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RISK MANAGEMENT PERSPECTIVES

Labor and Delivery Team:

Communication Strategies for Risk Reduction

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Labor and Delivery Team:
Communication Strategies for Risk Reduction

INTRODUCTION

During labor and delivery, when the passage of time can mean the difference between life and death or permanent disability, robust and effective communication is critical. Improving communication requires a coordinated effort by everyone on the labor and delivery (L&D) team, their affiliated practice groups, and the facilities in which labor and delivery occur. Everyone on the team should feel equally responsible for maternal and fetal safety and should support other members of the team to proactively manage risks.[1]

Several common nurse-physician communication breakdowns occurred in the birth injury closed claims analyzed for this article, including:

- Nurses failed to inform obstetricians (OBs) of worrisome changes in fetal or maternal status, OBs failed to recognize the significance of information reported to them, or OBs failed to obtain sufficient information during exchanges with nurses.
- OBs refused nurses' requests to examine/evaluate patients.
- Nurses and OBs failed to resolve disagreements about labor management.
- Fetal or maternal well-being was assumed because no one raised concerns.

Communication breakdowns such as these can contribute to delivery delays. Parents' assumptions that delivery delays caused their infants' brain injuries can prompt lawsuits. Strategies for improving communication among members of the labor and delivery team follow each case study.

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Clinical Conflicts:

Activating the Chain of Command During Labor

When a clinical conflict arises during labor, activating the chain of command can provide a pathway to avoid delivery delays.

CASE ONE

Allegation: Delayed delivery caused fetal brain injuries.

A 30-year-old patient at 34-weeks gestation presented to L&D reporting decreased fetal movement.

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10:14	The L&D nurse noted the fetal heart monitor (FHM) tracing showed minimal variability. To determine whether the lack of variability was due to a sleep state, she used vibroacoustic stimulation (VAS) but got no response.
10:34	Concerned for fetal well-being, the nurse contacted the on-call OB. In response to the nurse's report, the OB ordered an ultrasound for amniotic fluid index, and a lactated Ringer's bolus. The nurse suggested a biophysical profile (BPP), but the OB told her they were unreliable. The nurse obtained a BPP anyway.
11:31	The nurse called the OB to report 4/10 BPP results and continuing minimal and absent variability. The OB admonished the nurse for not executing her original order, and then ordered an obstetrical ultrasound for size and dates. The L&D nurse reported to the charge nurse her disagreement with the on-call OB's plan of care and concern for fetal well-being.
12:00	The L&D nurse called the OB to report the ultrasound results: estimated fetal weight: 2300 grams, gestational age: 34 weeks. The OB ordered continued observation. The nurse reminded the OB of the BPP score and the category 2 FHM tracing. She asked the OB to come to the patient's bedside immediately. The OB told her she would be there shortly.
12:37	The FHM tracing showed late decelerations, which continued until the infant was born.
12:44	The L&D nurse called the OB again to express her concerns about fetal well-being and request the OB's presence at bedside. The OB told the nurse she was on her way.
12:53	The OB was at the bedside. She ordered betamethasone to promote pulmonary maturity, continued observation, and consideration of a C-section if the tracings worsened.
13:37	The L&D nurse documented minimal variability, a late deceleration, and contractions at 5-15 minutes apart with a duration of 60 seconds.
14:55	The OB ordered a C-section (not emergency) due to a non-reassuring FHM tracing.
15:45	The C-section started.
15:51	The infant was delivered. Apgars were 0/2/5 at one, five, and 10 minutes.

The parents sued all members of the L&D team and the hospital, alleging the delay in delivery caused the infant's brain injuries. The child was diagnosed with cerebral palsy and profound intellectual disability. He would require lifelong attendant and/or nursing care.

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DISCUSSION

At the outset, the litigation targeted the OB. Defense standard of care consultants reviewing the OB's management of the patient were not supportive due to several issues. In their opinion, the FHM tracing was concerning on presentation and showed no signs of improvement. In response to the L&D nurse's initial report of minimal to absent variability with no response to VAS, the OB should have presented at the patient's bedside more quickly. Furthermore, the OB's disregard for the 4/10 BPP results could not be supported. In one consultant's opinion, most OBs would have delivered this baby within an hour of the mother arriving to L&D. Admittedly, the baby was at risk of respiratory distress with delivery at 34 weeks gestation. Accordingly, stalling delivery until the betamethasone was fully efficacious would have been appropriate under different circumstances. But given the continued non-reassuring tracing, the risk of fetal neurological injury or death outweighed the likely respiratory distress the baby would have due to prematurity and underdeveloped lungs.

In addition to standard of care issues, the defense of the OB was complicated because the OB and the other members of the L&D team blamed each other for the poor outcome.

OB consultants believed the L&D nurse's interpretation of the FHM tracing was accurate, and her advocacy for the patient was commendable. Plaintiff's nursing experts, however, believed the L&D nurse was required to activate the chain of command when the OB did not come into the hospital to evaluate the patient, which included continuing up the chain of command when the charge nurse failed to resolve the problem. (Although the L&D nurse believed she had activated the chain of command, the charge nurse did not register the severity of the L&D nurse's concern and did not understand the L&D nurse was expecting her to step in.)

In addition to standard of care issues, the defense of the OB was complicated because the OB and the other members of the L&D team blamed each other for the poor outcome. They were expected to testify against each other if the case went to trial, and their recollections of the events were different. Further complicating the OB's defense were sparse records and limited memories of the labor and delivery. The OB had a poor relationship with the L&D staff. Because of her past experiences, she doubted the competency of the L&D nurse and the sonographer who completed the BPP. Additionally, the patient and her husband witnessed the L&D nurse's frustration with the OB. Further complicating the defense, the nurse was openly critical of the OB's plan.

A final complicating factor in this case was the ease with which the OB could have examined the patient and accessed fetal status information. Her office was in the building next door. She also had the capacity to monitor fetal well-being remotely through a mobile application that was integrated into the hospital's electronic health system, which she chose not to use.

Due to lack of standard of care support for the OB, and other issues, the case against her was settled. Due to the chain of command issues, the hospital also settled.

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RISK REDUCTION STRATEGIES

Consider the following strategies:[2,3,4,5]

OBSTETRICIANS AND OTHER CLINICIANS INVOLVED IN L&D

- Conduct a briefing with the L&D team during which the rationale for the L&D plan is presented. Encourage anyone on the team to express concerns with the plan and discuss and resolve differences of opinion.
- Proactively monitor the patient's progress by regularly reviewing FHM tracings (using remote fetal monitoring when necessary and available), reading the nursing notes, and asking the nurses to describe the patient's progress and fetal status to the level of specificity necessary.
- When a nurse challenges your decision-making, ask for their rationale, and try to understand why the nurse is resisting your orders, taking into consideration the probability that they have spent more time observing and evaluating the patient than you have. If you believe a nurse's failure to follow your orders is putting maternal and fetal well-being at risk, and initial attempts to resolve conflict fail, take steps to address the situation within the organizational framework of the hospital.

NURSES

- Be assertive if an OB responds to a critical message in an unexpected manner.
  - ► Clarify the critical message and restate what you need using communication techniques such as the CUS[6] (I am **c**oncerned. I am **u**ncomfortable. This is a **s**afety issue.), 2-Challenge Rule,[6] and/or 4-Step Assertive Tool.[7]
  - ► If the OB needs to come to the patient's bedside immediately, state the request first, then describe the emergent circumstances.
- Have a low threshold for activating the chain of command if you are concerned about fetal or maternal well-being. Know the chain of command policy and procedure and ensure the next person up the chain understands you are activating the chain of command.
- Address conflicts with, and criticism of, other members of the L&D team in an area where the patient and family members are not likely to hear the conversation.

ADMINISTRATORS

- Implement L&D team communication and team collaboration training (e.g., TeamSTEPPs®[8]) that includes demonstrations with simulated scenarios, role-playing opportunities, and drills to test and hone skills. Include FHR pattern training to ensure team members describe FHR patterns consistently and can clearly understand each other during an emergency.
- To facilitate communication among team members, consider creating, publishing, and posting a lexicon/glossary of terms for ready reference.
- Create a process whereby members of the L&D team can meet at regular intervals (e.g., every four hours) during a shift to review each patient. The team can use this opportunity to comment on patient status and plan. These updates can also provide context for potential problems that may arise.
- Cultivate and support a culture of safety in which L&D nurses feel confident about and responsible for raising safety concerns.
  - ► Identify and manage intimidation.
  - ► Encourage error and near-miss reporting.
  - ► View errors as opportunities for improvement.
  - ► Follow up when safety concerns are reported.

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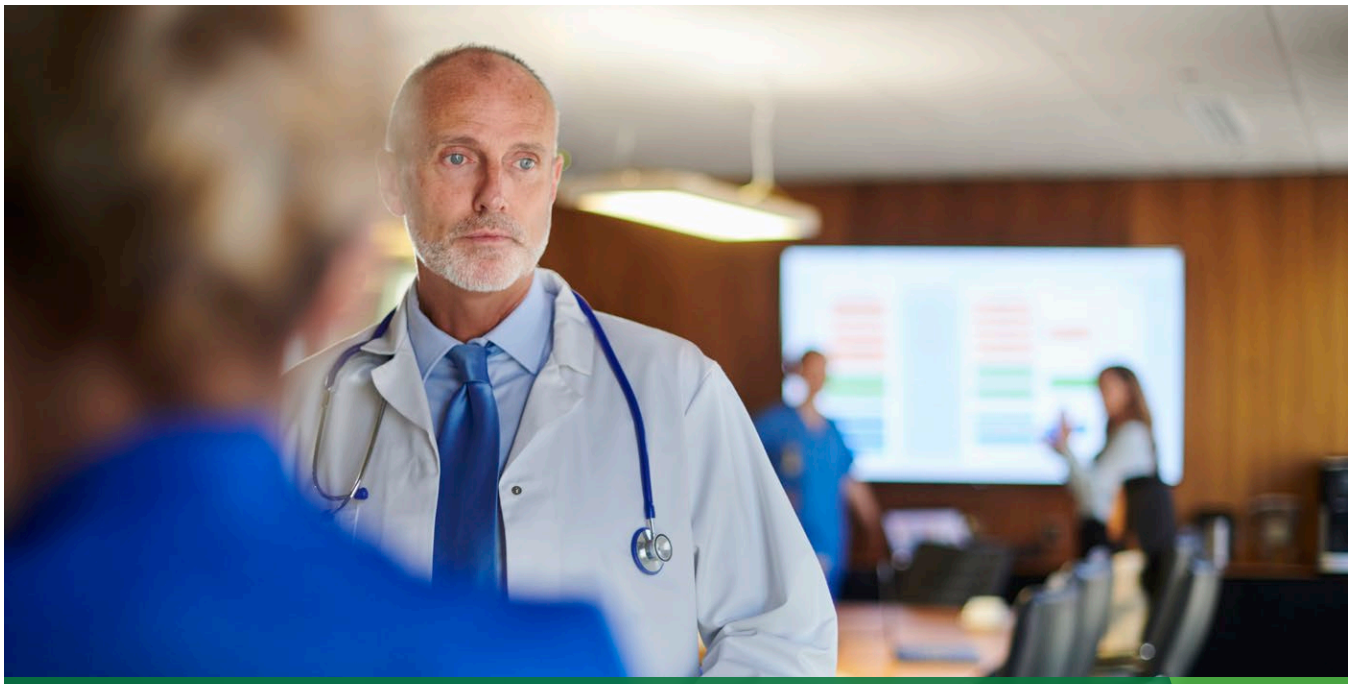
RISK MANAGEMENT STRATEGIES CONTINUED

- Create and implement a chain of command policy and procedure.
  - Outline a clear process detailing the steps to be taken, including the order in which levels of management should be contacted; how to accomplish each step; and when the chain of command should be used.
  - Evaluate the effectiveness of the chain of command policy and procedure, including barriers to using the chain of command.
- Educate and evaluate L&D team members to ensure competency in activating the chain of command. When staff members incorrectly or prematurely activate the chain of command, provide additional education instead of a reprimand.
- After an unanticipated event, conduct a root cause analysis or a case review conference to evaluate why the communication process broke down.



Birth Injury Claims:
Why Cases Settle

Potential damages in the multimillion-dollar range and extremely sympathetic plaintiffs are common complications the defense team must manage in birth injury claims. Consequently, birth injury cases often settle to contain the risk of going to trial. Cases may be settled instead of proceeding to trial even when the defense team can find an expert to testify in support of standard of care or causation, which would seem to indicate the case could be successfully defended. However, one or two supportive defense experts is generally not enough to tip the scales toward defending a case at trial instead of working toward a reasonable settlement. When any of the defense experts asked to review a case are critical, it is an indication that plaintiffs have a good chance of prevailing at trial. When strong standard of care and causation expert support is missing, many defendants request settlement, much like the defendant physicians did in the closed claims used for the case studies in this article.

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Fetal Well-Being Status Updates:
Avoiding Misunderstandings

In the following case, the OB relied entirely on the L&D nurses to keep him apprised of fetal well-being because he was not in the hospital for most of the labor, and he was unable to access the FHM tracing remotely. According to the plaintiff's nursing expert in this case, "The OB was at the mercy of the non-communicative nurse." Even so, the OB conceded that he should have asked more questions when the nurse reported fetal and maternal status, as he was aware of her limited experience.

Consider how the outcome in the following case could have been different if the OB had discussed his expectations with the L&D nurse and considered her level of expertise when obtaining status reports.

CASE TWO

Allegation: Delayed delivery resulted in fetal brain injuries.

A 25-year-old primigravida patient one week postdates presented to L&D in the early stages of labor at 4:00 p.m.

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5:30 P.M.	At the request of L&D Nurse 1, who was concerned with minimal variability on the FHM tracing, the OB came into the hospital to examine the patient. He noted she was 3 cm dilated, and the tracing was, "adequate but with variables." The FHR between the variables was in the 140s. He ruptured the membranes, noting mild meconium, then ordered amnio infusion and oxytocin.
7:00 P.M.	L&D Nurse 2 came on shift, did the amnio infusion, and started oxytocin.
8:30 P.M.	The tracing showed recurrent significant decelerations through 9:15 p.m. In response, the nurse stopped the oxytocin.
9:32 P.M.	The nurse documented meconium and called the special care nursery to put them on notice. There were several variables and subtle late decelerations, followed by tachysystole.
11:30 P.M.	The nurse restarted oxytocin. She noted the patient was 5 cm dilated and afebrile. Moderate to mild variable decelerations began on the FHM tracing, which continued until delivery. The OB called in for a status report.
1:20 A.M.	The nurse did a second amnio infusion.
3:12 A.M.	The mother was 6 cm dilated with contractions every two minutes.
4:16 A.M.	The mother was 8 cm dilated. The nurse called the OB to report the mother had a 101.6 temperature. He ordered antibiotics and acetaminophen.
5:32 A.M.	The nurse called the OB to report the patient was still 8 cm dilated and her temperature was 103.2. The OB ordered a cooling blanket.
6:07 A.M.	The mother was 10 cm dilated. The nurse called the OB to come in for the delivery. The FHM tracing showed fetal bradycardia from 140 with a gradual drop to the 70-80s with contractions, recovering to 90-100s until delivery.
6:30 A.M.	The infant was delivered with a nuchal cord x3 and thick meconium. Initial Apgars were 1/5/5 at one, five, and 10 minutes.

The infant's parents filed a lawsuit against the hospital, nurses, and OB alleging the failure to deliver by C-section early in the mother's labor was below the standard of care and caused the infant's brain injuries. At the time the lawsuit was filed the child was eight years old. She had been diagnosed with quadriplegic cerebral palsy and seizure disorder. Her developmental skills were consistent with a child with profound intellectual disability. Minimal developmental progress was expected, and she would require lifelong attendant care.

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DISCUSSION

The defense team had difficulty finding standard of care support for the OB and nurses. OB consultants believed the OB's decision to allow the patient to labor with the lack of variability on the tracing over an extended period would be difficult to defend. They noted the tracing was poor from the beginning, with no reactivity and no acceleration, which indicated a need to accelerate delivery. Failure to promptly deliver by C-section after being advised of the mother's elevated temperature, indicating likely chorioamnionitis (a placental pathology expert found the placenta showed severe acute chorioamnionitis), complicated the OB's defense even further. The OB should not have waited for the patient to become febrile.

The defense team had difficulty finding standard of care support for the OB and nurses. OB consultants believed the OB's decision to allow the patient to labor with the lack of variability on the tracing over an extended period would be difficult to defend.

The OB experts and nursing consultants criticized the nurse for failing to adequately communicate the maternal and fetal status to the OB. According to the nursing consultant, the records clearly indicated the nurse did not inform the OB of what was going on. She believed the nurse herself did not really know what was going on. Specifically, it did not appear that the nurse communicated the troubling situation fully or clearly when she called the OB at 4:16 a.m.; otherwise, the OB would have come in. Furthermore, the nurse failed to notify the OB that she stopped and then restarted oxytocin and provided amnio infusion boluses without orders to do so. In the opinion of the OB experts, the failure to report changes in condition and proceeding without orders breached the nursing standard of care.

In retrospect, the defendant OB believed he should have delivered the baby by 4:00 a.m. due to the infant's tachycardia, the mother's fever, and minimal variability on the tracing. He also believed he would be criticized for failing to go into the hospital at 1:30 a.m. to examine the patient. In his defense, he believed the L&D nurse underreported the findings on the FHM tracing and was not sufficiently alarming in her descriptions.

The defense team recognized that any attempt to share or pass blame to the nursing staff for underreporting would be ineffective. First, the OB knew the nurse was inexperienced, which called into question the degree to which he was justified in relying on the nurse's interpretation of the FHM tracing; and second, the OB acknowledged he did not inquire as he should have regarding the specifics of the tracing.

Standard of care support for the L&D team members was minimal, although the defense consultants believed the infant suffered brain damage prior to labor and delivery. Despite the positive causation support, the combination of potential damage amounts in the multi-millions of dollars, defendants who did not want to take the case to trial, and a very experienced medical malpractice plaintiffs' attorney made the potential for a plaintiff's verdict too likely to take the case to trial. All parties settled.

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RISK REDUCTION STRATEGIES

OBs cannot be responsible for ensuring the expertise of L&D nurses, but it is in their best interest to adapt their communications and expectations as needed. In addition to the risk reduction strategies listed in the first case study, consider the following:[3,4]

OBSTETRICIANS AND OTHER CLINICIANS INVOLVED IN LABOR AND DELIVERY

- Adjust communication style and expectations to nurse competency.
- Practice "closed-loop communication"—repeat back what you hear from an L&D nurse so you can confirm that what you heard is correct.
- Always inquire about fetal status utilizing conventional language (i.e., Category 1-, 2- ,or 3-type tracing).
- Set expectations for ongoing updates on fetal and maternal well-being.
- Proactively monitor the patient's progress.
- Communicate a plan for potential fetal or maternal emergencies, including issuing specific written orders for being contacted in the event of FHM abnormalities or unusual maternal pain or complaints.
- Outline the patient's labor management plan in the record, including parameters for contacting you and notifying other members of the L&D team in case of an emergency.

NURSES

- Tell the OB—or at a minimum, seek assistance and consultation—when labor management requires skills beyond your level of expertise.
- Be prepared for an exchange with the OB.
  - ► Write down critical information prior to speaking with the OB, to ensure that it is accurately communicated.
  - ► Anticipate questions and be prepared with answers.
  - ► Present information based on thorough assessment.
  - ► Ask the OB if they would like any more information than what you have already provided.

Labor and Delivery Team:
Communication Strategies for Risk Reduction

CONCLUSION

Communication deficits expose laboring mothers and their babies to injury risks and expose L&D team members to liability risk. A common theme in the birth injury claims analyzed for this article is a passive attitude toward obtaining patient information during labor and delivery. Many of the claims involved individuals who failed to see and evaluate patients often enough, failed to ask questions, failed to provide information, or failed to voice safety concerns. Why the failures occurred could be attributed to various causes: fear, overconfidence, distraction, fatigue, overcommitment, etc. Although organizational factors can frustrate communication, in many of these cases, communication failures could be directly traced to individuals who failed to listen and/or adequately express their concerns. Effective communication requires the individual and collective commitment of every team member and the institution in which labor and delivery occurs. With the goal of increasing patient safety and decreasing potential medical liability exposure, clinicians, staff, and administrators are encouraged to consider and, where appropriate, implement the risk management and patient safety strategies introduced in this publication.

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of ***Claims Rx***, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.

1. Audrey Lyndon et al, "Transforming Communication and Safety Culture in Intrapartum Care: A Multi-Organization Blueprint," *Journal of Midwifery & Women's Health* 60, no. 3 (April 7, 2015): 237-243, https://doi.org/10.1111/jmwh.12235.
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