prudent to seek out any opportunity to improve your interpretation of it and to hone your clinical judgment. We should always challenge ourselves to maintain and improve our skills.

You’re an ardent proponent of OBs and clinicians obtaining Fetal Monitoring Credentialing through the Perinatal Quality Foundation. Why?

Credentialing enables physicians to more expertly interpret the fetal heart rate monitor strip, which helps reduce the chances of an adverse event during delivery and prevent fetal injury. What we’ve learned over the years in evaluating obstetric claims is that at least half of these cases involve interpreting the fetal monitor strip and the appropriate management of the patient. As you know, OB claims often involve catastrophic injury—they’re devastating. What’s supposed to be the happiest day in a mother’s life can unexpectedly turn tragic. OB claims also are known to be the most expensive and devastating because when a child is born with a neurological injury, that child’s future medical care can be very costly.

Fetal monitoring is a dynamic process. It’s more than just an academic exercise in interpreting a strip—it’s also about appropriate management of the patient. If you ask five physicians to interpret a specific fetal monitor strip, you might get several different interpretations of the tracing. But as information is gathered about the clinical picture, those interpretations should “cone down.” As the clinical picture becomes clear, there should be greater agreement in interpreting the baby’s status as well as greater alignment on how to manage the labor. This alignment is important and is why this particular credentialing test is so unique and important. Instead of being an academic “rote” test of knowledge, it measures physician judgment in a true-to-life clinical scenario that’s constantly changing and sometimes ambiguous.

How does the test measure judgment?

Your traditional multiple choice test questions usually present a well-defined clinical scenario and a set of facts that lead you to one right answer. In contrast, this new testing pedagogy called “Script Concordance Testing” presents vague data, in a scenario that’s unclear and constantly changing, and there isn’t just “one right answer” — there may be several possible solutions. It’s a huge innovation in health sciences education. The test is produced by the Perinatal Quality Foundation, a nonprofit organization committed to improving the quality of obstetrical care. The test is unique in that it measures more than physician knowledge-base or recall of nomenclature. It goes further and evaluates one’s mental processes and reasoning in ambiguous clinical situations, which is far closer to the actual clinical experience.

Is there an educational component to this credential?

No, and that’s an important question. This is solely a test that results in a credential and doesn’t provide any additional education or tutorial. There are a number of very sophisticated, interactive learning programs for OB and other high-risk areas that assess the specific learning needs of the clinician, which then design a “customized curriculum” for that individual. Those programs are another excellent way to provide ongoing education and training for physicians and clinicians. The great push is to reduce clinical variation, improve quality, and employ best practices. Through education and credentialing, we can get everyone up to speed and speaking the same language.

Who do you think should obtain this credential?

Doctors, NPs, midwives, labor and
delivery nurses, perinatal clinicians—everyone on your team. In labor and delivery, we have a strong team ethic. Everyone needs to not only “speak the same language,” but improve their assessment and judgment of the clinical situation. I know from experience that we rely on each other and we listen to each other’s concerns. If someone says, “I’m concerned,” it’s essential to listen and investigate those concerns. This credential, I feel, gets at the truest test of one’s clinical judgment and reasoning. If a physician or nurse earns it, it definitely says something about the clinician’s expertise and also reflects well on the institution.

Simulation Training Improves Perinatal Outcomes

Ann Whitehead, RN, JD

Obstetrics is a high-risk specialty in which emergencies are, to some extent, inevitable. Traditional risk management strategies based on adverse event reports and investigation are reactive and not always effective in understanding the multiple communication errors that occur. Planning for potential emergency events is challenging. Statistics from The Joint Commission (TJC) indicate that inadequate communication between providers or between providers and patients/families is the root cause of 60% to 70% of investigated sentinel events in medicine.¹

Obstetric units face the same challenge. The Joint Commission Sentinel Event #30 investigated 47 perinatal deaths and reports that poor communication was the most frequent root cause, involved in 72% of adverse events, with 55% of cases additionally involving an organization culture preventing effective teamwork and communication.² Birth trauma, a high-severity, low-frequency event, makes obstetrics a major challenge for patient safety.

Errors in medicine are frequently due to an interaction of human factors, such as poor teamwork and poor communication rather than individual mistakes. Hence, continuous team training is needed. A study published in the Joint Commission Journal on Quality and Patient Safety,³ compared the impact of didactic training versus in situ simulation training on perinatal safety. The study concluded that a comprehensive interdisciplinary team training program using in-situ simulation can improve perinatal safety in the hospital setting. This is the first evidence providing a clear association between simulation training and improved patient outcomes. Didactic alone were not effective in improving perinatal outcomes.”

Simulation Training

Simulation training is a proactive approach to reducing errors and improving communication and teamwork in obstetrics. Studies have shown that there is a close relationship between effective teamwork, training, and patient safety.

Simulation training enhances team dynamics, builds confidence, and enhances skills in a risk-free environment. It is hoped to provide technical and behavioral skills to manage crises, avoid adverse events, and ultimately improve patient outcomes.

Simulation Training is also a way to enhance physician-RN teamwork and improve communication among the health care delivery team. In a team setting, simulation training can affect knowledge, attitudes, and team skills. Additionally, the participants can improve specific technical skills and equipment knowledge, and develop leadership and teamwork skills.

There are many advantages to simulation training over traditional didactic medical education, including, exposure to complicated high-risk clinical scenario, training opportunities in a controlled environment, ability to provide immediate feedback, and opportunities to learn from mistakes. Simulation training is recommended by TJC and should be considered part of yearly staff team training.

Inside This Issue

OB Claims Data and Risk Reduction Strategies Page 1

Shouldering Brachial Plexus Litigation Page 2

The Importance of Fetal Monitoring Certification and Owning the Strip Page 6

Simulation Training Improves Perinatal Outcomes Page 7