Section 8.0

Perinatal Services

Introduction

A number of factors contribute to rising liability in perinatal services. The information and tools presented in this section allow the risk management professional and clinical directors to proactively identify risk management and patient safety practices that could enhance current risk reduction strategies for a successful perinatal program.
Section 8.1

Proactive Risk & Patient Safety Practices

Perinatal Services - Common Medical Professional Liability Allegations

According to a survey conducted by The American College of Obstetricians and Gynecologists (ACOG), 73.6 percent of the Ob/Gyn respondents have had at least one medical professional liability claim filed against them; the average is 2.59 claims per Ob/Gyn respondent.¹ The primary allegation in obstetrical claims continues to involve a neurologically impaired infant (27.4 percent), followed by stillbirth or neonatal death (15.0 percent).² Fetal monitoring and shoulder dystocia (or brachial plexus injury) were significant factors in these types of claims.³

Medical professional liability claims alleging birth trauma have become common following delivery of an infant who exhibits any symptoms of neurological or psychomotor deficit. Infants with cerebral palsy (CP) are often compensated with physician and hospital insurance dollars based on allegations of fetal hypoxia or asphyxia during labor, typically because no alternative cause of fetal compromise has been suggested or evident in the medical record. In addition, no antenatal or congenital origins were ruled out or documented.

To defend against allegations of negligence involving CP or other conditions of fetal compromise, obstetrics departments must develop systems that enable them to counter the testimony of plaintiff experts that attributes the adverse outcome to trauma associated with labor and delivery. Identifying and documenting risk factors affecting the mother during her pregnancy are crucial, as are those associated with the labor and delivery process. In addition, mechanisms must be established to treat identified risks and to continually monitor the delivery of obstetrical care.

A sound obstetrics risk management program focuses on early identification of risk factors and early referral of high-risk patients to obstetrical or neonatal specialists and tertiary care centers. Documentation of risk factor identification and treatment is carefully monitored. Cord blood gas analysis, placental evaluation, and amniotic fluid and cytogenetic studies are performed when indicated by departmental protocols. The medical staff, in conjunction with quality and/or risk management, establishes criteria which will trigger the peer review process, to minimize negative outcomes, and prevent reoccurrence of avoidable errors.

The following allegations are frequently made against physicians practicing obstetrics:

- Inappropriate management of labor
- Delay in performing a cesarean section
- Inappropriate management of pregnancy
- Failure to perform a cesarean section
- Failure to obtain consultation or timely consultation
- Failure to identify non-reassuring fetal heart patterns

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Updated: February 2017
• Failure and/or delay in treating non-reassuring fetal heart patterns (e.g., delayed cesarean section)
• Negligent surgical technique
• Inappropriate choice of delivery method
• Inappropriate use of oxytocin/misoprostol
• Inappropriate use of vacuum/forceps
• Failure to communicate

The following allegations are frequently directed toward obstetrics nurses:

• Failure to assess or monitor
• Failure to correctly assess or monitor
• Failure to correctly interpret monitoring results
• Failure to communicate and document
• Failure to report pertinent patient information to the physician, including in a timely manner

Other contributing factors include:

• Telephone triage
• Emergency Medical Treatment and Active Labor Act (EMTALA)
• Fetal heart rate pattern interpretation, communication, and documentation
• Misoprostol (Cytotec) for cervical ripening/labor induction
• Oxytocin for labor induction/augmentation
• Tachysystole and treatment of tachysystole
• Pain relief during labor and birth
• Shoulder dystocia
• Second stage management
• Emergency cesarean readiness
• Vaginal birth after cesarean birth (VBAC)
• Multiple gestation
• Iatrogenic prematurity
• Prevention of perinatal group B streptococcal disease
• Neonatal resuscitation at birth
• Credentialing and privileging issues
• Management of post-partum hemorrhage
• Prevention of DVT and venous thrombosis

For additional information, please refer to the Perinatal Services Self-Assessment tool in the online Coverys Tool Chest.
Perinatal Services - Claims Trend Analysis

According to the Physicians Insurers Association of America (PIAA), between 2006 and 2015 obstetric and gynecologic surgery (Ob/Gyn) had the highest number of closed claims reported and the highest total paid indemnity ($1,396,522,114).4 Ob/Gyn claims also had the third highest average paid indemnity, $437,781.5

Coverys claims data from 2011–2015 reports paid indemnity for OB claims ranged from $450,000–$750,000.

Proactive Risk and Patient Safety Identification

Risk management professionals can be extremely helpful in assisting perinatal services with the proactive identification of actual and potential professional liability risk and safety issues through an effective incident and event reporting system. Effective event reporting systems that encourage the reporting of “near misses” and focus on trends and system issues, rather than isolated individual failures, can identify valuable opportunities for nurses to reduce risk and improve safety.

When collecting and analyzing quality and safety data, much may be gained by focusing on known high-risk areas of perinatal care. The following list includes prenatal risks worthy of such focus:

- Anemia (Hct. <28 percent, unresponsive to iron therapy)
- Asthma
- Cardiac disease
- Pulmonary disease
- Pre-gestational diabetes
- Epilepsy
- Abnormal Pap test result
- Herpes, active lesions 36 weeks
- Hypertension
- Prior preterm delivery or PROM
- Prior low birth weight (less than 2,500 grams)
- Renal disease
- Uterine malformation
- Drug and alcohol use6

Risk factors for pre-term labor and delivery include:

- Late or no health care during pregnancy
- Urinary tract infections
- Sexually transmitted infections
- Hypertension
• Vaginal bleeding
• Pregnancy resulting from *in vitro* fertilization
• Underweight or obese mother
• Short interval (less than six months) between birth and next pregnancy
• Blood clotting problems
• Placenta previa
• Prior cesarean delivery
• Age (under 18 and over 35)

### Perinatal Risk Reduction Elements

Proactive risk and patient safety practices begin with administrative leadership and effective risk management, quality improvement, and patient safety programs. The following are key components for consideration when developing a proactive obstetrics service program:

- Standardize clinical protocols based on professional evidence
- Create a culture of safety and accountability
- Consider oxytocin to be a high-alert medication
- Initiate teamwork and patient safety education
- Conduct daily interdisciplinary unit meetings
- Conduct peer review for all neonatal injuries
- Conduct drills for obstetric emergencies

### Safe Perinatal Environment

The physical environment of the perinatal unit must be consistently monitored and maintained to promote patient safety. Technical and aseptic practice guidelines should be in place to promote a safe environment.

All neonatal units should have facilities and/or equipment available for:

- Resuscitation and stabilization
- Admission and observation
- Normal newborn care (in a newborn nursery or, ideally, in the mother’s room)
- Isolation
- Visitation
- Supporting services

See Infant Security in Section 8.4.
Evidence-Based Practice

Growing evidence, including regulatory attention on patient safety, suggests that patient outcomes are affected by how effectively healthcare organizations coordinate the responsibilities of interdependent disciplines. Establishing an interdisciplinary, interdepartmental, evidence-based practice committee to review and make recommendations for clinical practice and patient safety protocols is an excellent way to meet this challenge.

Evidence-based practice (EBP) has been defined as follows:

EBP is “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

The responsibilities of an evidence-based practice committee may include, but not necessarily be limited to, the following:

- Reviewing recommendations for new clinical protocols - Professional organizations such as The American College of Obstetricians and Gynecologists (ACOG) and the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) have developed a number of practice guidelines and position statements.
- Developing privileging and competency requirements for advanced practice professionals, contracted physicians and staff physicians
- Identifying the educational needs of the staff (e.g., patient monitoring, high-risk presentations, assessment protocols, EMTALA, and documentation requirements)
- Determining the educational needs of patients
- Reviewing trends identified through quality monitors
- Reviewing the policies and procedures of various departments that also provide care to perinatal patients and ensuring that operational consistency exists with these other departments
- Identifying risk and clinical safety issues, utilizing data from event reports, sentinel events and near misses; making quality improvement recommendations
- Reviewing revisions to current practice protocols and guidelines, utilizing professional standards guidelines and evidence or research-based practice recommendations
- Overseeing the development of a physician orientation process that includes risk management education, reporting of incidents and sentinel events, and disclosure of errors
- Reviewing the current orientation program for clinical staff members and making recommendations to enhance it; developing reliable clinical processes to manage labor and delivery

Additionally, the Institute for Healthcare Improvement has identified four key components of the “safest and most reliable system of perinatal care,” to wit:
1. The development of reliable clinical processes to manage labor and delivery;
2. The use of principles that improve safety (i.e., preventing, detecting, and mitigating errors);
3. The establishment of prepared and activated care teams that communicate effectively with each other and with mothers and families; and
4. A focus on mother and family as the locus of control during labor and delivery.11

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**High-Reliability Unit**

High-reliability organizations conduct relatively error-free operations over long periods of time and consistently make good decisions. Safety in these organizations has been established as a core value and a top priority. According to the Agency for Healthcare Research and Quality (AHRQ), three specific trends in the overall healthcare environment have contributed to an increased emphasis on high-reliability concepts:

1. Increased public awareness of medical errors and quality
2. Health information technology which affords more precise monitoring of care
3. Emergence of quality improvement methodologies, such as Lean Thinking and Six Sigma®

A high-reliability mindset impacts the following areas:

- How the organization responds to the internal and external environment
- Planning and implementing improvement initiatives
- Approaches to doing work
- Approaches to measuring progress
- Specific choices of improvement initiatives
- Spreading improvements to other units12

High-reliability principles (HRPs) include:

- Preoccupation with failure
- Reluctance to simplify
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise13

HROs achieve success by:

- Having peers who respect and trust one another
- Providing a safe environment for all
- Reflecting and learning from past experiences14
One example of a high-reliability unit is based on the Idealized Design of Perinatal Care project, which was based on principles of reliability science and a model from the Institute for Healthcare Improvement (IHI). The focus of the Idealized Design project was to achieve a new level of safer, more effective care and to minimize some of the risks identified in medical professional liability cases. The four key components of the model are:

1. The development of reliable clinical processes to manage labor and delivery;
2. The use of principles that improve safety (i.e., preventing, detecting, and mitigating errors);
3. The establishment of prepared and activated care teams that communicate effectively with each other and with mothers and families; and
4. A focus on mother and family as the locus of control during labor and delivery.\textsuperscript{15}

Perinatal unit high-reliability does not just happen at an organization. It must begin within the context of an accountability model that focuses on system issues and human factors in patient safety and risk reduction. For example, if staff members on a medical surgical unit are reprimanded because the unit has a higher rate of medication errors, they will be less likely to report them in the future, and the organization will miss an opportunity to determine the real issues behind the data. Conversely, organizations that reward staff members for reporting of errors are more likely to gain valuable information that enables them to be proactive in correcting issues before they reach the level of the patient.

The unit must have well-established safety goals, not just the goals of external organizations such as The Joint Commission, and evaluate these goals in light of unit and organization-wide performance expectations. Perceptions of risk may be heightened by evaluation of both internal and external data. Staff members often need additional education to supplement knowledge deficits. Each unit needs its own plan for increasing knowledge related to risk, quality, and safety management within the individual unit’s environment. For example, perinatal units may have regular reviews of risk issues pertaining to cesarean sections, inductions, and other high-risk presentations. Each unit must develop its own rules, training, and redundant systems specific to known areas of risk for that unit, while also functioning within the global rules of high-reliability for the organization.

Additional strategies to ensure high-reliability may include:

- Conducting unit-based safety rounds, asking:
  - What have staff members seen today that caused harm?
  - What have staff members seen that could have caused harm?
  - What have staff members done to prevent harm?

- Providing regular feedback to staff members about follow-up on identified issues and concerns

- Making an anonymous safety hotline available and encouraging staff members and patients to report safety issues

- Using failure mode and effects analyses (FMEAs) and root cause analyses (RCAs) to prioritize changes and improve care

- Conducting simulation training and drills to practice response to potentially high-risk or problem-prone situations (e.g., shoulder dystocia and cesarean section drills)
• Implementing a rapid response team
• Adopting a common language for fetal monitoring and training all members of the care
team together in its use.
• Applying communication techniques, such as SBAR (situation, background, assessment,
and recommendation)
• Implementing perinatal care bundles (e.g., augmentation)
• Providing competency-based education and training
• Making safety the hallmark of the organization’s culture and the basis for professional
behavior
• Identifying high-risk clinical presentations
• Establishing plans for recognizing emergencies and responding to them

ACOG has published a number of Committee Opinions related to enhancing patient safety,
including the following:
  • Patient Safety in Obstetrics and Gynecology
  • Patient Safety in the Surgical Environment
  • Fatigue and Patient Safety
  • Patient Safety and Health Information Technology
  • Health Literacy to Promote Quality of Care
  • Behavior That Undermines a Culture of Safety
  • Partnering With Patients to Improve Safety
  • Improving Medication Safety
  • Communication Strategies for Patient Handoffs
  • Effective Patient–Physician Communication
  • Clinical Guidelines and Standardization of Practice to Improve Outcomes
  • Tracking and Reminder Systems
  • The Use and Development of Checklists in Obstetrics and Gynecology
  • The Obstetric and Gynecologic Hospitalist
  • Preparing for Clinical Emergencies in Obstetrics and Gynecology
  • Disclosure and Discussion of Adverse Events
  • Influenza Vaccination During Pregnancy
  • Guidelines for Diagnostic Imaging During Pregnancy and Lactation
  • Informed Consent
  • Nonmedical Use of Prescription Drugs

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Proactive risk identification can assist the risk, quality, and patient safety manager in identifying
quality and patient safety practices to deal with issues that place the OB department at risk. Event
reporting and quality indicators are two mechanisms for identifying risk. Reporting all events to
risk management not only facilitates the investigation of single events as warranted, but also
provides routine monitoring and trending which can help identify broader risk issues.
Reviewing episodes of obstetrical care, including pre-hospital episodes, triage, medical screening examinations, patient assessments, admissions, procedures, discharge instructions, stabilizations, and transfers, provides a proactive model for review of evidence-based practice standards, medical and nursing care, and documentation.

At a minimum, the following obstetrical events and quality indicators should be monitored:
- Fetal/maternal death
- Unplanned maternal readmission within 14 days
- Excessive maternal blood loss
- Birth injuries
- Medication errors
- High-risk clinical presentations (e.g., VBAC, hemorrhage)
- Shoulder dystocia
- Vacuum extraction
- Forceps delivery
- Induction of labor
- Fetal heart monitor interpretations
- Timely performance of cesarean section
- Scheduled cesarean section
- VBAC
- Triage decision-making
- Maternal or neonatal transfers

The Joint Commission’s Standard RC.01.04.01 calls for hospitals to audit their medical records; Element of Performance 1 for Standard RC.01.04.01 states:

The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (See also MS.05.01.03, EP 3)16

### Clinically Pertinent Assessment, Intervention, Communication and Documentation

According to *Guidelines for Perinatal Care*, Seventh Edition:

Written departmental policies regarding triage of patients who come to a labor and delivery area should be reviewed periodically for compliance with appropriate regulations. A pregnant woman who comes to the labor and delivery area should be evaluated in a timely fashion. Obstetric nursing staff may perform this initial evaluation, which should minimally include assessment of:

- Maternal vital signs
The responsible obstetric provider should be informed promptly if any of the following findings are present or suspected:

- Vaginal bleeding
- Acute abdominal pain
- Temperature of 100.4º F or higher
- Preterm labor
- Preterm premature rupture of membranes (PROM)
- Hypertension
- Category II or category III (non-reassuring) change throughout fetal heart rate pattern
- Any patient who is suspected to be in labor, has rupture of the membranes, or has vaginal bleeding should be evaluated promptly in an obstetric service area.

Whenever a pregnant woman is evaluated for labor, the following factors should be assessed and recorded in the patient’s permanent medical record:

- Maternal vital signs
- Frequency and duration of uterine contractions
- Documentation of fetal well-being
- Cervical dilatation and effacement, unless contraindicated (eg, placenta previa, preterm PROM) or cervical length as ascertained by transvaginal ultrasonography
- Fetal presentation and station of the presenting part
- Status of the membranes
- Date and time of the patient’s arrival and of notification of the provider
- Estimation of fetal weight and assessment of maternal pelvis

Triage and medical screening facilitate timely treatment. Development of protocols or guidelines can help expedite care. When developing protocols or guidelines, consider using both a team and a systems approach. It is also important to adopt and implement a common communication technique, such as SBAR.

SBAR is a structured communication technique designed to convey a great deal of information in a succinct and brief manner.

(S) Situation: What is the situation you are calling about?
- Identify self, unit, patient, room number.
- Briefly state the problem, what is it, when it happened or started, and how severe.
(B) **Background:** Pertinent background information related to the situation could include the following:
- The admitting diagnosis and date of admission
- List of current medications, allergies, IV fluids, and labs
- Most recent vital signs
- Lab results: provide the date and time test was done and results of previous tests for comparison
- Other clinical information
- Code status

(A) **Assessment:** What is the nurse’s assessment of the situation?

(R) **Recommendation:** What is the nurse’s recommendation or what does he/she want?
Examples:
- Notification that patient has been admitted
- Patient needs to be seen now
- Order change

Five SBAR tools have been adapted specifically for use in labor and delivery. The tools are available for download from the Institute for Healthcare Improvement’s website at www.ihi.org. The tools include a perinatal SBAR report tool to notify a physician about a critical situation, a report tool to describe a fetal heart rate tracing, a survey for physicians and nurses to improve communication and patient care, and a perinatal SBAR report that presents SBAR scenarios for three different clinical situations. Physicians should be aware that complete and accurate communication of medical information is important for reducing preventable medical errors. Improving communication skills merits the same attention as improving clinical skills.

The medical record is a legal document and must be documented in a manner that follows regulations and laws. Undocumented obstetrical care is often challenged when medical professional liability allegations are made. An OB patient’s medical records should provide a chronological summary of ongoing physician and nursing assessments, monitoring, diagnostic testing, and treatment interventions. The quality of the medical record documentation will often determine whether or not an allegation may be successfully defended. Therefore, the delivery of services must always be accompanied by a comprehensive documentation of the care provided.

According to *Guidelines for Perinatal Care*, Seventh Edition, “The obstetric staff should record the following information, which also should be available on a medical record that accompanies the newborn during any transfer of responsibility for care:”

- The mother’s name, medical record number, blood type, serologic test result, rubella status, hepatitis B test result, and human immunodeficiency virus (HIV) status
- Other maternal test results, if obtained, that are relevant to neonatal care, such as colonization with group B streptococci or intrapartum maternal antibiotic therapy (including type and number of doses of antibiotics)
• Maternal illness potentially affecting the fetus, evidence of chorioamnionitis, and maternal medications (including tocolytics and corticosteroids)
• Any history of illicit substance abuse or any other known socially high-risk circumstances, such as unstable housing, adolescent mother, maternal psychiatric disease, domestic violence, or history of previous child abuse or neglect
• Complications of pregnancy associated with abnormal fetal growth, fetal anomalies, or abnormal results of fetal well-being and corresponding interpretation
• Information regarding the labor (eg, duration) and delivery (eg, method) complications of labor (eg, deviations in fetal heart rate patterns), duration of rupture of amniotic membranes, presence or absence of meconium in amniotic fluid, and need for resuscitation
• Situations in which lactation may be compromised, such as history of breast surgery, trauma, or previous lactation failure

For additional information, recommendations and policies and procedures on documentation, please refer to the Coverys Risk Management Healthcare Facility Risk Management Manual, Volume 3, Section 7.

References
2. Ibid.
3. Ibid.
5. Ibid.
10. Duke University Medical Center, “Introduction to Evidence-Based Practice – What is Evidence-Based Practice?” Page last updated November 22, 2016,


15. Ibid.


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Section 8.2

Patient Safety Practices: Care of the Perinatal Patient

Preregistration for Labor and Delivery

In order to provide the safest care possible to patients, prenatal information regarding the OB patient should be current and available to the hospital. According to *Guidelines for Perinatal Care*, Seventh Edition, the pregnant woman should be preregistered for labor and delivery at the hospital, and a copy of her prenatal medical record, or access to her electronic prenatal medical record, should be available in the hospital’s labor registration area by 36 weeks gestation.1

Labor Evaluation

Emergency Department

Limited access to care and healthcare coverage has resulted in more obstetrical patients with suspected labor or other obstetrical complications seeking care in the emergency department. It is important to ensure that emergency departments have access to trained personnel and have policies and procedures in place to address the appropriate management of obstetrical patients, making certain to comply with federal and state laws.2

According the Centers for Disease Control and Prevention (CDC), there were 3,998,076 births in the United States in 2014.3 While most pregnancies are low-risk and uneventful, a significant number each year are high-risk and/or have unplanned events, such as premature labor, bleeding, fetal distress, and/or maternal trauma.4

It is essential to have a systematic approach in place for triage and initial assessment of obstetric patients in the emergency department.5 The presence or absence of pregnancy-related complications dictates whether the woman’s care will be provided in the emergency department or in the OB department.6 Interdepartmental collaboration is essential to ensure optimal maternal/fetal care. Obstetric complications may not be recognized by ED providers who have little experience with perinatal patients.7 For example, a blood pressure greater than 140 mmHg systolic or 90 mmHg diastolic may not concern the ED provider, but requires further evaluation in a pregnant patient to rule out early signs and symptoms of preeclampsia.8

From AWHONN:

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Updated: February 2017
AWHONN has developed the Maternal Fetal Triage Index (MFTI), a tool that provides a standardized approach to obstetric triage. The MFTI is a five-level obstetric acuity tool for nurses to use when they triage a woman presenting for care to a birth unit in order to prioritize the woman's urgency for provider evaluation. It is the first obstetric acuity tool developed by a professional society for use across the United States.9

From ACOG:

**Recommendations**

- Hospital-based obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women.
- Recently developed, validated obstetric triage acuity tools may improve quality and efficiency of care and guide resource use, and they could serve as a template for use in individual hospital obstetric units.10

The emergency department medical record should of course document the OB triage assessment on all pregnant patients presenting to the ED, including presentations that are not necessarily related to obstetrics.

EMTALA has specific application to pregnant patients having contractions, to wit.

The definition of an emergency medical condition also makes specific reference to a pregnant woman who is having contractions. It provides that an emergency medical condition exists if a pregnant woman is having contractions and “... there is inadequate time to transfer to another hospital before delivery; or that transfer may pose a threat to the health or safety of the woman or the unborn child.” An emergency medical condition does not exist, even when a woman is having contractions, as long as there is adequate time to effect a safe transfer before delivery and the transfer will not pose a threat to the health or safety of the mother or the fetus. Labor is defined as the process of childbirth beginning with the latent phase of labor or early phase of labor and continuing through delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. Under this definition, a qualified medical person must certify that a woman is in false labor before she can be released.11

In order to comply with the above-quoted section, hospitals should develop a labor evaluation policy to address the process that is used at the facility. They should also identify, in the hospital bylaws or medical staff rules and regulations, those persons who are qualified to perform a medical screening examination. As stated by the Centers for Medicare and Medicaid Services (CMS):
A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.12

If nurses are performing OB medical screening examinations, consider the following wording:

A qualified Labor and Delivery Nurse (the facility needs to define qualified: e.g., 24 months of OB experience) may perform a MSE in consultation with the attending physician to determine the presence/absence of active labor in the full term patient (>37 weeks, your facility needs to define) who is an established patient of a physician with OB privileges at the hospital.

With respect to transferring pregnant patients from the emergency department to labor and delivery, the Emergency Nurses Association (ENA) states:

Obstetrical patients with a fetal gestation of 20 weeks or more, with active or suspected labor or obstetrical complications should be referred to the obstetrician or L&D for evaluation. The criteria for an internal transfer from the emergency department to labor and delivery are dependent upon institutional policies, procedures, and resources.13

Pregnant women may present to the emergency department for reasons other than the pregnancy, including trauma. Indeed, trauma is the leading cause of nonobstetric maternal death, with most cases being attributable to motor vehicle accidents.14

When a pregnant woman does suffer a trauma that lands her in the emergency department, coordination among providers is a key factor in achieving the best possible outcome:

Necessary evaluation and management of the trauma patient should not be changed because she is pregnant. Optimum management of the seriously injured pregnant woman requires an integrated effort of multiple specialties, starting with emergency medical technicians, emergency medicine physicians, trauma surgeons, and other specialists, depending on the type of injury. Obstetricians play a central role in the management of injured pregnant women. Their knowledge and expertise are vital to management decisions regarding both the woman and the fetus. The obstetrician may be consulted regarding the condition of a pregnant trauma patient and her fetus or, more commonly, may be the primary physician caring for the patient following trauma. To improve multidisciplinary management of the trauma patient who is pregnant, hospital-based guidelines for clinical
management should be established with input from multiple care providers (eg, emergency medicine physicians, obstetrician–gynecologists, trauma surgeons).\textsuperscript{15}

### Admission Assessment Including Fetal and Maternal Risk Factors

#### Normal and High-Risk Monitoring Criteria

A pregnant woman who comes to the labor and delivery area should be evaluated in a timely fashion. The initial evaluation should minimally include:

- Maternal vital signs
- Fetal heart rate
- Uterine contractions\textsuperscript{16}

The obstetrical provider should be informed promptly if complications are present or suspected. Some of these complications include:

- Vaginal bleeding
- Acute abdominal pain
- Temperature of (100.4°F) or higher
- Preterm labor
- Premature rupture of membranes (PROM)
- Hypertension
- Category II or category III (non-reassuring) change throughout fetal heart rate pattern\textsuperscript{17}

According to Guidelines for Perinatal Care, Seventh Edition:

Evaluation of the quality of the uterine contractions and pelvic examinations should be sufficient to detect abnormalities in the progress of labor. Vital signs should be recorded at regular intervals of at least every 4 hours. This frequency may be increased, particularly as active labor progresses, according to the clinical signs and symptoms, and is increased in the presence of complications, such as infection or preeclampsia.\textsuperscript{18}

According to a Coverys Risk Management obstetric physician advisor, the following are indicators to consider for continuous fetal heart rate monitoring (this is not an exhaustive list):

- **Factors related to the mother**
  - Age > 35 or < 16
  - Diabetes mellitus
  - Hypertension
  - Maternal disease (e.g., cardiac, pulmonary, renal, neurological)
  - Substance abuse
  - Obesity (BMI > 30 or Underweight BMI <18)
  - Parity 5 or greater
Factors related to previous obstetric history
- Previous cesarean section delivery (VBAC attempt)
- Previous stillbirth
- Non-reassuring fetal heart rate tracing resulting in delivery

Factors related to present pregnancy
- Gestational diabetes mellitus
- Gestational hypertension
- Intrauterine growth restriction
- Polyhydramnios, oligohydramnios
- Vaginal bleeding
- Induction of labor
- Premature labor
- Placental abruption
- Gestational age < 37 or > 42 weeks
- Estimated fetal weight < 2500 gm or > 4000 gm
- Multiple pregnancies
- Premature rupture of the membranes
- Detection of fetal bradycardia
- Fetal congenital heart problems
- Abnormal fetal presentation (e.g., breech, brow face)

Factors which may emerge during the current labor
- Vaginal bleeding
- Stimulation of labor (Pitocin - augmentation or induction)
- Determination of an abnormal FHR by intermittent auscultation
- Maternal fever > 100.4 degrees Fahrenheit
- Meconium stained fluid
- Fetal bradycardia or tachycardia
- Epidural analgesia during labor

Fetal Heart Rate Monitoring

When it comes to monitoring the fetal heart rate (FHR) to determine fetal status, this may be done either electronically or by intermittent auscultation. The obstetric unit should have guidelines in place which "clearly delineate the procedures to be followed for using these techniques, according to the phase and stage of labor."

According to Guidelines for Perinatal Care, Seventh Edition:

If no risk factors are present at the time of the patient’s admission, a standard approach to fetal surveillance is to determine, evaluate, and record the FHR every 30 minutes in the active phase of the first stage of labor and at least every 15 minutes in the second stage of labor.

If risk factors are present at admission or appear during labor, there is no difference in perinatal outcome between intermittent auscultation and continuous fetal monitoring if one of the following methods for fetal heart rate monitoring is used:
During the active phase of the first stage of labor, the fetal heart rate should be determined, evaluated and recorded at least every 15 minutes, preferably before, during, and after a uterine contraction, when intermittent auscultation is used. If continuous electronic FHR monitoring is used, the heart rate tracing should be evaluated at least every 15 minutes.

During the second stage of labor, the FHR should be determined, evaluated, and recorded at least every 5 minutes if auscultation is used. If continuous electronic FHR monitoring is used, the tracing should be evaluated at least every 5 minutes.

ACOG has recommended the use of a three-tiered system for intrapartum electronic fetal monitoring. The three-tiered system has been summarized as follows:

**Category I**
Category I FHR tracings include all of the following:
- Baseline rate: 110-160 beats per minute
- Baseline FHR variability: moderate
- Late or variable decelerations: absent
- Early decelerations: present or absent
- Accelerations: present or absent

**Category II**
Category II FHR tracings include all FHR tracings not categorized as Category I or Category III. Category II tracings may represent an appreciable fraction of those encountered in clinical care. Examples of Category II FHR tracings include any of the following:

Baseline rate
- Bradycardia not accompanied by absent baseline variability
- Tachycardia

Baseline Variability
- Minimal baseline variability
- Absent baseline variability with no recurrent decelerations
- Marked baseline variability

Accelerations
- Absence of induced accelerations after fetal stimulation

Periodic or episodic decelerations
- Recurrent variable decelerations accompanied by minimal or moderate baseline variability
- Prolonged deceleration more than 2 minutes but less than 10 minutes
- Recurrent late decelerations with moderate baseline variability
- Variable decelerations with other characteristics, such as slow return to baseline, overshoots, or “shoulders”
Category III

Category III FHR tracings include either

- Absent baseline FHR and any of the following:
  - Recurrent late decelerations
  - Recurrent variable decelerations
  - Bradycardia
- Sinusoidal pattern\(^{23}\)

According to AWHONN:

Fetal heart monitoring requires advanced assessment and clinical judgment skills and should not be delegated to unlicensed assistive personnel or others who do not possess the appropriate licensure, education, and skills validation. A woman’s preferences and clinical presentation should guide selection of FHM techniques with consideration given to use of the least invasive methods. In general, the least invasive method of monitoring is preferred in order to promote physiologic labor and birth. Labor is dynamic; therefore, consideration of maternal preferences and identification of risk factors should occur upon admission to the birth setting and should be ongoing throughout labor.\(^{24}\)

When using electronic FHR monitoring, ensure that a mechanism is in place for permanently retaining the monitoring strips with the mother’s medical record. Each FHR strip should be documented with the patient’s name, the hospital’s medical record number, and the date and time of admission.\(^{25}\)

The facility’s policies should also require that fetal monitoring strips include the signature or initials of the nurse making the entry. EFM strips are considered part of the patient’s medical record and therefore the same documentation standards apply. In most states, if a hospital uses a fetal monitor strip system, those records must be kept for seven years beyond the age of majority.\(^{26}\)

It is also good practice to have a qualified AWHONN certified nurse evaluate a select sample of records for each nurse monthly. Such an audit would include a review of maternal/fetal assessments, interpretation of EFM strips, responses/interventions, appropriateness of documentation, and compliance with internal policy. Based upon the results of the clinician’s audit, a corrective action plan should be developed and implemented. Follow-up audits can help assess the effectiveness of the action plan and also whether improvements are sustained over time.

For additional information, please refer to the following samples in the online Coverys Tool Chest: EFM Medical Record Audit Tool and Risk Factors to Consider for High Risk Fetal Monitoring.

Cervical Ripening and Induction of Labor

Cervical ripening refers to the softening and thinning of the cervix in response to uterine contractions and a series of complex biochemical processes.\(^{27}\) Cervical ripening is basically necessary to allow the fetus to pass through it.\(^{28}\) When this process does not proceed naturally, cervical ripening may need to be assisted or induced in order to deliver the child vaginally.\(^{29}\)
Methodologies for cervical ripening include the use of mechanical cervical dilators and the administration of synthetic prostaglandins. Induction of labor is basically performed to stimulate uterine contractions before the spontaneous onset of labor. Labor contractions may also be augmented if they prove to be insufficient. Labor may be induced by administration of oxytocic agents (e.g., oxytocin, misoprostol), membrane stripping, or amniotomy. It is advised to have accurate dating of the pregnancy before inducing cervical ripening or labor, as mistimed inductions may result in iatrogenic preterm birth and increased neonatal morbidity.

With respect to timing:

Current ACOG guidelines recommend against elective induction of labor before 39 completed weeks of pregnancy, unless medical indications for earlier delivery are noted. Elective inductions account for about half of all inductions and 10% of deliveries.

The ACOG recommends that dating be confirmed with at least one of the following:
- Ultrasonography dating at less than 20 weeks' gestation is consistent with gestational age of 39 weeks or more
- Fetal heart tones have been documented in the patient's medical records for at least 30 weeks by Doppler ultrasonography
- 36 weeks have passed since a positive urine or serum pregnancy test for human chorionic gonadotropin

Additionally, patients need to be fully advised and counseled regarding the indications for an induction, the agents and methods that may be used, and the possibility that additional induction or a cesarean delivery may be needed.

With respect to hospital protocols and procedures, the following are advised:

Each hospital’s department of obstetrics and gynecology should develop written protocols for preparing and administering oxytocin solution or other agents for labor induction or augmentation. Indications for induction and augmentation of labor should be stated. Personnel who are familiar with the effects of the agents used and who are able to identify both maternal and fetal complications should be in attendance during administration of the induction agent(s). The qualifications of personnel authorized to administer oxytocic agents for this purpose should be described. The methods for assessment of the woman and the fetus before and during administration of these agents should be specified. A physician capable of performing a cesarean delivery should be readily available.

**Epidurals**

The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) maintains that there is no body of research or evidence available “to support the management of regional labor
analgesia by non-anesthetist registered nurses as a safe practice." AWHONN goes on to state as follows:

Following stabilization of vital signs after either initial insertion, initial injection, bolus injection, rebolus injection, or initiation of continuous infusion by a licensed, credentialed anesthesia care provider, RNs in communication with the obstetric and anesthesia care providers, may:

- Monitor the patient’s vital signs, level of mobility, level of consciousness, and perception of pain and level of pain relief.
- Monitor fetal status.
- Pause the infusion to replace empty infusion syringes or infusion bags with new, pre-prepared solutions containing the same medication and concentration, according to orders provided by the anesthesia care provider and re-start the infusion.
- Stop the continuous infusion if there is a safety concern or the woman has given birth.
- Remove the catheter, if the RN has had appropriate educational training, criteria have been met, and institutional policy and law allow. Removal of the catheter by an RN is contingent upon receipt of a specific order from a qualified anesthesia or physician provider.
- Initiate emergency therapeutic measures if complications arise according to institutional policy, protocol, and RN scope of practice.
- Communicate clinical assessments and changes in patient status to the obstetric and anesthesia care providers as indicated by institutional policy.

RNs who are not licensed anesthesia providers should not:

- Bolus or re-bolus regional/intrathecal analgesia or anesthesia doses by injecting medication into the catheter.
- Manipulate doses of regional/intrathecal analgesia and anesthesia delivered by continuous infusion.
- Manipulate doses of regional/intrathecal analgesia and anesthesia or dosage intervals for PCEA.
- Increase or decrease the rate of a continuous infusion.
- Re-initiate an infusion once it has been stopped.
- Be responsible for obtaining informed consent for analgesia and anesthesia procedures; however, the nurse may witness the patient signature for informed consent prior to analgesia and anesthesia administration.

AWHONN maintains that only qualified, credentialed, licensed anesthesia care providers as described by the American Society of Anesthesiologists and the American Association of Nurse Anesthetists and/or as authorized by state law should perform the following procedures:

- Insertion, initial injection, bolus injection, rebolus injection or initiation of a continuous infusion of catheters for analgesia/anesthesia,
- Preparation and programming the medication and infusion devices,
• Verification of correct catheter placement, and
• Increasing or decreasing the rate of the continuous infusion and program
doses for PCEA administration.38

Underwater Births

According to Guidelines for Perinatal Care, Seventh Edition, “underwater birth has become more
popular in certain parts of the world despite a paucity of data demonstrating that it is either
beneficial or safe.”39 Numerous reports indicate that underwater birth is not safe for the infant,
having been associated with “respiratory distress, hyponatremia, infections, hypoxic ischemic
encephalopathy, ruptured umbilical cords, seizures, tachycardia and fever (related to water
temperature of the bath), and near drowning in newborns or fetuses.”40 Indeed, Guidelines for
Perinatal Care, Seventh Edition, has gone so far as to state that underwater birth should be
“considered an experimental procedure that should not be performed except within the context of
an appropriately designed randomized controlled trial after informed parental consent.”41

From ACOG:

Summary

Immersion in water during the first stage of labor may be associated with shorter
labor and decreased use of spinal and epidural analgesia and may be offered to
healthy women with uncomplicated pregnancies between 37 0/7 weeks and 41 6/7
weeks of gestation. There does not appear to be an associated increased risk of
adverse maternal, fetal, or neonatal outcomes.

There are insufficient data on which to draw conclusions regarding the relative
benefits and risks of immersion in water during the second stage of labor and
delivery. Several serious neonatal complications have been reported, but the
actual incidence has not been determined in population-based analyses.
Therefore, until such data are available, it is the recommendation of the College
that birth occur on land, not in water. The College supports conducting well-
designed prospective studies of the maternal and perinatal benefits and risks
associated with immersion during labor and delivery. Specifically, this document is
not intended to prevent the conduct of such studies.

Furthermore, the College recognizes that despite the opinions expressed in this
document, a woman may request immersion during the second stage of labor,
including giving birth while submerged. This decision should represent an informed
choice; a woman who requests to give birth while submerged in water should be
informed that the maternal and perinatal benefits and risks of this choice have not
been studied sufficiently to either support or discourage her request. She also
should be informed of the rare but serious neonatal complications associated with
this choice. If the physician believes, based on evidence, that second-stage
immersion and giving birth while submerged would be detrimental to the overall
health and welfare of the woman or the fetus, he or she should not perform such a delivery (39).

Although it has not been the focus of specific trials, facilities that plan to offer immersion during labor and delivery need to establish rigorous protocols for candidate selection; maintenance and cleaning of tubs and pools; infection control procedures, including standard precautions and personal protective equipment for health care personnel; monitoring of women and fetuses at appropriate intervals while immersed; and moving women from tubs if urgent maternal or fetal concerns or complications develop.42

### Group B Streptococcal Disease

Approximately 10-30 percent of pregnant women are colonized with group B streptococci (GBS); the colonization may be transient, intermittent or persistent.43 “Group B streptococci can cause maternal urinary tract infections, amnionitis, endometritis, sepsis, or, rarely, meningitis.”44 If GBS is transferred to the infant during labor or delivery, an invasive infection may result during the first six days following birth, characterized usually by sepsis or pneumonia, and less often by meningitis in the newborn.45

The CDC revised its 2002 guidelines pertaining to the prevention of perinatal Group B in 2010, offering the following in terms of the screening strategy:

The following are key components of the screening strategy:

- Women with GBS isolated from the urine at any time during the current pregnancy or who had a previous infant with invasive GBS disease should receive intrapartum antibiotic prophylaxis and do not need third trimester screening for GBS colonization (AII). Women with symptomatic or asymptomatic GBS urinary tract infection detected during pregnancy should be treated according to current standards of care for urinary tract infection during pregnancy and should receive intrapartum antibiotic prophylaxis to prevent early-onset GBS disease (AIII).
- All other pregnant women should be screened at 35–37 weeks’ gestation for vaginal and rectal GBS colonization (AII).
- At the time of labor or rupture of membranes, intrapartum antibiotic prophylaxis should be given to all pregnant women who tested positive for GBS colonization (AII), except in the instance of cesarean delivery performed before onset of labor on a woman with intact amniotic membranes.
- For circumstances in which screening results are not available at the time of labor and delivery, intrapartum antibiotic prophylaxis should be given to women who are <37 weeks and 0 days’ gestation, have a duration of membrane rupture ≥18 hours, or have a temperature of ≥100.4°F (≥38.0°C) (AII).
- In the absence of GBS urinary tract infection, antimicrobial agents should not be used before the intrapartum period to eradicate GBS genitorectal
colonization, because such treatment is not effective in eliminating carriage or preventing neonatal disease and can cause adverse consequences (DI).

- Intrapartum antibiotic prophylaxis to prevent early-onset GBS disease is not recommended as a routine practice for cesarean deliveries performed before labor onset on women with intact amniotic membranes, regardless of the GBS colonization status of the woman or the gestational age of the pregnancy (CIII). The use of perioperative prophylactic antibiotics to prevent infectious complications of cesarean delivery should not be altered or affected by GBS status. Women expected to undergo cesarean deliveries should undergo routine vaginal and rectal screening for GBS at 35–37 weeks’ gestation because onset of labor or rupture of membranes can occur before the planned cesarean delivery, and under those circumstances GBS-colonized women should receive intrapartum antibiotic prophylaxis (AII).

- Health-care providers should inform women of their GBS screening test result and the recommended interventions (BIII).

The following key changes were made from the 2002 guidelines:

- Guidance regarding cesarean deliveries performed before onset of labor on a woman with intact amniotic membranes is clarified as applying to cesarean deliveries performed at any gestational age (CIII).
- In settings in which NAAT for GBS is available, obstetric providers can choose to perform intrapartum testing of vaginal-rectal samples from women with unknown GBS colonization status and no intrapartum risk factors (temperature of ≥100.4°F [≥38.0°C] or rupture of amniotic membranes ≥18 hours) at the time of testing and who are delivering at term (CII). If an intrapartum risk factor subsequently develops, antibiotic prophylaxis should be administered regardless of the intrapartum testing results (AIII).
- Women with positive intrapartum NAAT results for GBS should receive antibiotic prophylaxis (AII). NAAT testing is optional and might not be available in all settings.46

The 2010 guidelines from the CDC may be accessed in their entirety.

### Breast-Feeding Evaluation

The evidence regarding the value of breast-feeding for women and their infants continues to mount.47 Indeed, breast-feeding is the preferred method for feeding newborns and infants.48 Human milk provides not only health, developmental, nutritional, and immunologic benefits, but also offers psychological, social, and economic benefits.49 If the mother chooses to breast-feed, trained caregivers should observe and assess the adequacy of the breast-feeding using a standardized tool (e.g., LATCH) during the newborn’s hospitalization.50 Encouraging the mother to record the time and duration of each feeding, as well as the output of urine and stool, will help facilitate the evaluation process.51
AWHONN has taken the following position:

The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) supports, protects, and promotes breastfeeding as the ideal and normative method for feeding infants, including the provision of human milk for preterm and other vulnerable newborns. Women should be encouraged and supported to exclusively breastfeed for the first six months of an infant’s life and continue to breastfeed for the first year and beyond.52

The breast-feeding newborn infant should be seen by a pediatrician or other knowledgeable and experienced healthcare professional at three to five days of age or within 48 hours of discharge; a second ambulatory visit should take place at two to three weeks of age, unless a reason to be seen earlier presents itself.53 If the infant experiences weight loss beyond three days of age, has a total weight loss of more than 7 percent of his/her birth weight, or fails to regain his/her birth weight by two weeks of age, a careful evaluation of the feeding techniques being used, including the adequacy of breast-feeding, should be undertaken.54

From ACOG:

**Support for Breastfeeding Women**

The American College of Obstetricians and Gynecologists (the College) strongly encourages women to breastfeed and supports each woman’s right to breastfeed. The College recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant’s first year of life.

Obstetrician–gynecologists and other obstetric care providers should support each woman’s informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant.

A breastfeeding history should be obtained as part of prenatal care, and identified concerns and risk factors for breastfeeding difficulties should be communicated to the infant’s health care provider.

All obstetrician–gynecologists and other obstetric care providers should support women who have given birth to preterm and other vulnerable infants to establish a full supply of milk by providing anticipatory guidance, support, and education for women. Obstetrician–gynecologists and other obstetric care providers should work with hospital staff to facilitate early, frequent milk expression.

Women who experience breastfeeding difficulties are at higher risk of postpartum depression, and should be screened, treated, and referred appropriately.
Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace.

The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding women through the infant’s first year of life, and for those who continue to breastfeed beyond the first year.55

ACOG also offers a Breastfeeding toolkit for Healthcare Providers.

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54. Ibid.


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Section 8.3

Perinatal Services - High-Risk Clinical Presentations

Operative Vaginal Delivery - Forceps and Vacuum Extraction

Operative vaginal deliveries basically involve the application of traction using two types of instruments; forceps are used to apply direct traction to the fetal skull, while a vacuum extractor is used to apply traction to the fetal scalp. Use of either instrument is considered to be safe and acceptable. Which instrument is used in particular situations should be determined, at least in part, upon the experience of the provider in using the instrument. It is also important to make neonatal care providers aware of which instrument may have been used, so that they may observe for the potential complications associated with that instrument.

An operative vaginal delivery is used to “achieve or expedite” a safe vaginal delivery; the decision to proceed may be based on maternal or fetal indications. According to The American College of Obstetricians and Gynecologists (ACOG):

Examples include maternal exhaustion and an inability to push effectively; medical indications such as maternal cardiac disease and a need to avoid pushing in the second stage of labor; prolonged second stage of labor, arrest of descent, or rotation of the fetal head; and nonreassuring fetal heart rate patterns in the second stage of labor.

Contraindications for a forceps-assisted delivery include the following:

- Any contraindication to vaginal delivery
- Refusal of the patient to verbally consent to the procedure
- Cervix not fully dilated or retracted
- Inability to determine the presentation and fetal head position
- Inadequate pelvic size
- Confirmed cephalopelvic disproportion
- Unsuccessful trial of vacuum extraction (relative contraindication)
- Absence of adequate anesthesia/analgesia
- Inadequate facilities and support staff
- Inexperienced operator

Contraindications for a vacuum extraction assisted delivery include the following:

- General contraindications:
  - Operator inexperience

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Some neonatal injuries or complications associated with forceps-assisted deliveries include facial bruising, lacerations, transient or permanent facial nerve injuries, corneal abrasions, intracranial bleeding, skull fractures, and possibly shoulder dystocia, brachial plexus injuries, and cerebral palsy (shoulder dystocia and cerebral palsy may be associated with prolonged labor and delivery, rather than the use of forceps per se). Maternal injuries or complications associated with forceps include lacerations, bleeding, and perineal tears that may result in nerve damage and/or defects in rectal sphincter function.

Some neonatal injuries or complications associated with vacuum extraction deliveries include scalp injuries (bruising, lacerations, cephalohematomas, subgaleal hemorrhages), brachial plexus injuries, and retinal hemorrhages. Maternal injuries occur less frequently with vacuum extraction than with forceps, but still include perineal lacerations and potential urinary and stool incontinence.
Obstetric Obesity - Maternal and Neonatal Risk Factors

It has been reported that fully one-half of pregnant women are overweight or obese. A recent study concluded, “Increased health service usage and healthcare costs during pregnancy are associated with increasing maternal BMI [body mass index].”

Overweight and obese women are at an increased risk for several complications during pregnancy, including the following:

- Gestational diabetes
- Preeclampsia
- Preterm birth
- Cesarean delivery
- Operative and post-operative complications, including
  - Prolonged operating times
  - Increased rates of excessive blood loss
  - Wound infection
  - Endometritis
  - Difficulties with anesthesia management

Complications for the fetus include:

- Increased risks of congenital anomalies
- Growth abnormalities
- Miscarriage
- Stillbirth

ACOG has made the following recommendations for obese women who are either pregnant or plan to become pregnant:

- Preconception assessment and counseling are strongly encouraged and should include the provision of specific information concerning the maternal and fetal risks of obesity in pregnancy and encouragement to undertake a weight-reduction program.
- At the initial prenatal visit, height and weight should be recorded for all women to allow calculation of BMI, and recommendations for appropriate weight gain, guided by IOM recommendations, should be reviewed both at the initial visit and periodically throughout pregnancy.
- Nutrition consultation should be offered to all overweight or obese women, and they should be encouraged to follow an exercise program. Nutrition and
exercise counseling should continue postpartum and before attempting another pregnancy.

- Women who have undergone bariatric surgery should be evaluated for nutritional deficiencies and the need for vitamin supplementation, when indicated, because they are at increased risk of deficiencies in iron, vitamin B₁₂, folate, vitamin D, and calcium.
- For patients undergoing cesarean delivery who have additional risk factors for thromboembolism such as obesity, individual risk assessment may require thromboprophylaxis with pneumatic compression devices and unfractionated heparin or LMW heparin.
- Consideration should be given to using a higher dose of preoperative antibiotics for cesarean delivery prophylaxis.
- The use of suture closure of the subcutaneous layer after cesarean delivery in obese patients may lead to a significant reduction in the incidence of postoperative wound disruption.
- Anesthesiology consultation early in labor should be considered.
- Consultation with a weight-reduction specialist before attempting another pregnancy should be encouraged.¹⁸

Please see the ACOG Obesity Toolkit.

### VBAC

Vaginal birth after a cesarean section (VBAC) is an alternative to routinely performing a repeat cesarean section delivery. The other associated terminology is a trial of labor after previous cesarean delivery (TOLAC). These procedures are certainly not without risks. Some of the risks associated with VBAC include:

- Uterine rupture
- Maternal hemorrhage
- Infection
- Operative injury
- Thromboembolism
- Hysterectomy
- Death¹⁹

ACOG has made the following summary recommendations with respect to VBAC and TOLAC:

*The following recommendations are based on good and consistent scientific evidence (Level A):*

- Most women with one previous cesarean delivery with a low-transverse incision are candidates for and should be counseled about VBAC and offered TOLAC.
- Epidural analgesia for labor may be used as part of TOLAC.
• Misoprostol should not be used for third trimester cervical ripening or labor induction in patients who have had a cesarean delivery or major uterine surgery.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

• Women with two previous low transverse cesarean deliveries maybe considered candidates for TOLAC.
• Women with one previous cesarean delivery with a low transverse incision, who are otherwise appropriate candidates for twin vaginal delivery, may be considered candidates for TOLAC.
• External cephalic version for breech presentations is not contraindicated in women with a prior low transverse uterine incision who are at low risk for adverse maternal or neonatal outcomes from external cephalic version and TOLAC.
• Those at high risk for complications (e.g., those with previous classical or T-incision, prior uterine rupture, or extensive transfundal uterine surgery) and those in whom vaginal delivery is otherwise contraindicated (e.g., those with placenta previa) are not generally candidates for planned TOLAC.
• Induction of labor for maternal or fetal indications remains an option in women undergoing TOLAC.
• TOLAC is not contraindicated for women with previous cesarean delivery with an unknown uterine scar type unless there is a high clinical suspicion of a previous classical uterine incision.

The following recommendations are based primarily on consensus and expert opinion (Level C):

• A trial of labor after previous cesarean delivery should be undertaken at facilities capable of emergency deliveries. Because of the risks associated with TOLAC and that uterine rupture and other complications may be unpredictable, the College recommends that TOLAC be undertaken in facilities with staff immediately available to provide emergency care. When resources for immediate cesarean delivery are not available, the College recommends that healthcare providers and patients considering TOLAC discuss the hospital's resources and availability of obstetric, pediatric, anesthetic, and operating room staffs. Respect for patient autonomy supports that patients should be allowed to accept increased levels of risk, however, patients should be clearly informed of such potential increase in risk and management alternatives. After counseling, the ultimate decision to undergo TOLAC or a repeat cesarean delivery should be made by the patient in consultation with her healthcare provider. The potential risks and benefits of both TOLAC and elective repeat cesarean delivery should be discussed. Documentation of counseling and the management plan should be included in the medical record.20

For additional information, please refer to the sample VBAC Guidelines in the online Coverys Tool Chest.
Shoulder Dystocia

Shoulder dystocia occurs when the anterior shoulder becomes wedged above the symphysis pubis preventing birth of the fetal body. Impacted shoulders that do not respond to simple maneuvers to facilitate the birth of the body become a labor emergency.

The reported incidence of shoulder dystocia varies from less than 1 percent to 2 percent of vaginal cephalic births. Risk factors for shoulder dystocia include:

- Fetal macrosomia
- Maternal diabetes
- Postdates pregnancy
- Maternal obesity
- Estimated fetal weight one pound or more larger than prior birth weights
- Prolonged labor
  
  [and also]
- Excessive weight gain
- Abnormal pelvis
- Short stature
- Previous large infant over 5000 grams.

To reduce patient injury and to minimize loss exposure, physicians with obstetrical privileges and delivery room nurses should be confident and competent in the management of shoulder dystocia. Patient management begins with prenatal risk assessment, informed decision-making, risk factor communication, and complete documentation. Management then proceeds to a structured institutional protocol/action plan that is practiced and evaluated. It all concludes with an organized delivery. This process also includes a discussion with the parents and thorough and comprehensive documentation of the maneuvers used, their sequence, the timing of events, and the maternal/fetal outcomes.

Risk management and patient safety tips include:

- Appropriate risk recognition and assessment can assist in preparation for this manageable birth crisis.
- Document a narrative note that clearly and accurately summarizes the series of interventions and clinical events, with a focus on a logical step-by-step approach to relieving the impacted shoulder and resuscitating the newborn. Accurate documentation of which shoulder was impacted and whether it was anterior or posterior may be critical to defending a medical professional liability claim. Consider using a shoulder dystocia documentation tool.
- Ensure that adequate staff members are present for both the mom and newborn; assign roles.
- Develop a protocol or policy for shoulder dystocia.
- Conduct shoulder dystocia drills.
Emergency Cesarean Section

According to Guidelines for Perinatal Care, Seventh Edition:

All hospitals offering labor and delivery services should be equipped to perform emergency cesarean delivery. The required personnel, including nurses, anesthesia personnel, neonatal resuscitation team members, and obstetric attendants, should be in the hospital or readily available. Any hospital providing an obstetric service should have the capability of responding to an obstetric emergency. Historically, the consensus has been that hospitals should have the capability of beginning a cesarean delivery within 30 minutes of the decision to operate. However, the scientific evidence to support this threshold is lacking. The decision-to-incision interval should be based on the timing that best incorporates maternal and fetal risks and benefits.23

When a woman requires an unscheduled cesarean section, fetal surveillance should continue up until the time that abdominal sterile preparation has been started; if internal fetal heart rate monitoring is being used, such monitoring should continue until the abdominal sterile preparation is completed.24

Clear and accurate documentation of the time when the decision to proceed with an emergency cesarean delivery was made as well as the time when the incision was made is essential to later determining whether the procedure was indeed carried out in a timely manner. This so-called decision-to-incision interval could very well be the focus of a medical professional liability claim in the event of an untoward outcome, so accurate documentation is very important.

For additional information, please refer to the sample Mock Emergency Cesarean Section Drill tool in the online Coverys Tool Chest.

Neonatal Resuscitation

It has been reported that about 10 percent of newborns require intervention by a skilled individual or team for making the transition to living outside the womb.25 Accordingly, every hospital at which deliveries are performed should have policies and procedures in place to address the resuscitation of newborns as well as specifying the qualifications of all involved personnel and ensuring their credentialing and competency.26

Additionally, as stated in Guidelines for Perinatal Care, Seventh Edition:

At every delivery, there should be at least one individual whose primary responsibility is the newborn and who is capable of initiating resuscitation, including positive-pressure ventilation and chest compressions. This individual may be a physician, advance practice neonatal nurse, nurse anesthetist, nursery nurse, physician assistant, respiratory therapist, certified nurse-midwife, or a labor
and delivery nurse. Either this individual or someone else who is immediately available should have the skills required to perform a complete resuscitation, including endotracheal intubation, establishment of vascular access, and the use of medications.\textsuperscript{27}

Moreover, it is important to keep in mind that resuscitation of a newborn infant also requires a lot of understanding and judgment:

Along with the necessary skills, the practitioner should approach any resuscitation with a good comprehension of transitional physiology and adaptation, as well as an understanding of the infant's response to resuscitation. Resuscitation involves much more than possessing an ordered list of technical skills and having a resuscitation team; it requires excellent assessment skills and a grounded understanding of physiology.\textsuperscript{28}

### Multiple Births

In terms of statistics, the incidence of monozygotic twins is about four per 1000 births; the incidence for dizygotic twins varies by race, with about 10 to 40 per 1000 in African Americans, about seven to 10 per 1000 in Caucasians, and about three per 1000 in Asians; naturally occurring triplets occur about one per 7,000–10,000 births; naturally occurring quadruplets occur in about one per 600,000 births.\textsuperscript{29}

According to \textit{Guidelines for Perinatal Care}, Seventh Edition, consideration should be given to the following in the delivery of multiple gestations:

- **Labor and delivery**
  - Performing an ultrasound examination upon admission to confirm fetal presentations
  - Monitoring of each fetus continuously during labor
  - Having a pediatrician, an anesthesia provider, and blood bank service immediately available
- **Route of delivery**
  - Preferred route remains somewhat controversial – especially for twins
  - Cesarean delivery frequently used for three or more fetuses – though some suggest that vaginal delivery of triplets is safe when patients are appropriately monitored
  - Decision based on individual patient needs and the clinician’s practice and experience – generally speaking:
    - Twins presenting as vertex-vertex – anticipate vaginal delivery
    - Presenting twin is nonvertex – cesarean delivery preferred by most physicians
    - Vertex-nonvertex presentations – vaginal delivery of twin B in the nonvertex presentation may be reasonable option
• Interval between deliveries
  o If other complications (e.g., bleeding, fetal heart rate abnormalities) are not present – the interval between deliveries for twins not a critical factor in determining the outcome of twin B
  o After twin A delivered, monitor the fetal heart rate of twin B
• The labor and delivery of patients with multiple gestations should be managed by a physician who is capable of carrying out an emergency cesarean delivery.30

**Placental Evaluation**

The placenta is a fetal organ which consists of the umbilical cord, membranes (chorion and amnion), and the parenchyma.31 Disorders in either the mother or fetus may impact the placenta, as this is the site where the mother and fetus interface.32 It logically follows that a placental abnormality may impact the mother, the fetus, or both.33

Accordingly, placental examinations may provide valuable information with regard to the impact of maternal disorders on the fetus or the cause(s) of a pre-term delivery, fetal growth restriction, or neuro-developmental impairments.34 Examination of the placenta is considered essential in fetal or newborn deaths.35

Placental examinations may also throw some light on a variety of other issues, including:

• Legal issues regarding the presence of acute versus chronic perinatal stresses and insults, and the timing of these insults
• Diagnosis of the specific etiologies of adverse pregnancy outcomes
• Identification of zygosity and pathology (e.g., twin-to-twin transfusion) in multifetal gestation
• Identification of potentially recurrent disorders, potentially leading to changes in management and improved outcome of subsequent pregnancies36

The College of American Pathologists (CAP) has published extensive criteria for placental evaluation, which include maternal indications such as:

• premature delivery,
• peripartum fever or infection, and
• unexplained third trimester bleeding,

as well as fetal indications such as:

• stillbirth or neonatal death,
• compromised clinical condition (cord blood pH less than 7.0; Apgar score of 6 or less at five minutes; ventilator assistance, more than 10 minutes; or severe anemia, hematocrit less than 35 percent),
• hydrops fetalis, and
birthweight below the 10th percentile. \(^{37}\)

A study suggested that if the CAP guidelines were used, approximately 37 percent of all deliveries would meet the criteria for placental evaluation, but in reality, less than half of that percentage are examined. \(^{38}\)

By way of further describing the CAP guidelines:

The guidelines arose from a consensus conference that included representatives from perinatal pathology, neonatology, and perinatology, among others. The committee recommended that all placentas be examined by the clinician and triaged in the delivery room. Placentas that had clinical indications for examination or were grossly abnormal were recommended to be submitted for detailed gross and light microscopic study; placentas grossly normal and without clinical indications for examination were recommended to be refrigerated for three days and submitted only if maternal or neonatal complications arose in the interim. \(^{39}\)

Indeed, there is a general consensus that all placentas should be examined grossly, either by the delivering clinician or a pathologist. \(^{40}\)

The clinician should at least determine the following:

- The number of vessels in the cord
- Whether there are any gross abnormalities (e.g., discoloration, multiple lobes, or focal lesions)
- The length of the cord – Note: It is easier and more accurate for the clinician to measure the length of the umbilical cord since the portion of the cord attached to the infant is discarded and not available to the pathologist. \(^{41}\)

Also, from a risk management perspective, it is recommended that placentas from all other deliveries that do not meet the immediate criteria for examination be refrigerated for at least 72 hours, to be available for examination if a new maternal or neonatal complication arises. \(^{42}\)

### High-Risk Clinical Situation Drills

Safety is enhanced when all team members know what to do during common obstetric emergencies, such as shoulder dystocia, emergency cesarean section delivery, maternal hemorrhage, and neonatal resuscitation. Routine clinical drills and team debriefings for these emergent clinical situations have been recommended by The Joint Commission. \(^{43}\)

According to a Committee Opinion from ACOG:

An obstetrician–gynecologist may be faced with a sudden patient emergency at any time. Whether it is severe shoulder dystocia, catastrophic surgical or obstetric
hemorrhage, or an anaphylactic reaction to an injection in the office, it will require a prompt response. Over the past decade, severe maternal morbidity in the United States has increased by 75% for complications associated with delivery and, specifically, 114% for postpartum hemorrhage [i]. Preparation for potential emergencies requires planning and interdisciplinary collaboration [ii]. Issues to consider include advance provisioning of resources, establishing an early warning system, designating specialized first responders, and holding drills to ensure that everyone knows what to do … Excellent communication and teamwork will further increase the efficiency and effectiveness of the emergency response.44

For additional information, please see Preparing for Clinical Emergencies in Obstetrics and Gynecology, ACOG Committee Opinion 590, March 2014.

References

2. Ibid.
4. Ibid.
5. The American College of Obstetricians and Gynecologists (ACOG), Operative Vaginal Delivery.
6. Ibid.
10. The American College of Obstetricians and Gynecologists (ACOG), Operative Vaginal Delivery.
11. Ibid.
12. Ibid.
17. The American College of Obstetricians and Gynecologists (ACOG), Obesity in Pregnancy.
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39. Ibid.
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41. Ibid.
42. Ibid.
44. The American College of Obstetricians and Gynecologists (ACOG), *Preparing for Clinical Emergencies in Obstetrics and Gynecology*, ACOG Committee Opinion 590, March 2014,

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Section 8.4

OB Risk Management and Legal Issues

Medical Staff Credentialing and Privileging

Credentialing and granting privileges is an important responsibility of any healthcare facility. The medical staff is responsible for delineating the scope of privileges, evaluating the competency of providers, and providing leadership for performance improvement activities. The medical expertise or the scope of practice should be based on the perinatal setting, the geographic location, and the patient population served. While credentialing is a multifaceted process, determining privileges is a difficult and critical aspect of the credentialing process. The granting of privileges should be based on training, experience, and demonstrated clinical competence.

Pertinent standards from The Joint Commission include the following:

- Standard MS.06.01.05 – The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

- Standard MS.06.01.07 – The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.

- Standard MS.08.01.03 – Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

For example, in order to maintain or receive privileges to perform operative vaginal deliveries with forceps or vacuum, it is generally recommended that physicians demonstrate clinical competence. The evaluation of clinical competence could include a frequency criterion, such as having performed the procedure five times in the past year. Alternative methods of evaluating clinical competence include a preceptor program, CME training, or simulation training. The frequency criterion of having performed five procedures in the past year is not an ACOG recommendation or requirement. In fact, ACOG, in a response to an inquiry from the Coverys Risk Management perinatal physician expert, stated, “Our guidelines on privileges are not based upon a specific number performed. Rather, privileges are based on training, experience, and demonstrated competence. … Numbers alone do not guarantee competence.”

The frequency criterion is, however, a result of collaboration among Coverys Risk Management’s perinatal physicians and consultant staff experts, who, based on their wisdom, research, and
experience, agree that if volume alone were a factor in evaluating competency to execute vacuum deliveries, the performance of five procedures in the most recent 12 months would be a reasonable indicator.

Also, review Appendix D, *Granting Obstetric Privileges* in the *Guidelines for Perinatal Care*, Seventh Edition.

### Certified Nurse-Midwives and Certified Midwives

The distinctions between certified nurse-midwives and certified midwives are aptly explained in *Guidelines for Perinatal Care*, Seventh Edition:

Certified nurse–midwives are registered nurses who have graduated from a midwifery education program accredited by the Accreditation Commission for Midwifery Education and have passed a national certification examination administered by the American Midwifery Certification Board, Inc., formerly the American College of Nurse–Midwives Certification Council, Inc. Certified midwives undergo the same certification process as certified nurse–midwives, but their training does not include education in nursing. They are graduates of a midwifery education program accredited by the Accreditation Commission for Midwifery Education and have successfully completed the American Midwifery Certification Board, Inc. certification examination and adhere to the same professional standards as certified nurse–midwives.²

Certified nurse-midwives and certified midwives work in a variety of settings (e.g., private practice, community health facilities, clinics, hospitals, and accredited birth centers) and may engage in the following activities:

- Managing the care of low-risk women in the antepartum, intrapartum, and postpartum periods
- Managing healthy newborns
- Providing primary gynecologic services in accordance with state laws or regulations
- Collaborating with obstetricians in the care of women with medical or obstetric complications³

The American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) have issued the following joint statement (in part):

The American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM) affirm our shared goal of safe women’s healthcare in the United States through the promotion of evidence-based models provided by obstetrician–gynecologists (ob-gyns), certified nurse-midwives (CNMs), and certified midwives (CMs). ACOG and ACNM believe healthcare is most effective when it occurs in a system that facilitates
communication across care settings and among providers. Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients. Quality of care is enhanced by collegial relationships characterized by mutual respect and trust, as well as professional responsibility and accountability.

Recognizing the high level of responsibility that ob-gyns and CNMs/CMs assume when providing care to women, ACOG and ACNM affirm their commitment to promote the highest standards for education, national professional certification, and recertification of their respective members and to support evidence-based practice. Accredited education and professional certification preceding licensure are essential to ensure skilled providers at all levels of care across the United States.4

### Coverage and Consulting Services

The mechanism for providing ongoing physician coverage needs to be addressed by the medical staff. A pediatrician or neonatologist must be available for consultation at all times. A qualified anesthesiologist must also be available in-house during normal work hours and on-call at other times. It is recommended that CRNAs not be assigned to cesarean section cases unless they are under the direct supervision of an anesthesiologist.

All consulting physicians are to be identified in the medical record and their assessments and recommendations must be documented. This is particularly important when consultation has taken place over the telephone. Both the information provided to the consultant and the consultant’s recommendations need to be recorded.

It is recommended that the medical director of the obstetrics department serves as the chairperson for the obstetrics patient care committee and also oversees the credentialing and peer review functions for all physicians and advanced practice professionals involved in perinatal services.

### Nursing Education and Competency

Orientation programs should be established for all new obstetric nurses. Following orientation, planned learning experiences that are designed to promote clinical competence and identify barriers to safe clinical practice should be provided. Educational programs need to include a risk management component. Involvement in career development and professional activities is to be encouraged.

It is important to ensure that all members of the nursing staff are competent in resuscitation, electronic fetal monitoring, oxytocin administration (including use of “smart pumps” if used for infusion), high-risk perinatal presentations, and the use of chain-of-command policies (see Chain-
Consideration may be given to employing a “patient safety nurse” to coordinate team training, obstetric emergency drills, collection of data, and implementation of protocol changes.\(^5\)

Ensure that a competency assessment is in place for common perinatal nursing procedures, such as vaginal examinations and the placement of internal fetal scalp electrodes.

### EMTALA

Federal law requires that all Medicare-participating hospitals with a dedicated emergency department must provide an “appropriate medical screening examination” to any individual who comes to the emergency department for medical treatment or examination to determine whether the patient has an emergency medical condition. Woman in labor are specifically referenced in the definition of an emergency medical condition.

EMTALA has specific application to pregnant patients having contractions, to wit. The definition of an emergency medical condition also makes specific reference to a pregnant woman who is having contractions. It provides that an emergency medical condition exists if a pregnant woman is having contractions and “. . . there is inadequate time to transfer to another hospital before delivery; or that transfer may pose a threat to the health or safety of the woman or the unborn child.” An emergency medical condition does not exist, even when a woman is having contractions, as long as there is adequate time to effect a safe transfer before delivery and the transfer will not pose a threat to the health or safety of the mother or the fetus. Labor is defined as the process of childbirth beginning with the latent phase of labor or early phase of labor and continuing through delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. Under this definition, a qualified medical person must certify that a woman is in false labor before she can be released.\(^6\)

In order to comply with the above-quoted section, hospitals should develop a labor evaluation policy to address the process that is used at the facility. They should also identify, in the hospital bylaws or medical staff rules and regulations, those persons who are qualified to perform a medical screening examination. As stated by the Centers for Medicare and Medicaid Services (CMS):

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners
designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.7

If nurses are performing OB medical screening examinations, consider the following wording:

A qualified Labor and Delivery Nurse (the facility needs to define qualified: e.g., 24 months of OB experience) may perform a MSE in consultation with the attending physician to determine the presence/absence of active labor in the full term patient (>37 weeks, your facility needs to define) who is an established patient of a physician with OB privileges at the hospital.

In addition, if the OB RNs are conducting the medical screening, additional education and competency are necessary:

The common practice of L&D nurses assessing mothers for possible delivery and discharging them with a phone call to the doctor after only a short observation is not sufficient to meet EMTALA MSE requirements. …

Even where physicians are not present, the MSE by an L&D nurse may require further physician assessment. In those cases, the physician is required to respond promptly to provide a complete medical screen exam.

It is important to note that this is not a request for the physician to come in to deliver the baby, but to complete the physician assessment.

Response is not optional and should be considered a STAT response requirement of less than 30 minutes.

Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of an EMC, because these resources are within the capability of the hospital. …

Documentation:

- Policies and procedures for OB assessment;
- Standard documentation;
- Detailed standard protocol or scoring system;
- L&D nurse training on policies, procedures, and EMTALA in training files;
- Evidence of physician contact and details;
- In most states, verbal orders of physician [sic] to discharge a patient home following MSE may be taken and signed by qualified nurses and countersigned or validated by physician [sic] within state time limits or 24 hours, whichever is less (Check with State Board of Nursing for scope of practice limitations.)8
To minimize risks to the patient and the facility, ensure that transfers are guided by written policies and procedures. Have the medical staff draft and approve protocols for maternal and/or fetal transport that comply with EMTALA requirements. (See Volume 3, Section 8 of the Coverys Risk Management Healthcare Facility Risk Management Manual for a complete discussion of patient transfer and transport.) Transfer protocols must include criteria for assessing the risk factors for both the mother and the fetus, as well as consider whether the hospital has adequate medical expertise (consultants) and internal resources to handle potential complications. External resources and capabilities must be considered along with the risks associated with transfer. Make certain that these considerations are documented in the medical record.

As transfers usually result from high-risk situations, it is recommended that transfer policies and procedures address the following:

- Indications for transfer
- Responsibility for the transfer decision
- Informed consent for transport and treatment
- Communication with the referring/receiving facility and with the family
- Stabilization prior to transport
- Transfer of physician responsibility
- Roles and responsibilities of the transport team
- Appropriate care during transport
- Appropriate medical record documentation and release

**Telephone Triage**

Providing telephone advice may increase risk to both the hospital and practitioner.

The common allegations in medical professional liability cases associated with telephone triage include:

- Failure to accurately assess maternal-fetal status over the telephone
- Failure to advise the woman to seek in-patient evaluation and treatment
- Failure to correctly communicate maternal-fetal status to the primary healthcare provider
- Failure of the physician/nurse-midwife to come to the hospital to see the woman when requested by the nurse

It has also been stated:

Telephone advice to pregnant patients by labor and delivery nurses should be limited to two comments: Call your primary healthcare provider or come to the hospital to be evaluated... The liability for assessing and diagnosing conditions of pregnancy and labor should remain with the primary care providers rather than being assumed by the institution.
In light of the potential problems, the following recommendations are offered for consideration:

- Do not allow nurses (or physicians) to give advice over the telephone.
- Direct switchboard employees to channel calls to one department or to a designated person within the facility. This will allow the organization to train a limited number of personnel to respond appropriately to calls requesting advice.
- Instruct labor and delivery nurses who receive calls from pregnant patients requesting advice to direct the pregnant individual to see her primary healthcare provider or come to the hospital to be evaluated.
- Keep a written log of all emergency department telephone inquiries, referrals, and recommendations.
- Ensure that follow-up discharge advice is time-specific (e.g., within 24 hours), provided by protocol and documented in the medical record.

### Infant Security

The Joint Commission requires that organizations manage security risks, including the possibility of infant abduction.  

The risk of infant abductions may be minimized by putting policies in place which address the following:

- Educating staff members on the risk factors for infant abduction
- Educating family members regarding the facility’s approved procedures for handing over their infant to anyone
- Controlling access to the post-partum area

Facilities delivering infants should develop a security system that is designed to protect the newborns from abduction; such a system may include electronic sensors or other devices.

Additionally, policies and procedures need to be in place that address visitation, transfer, and discharge of newborns and include requirements pertaining to identification and verification of the newborn and any and all attendants, visitors, and family members.

According to Guidelines on Prevention of and Response to Infant Abductions:

Conduct at least one unannounced, facility wide infant abduction drill each year involving all facility personnel taking into account more than one drill may need to be held in order to include personnel who work day, evening, weekend and/or nontraditional shifts. In addition to the facility wide drill, facilities should conduct quarterly unit specific drills, tabletop exercises or audit type exercises. Critique each exercise to identify opportunities for improvement to enhance policy, procedure or performance standards. Tabletop exercises take place around the table with the key players acting out a specific scenario generally without simulated
or actual patients involved. An audit type exercise may be a formal review of a procedure by actually walking through the procedure or testing a procedure. During drills, when using a person posing as an abductor, the scenario should be patterned after the typical offender profile and include realistic scenarios foreseeable to health care personnel.\textsuperscript{15}

Additional resources to assist with preventing infant abduction are available from the National Center for Missing and Exploited Children.

### Chain of Command

Patient safety is enhanced when staff members are provided with clear direction on how to respond when patient care is questioned. Following a chain-of-command policy is an effective way for staff members on perinatal units to voice concerns about patient safety when the usual lines of communication prove to be inadequate.

An effective implementation of a chain-of-command policy can:

- Provide for physician attention to patient care in the event the attending or covering physician is unavailable or does not respond in a timely manner to an urgent or emergent situation
- Provide a mechanism for any caregiver to receive assistance when there is a concern regarding the safety of the patient

### Medication Safety

The process of selecting, ordering, preparing, delivering, and administering medications is complex and subject to errors. This complex process is repeated so often that inattention and workarounds pose significant risks to patients. Misoprostol and oxytocin are medications that are often associated with litigation involving obstetrics. Serious medication errors involving these and other medications have resulted in serious injuries and fatal outcomes.

It is important to ensure that the use of all high-risk drugs (e.g., magnesium sulfate, oxytocin) is directed by medical staff protocols which address the following:

- Indications/contraindications
- Appropriate dosage levels
- Side effects and symptoms of toxicity
- Required patient assessment, monitoring, periodic blood levels
- Physician attendance
- Medical record documentation
- Administration during transport
- Uterine monitoring and fetal monitoring frequency
ACOG’s Improving Medication Safety Committee Opinion provides broad-based strategies for medication safety and addresses using health information technology, electronic prescribing, and computerized physician order entry.

### Video Recording

Photography, digital imaging, and other means of recording patient care are common in today's high-tech healthcare environment. Some equipment used in various procedures routinely records events. Each time a patient's image is captured and recorded, a potential liability exposure arises.

Consent is generally not needed for photography done by the patient's family or friends, but the hospital/organization should have policies and procedures to govern personal photography within the institution. Pay special attention to protocols that govern the video recording of childbirth. Be sure to provide a copy of the facility's written policy regarding photography and video recording to prospective parents during the prenatal period.

It is helpful if family members understand that photography may be discontinued if the physician encounters a complication or unexpected event during the delivery. Be sure to obtain specific consent before taking any routine photographs of newborns to give or sell to parents.

For assistance in developing a policy, please refer to the Coverys Risk Management Healthcare Facility Risk Management Manual, Volume 3, Section 6.1.

### Minors: Informed Consent, Access to Records, and Increased Risk

The right to consent to or refuse medical care for minor children generally falls to a parent or legal guardian. However, some federal and state laws address circumstances, such as pregnancy and the treatment of venereal disease and substance abuse, for which older minors may seek treatment without parental knowledge. Also, emancipated minors may be treated as adults for purposes of informed consent. Emancipation usually involves a demonstrated measure of independence from their parents, such as marriage, living on their own, having financial independence, being pregnant, or having children of their own.

Since informed consent is based on understanding, any barriers to communication must be dealt with effectively. Therefore, it is essential to assess and record that the minor is indeed able to understand the risks and benefits of the treatment being considered. The interpretive guidelines for §482.13(b)(2) state:

> The patient or the patient’s representative should receive adequate information, provided in a manner that the patient or the patient’s representative can understand, to assure that the patient or the patient’s representative can effectively exercise the right to make informed decisions.\textsuperscript{16}
The release of information regarding emancipated minors is protected by most state statutes. Policies and procedures should direct the appropriate use and disclosure of protected health information in response to requests for access to the minor’s records from parents or others.

For more information regarding informed consent, please refer to the Coverys Risk Management Healthcare Facility Risk Management Manual, Volume 3, Section 6.0 and the State Statutes and Links Tool Chest for examples of state-specific laws related to minors.

Pregnant adolescents are at increased risk for several conditions which require increased monitoring and appropriate medical management, including:

- Delivering low birth weight neonates
- Neonatal death
- Pre-term delivery
- Pre-eclampsia
- Anemia
- Sexually transmitted diseases

As it has been demonstrated that adolescents who have been pregnant once are likely to become pregnant again, post-partum contraception should be discussed and arrangements made to provide the chosen contraceptive before discharge.

Fetal Death

Fetal death has been defined as follows:

Death before the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of pregnancy that is not an induced termination of pregnancy. The death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

After a stillbirth or neonatal death, a careful perinatal and family history, a physical examination of the fetus or infant, and indicated laboratory studies should be obtained and documented. The reporting requirements for fetal deaths are state-specific.

Perinatal staff members and providers have an important role in the healing process of bereaved parents following fetal or neonatal death. The skills of empathy, honesty, and communication are critical in these situations. Listening to the parents and accepting their emotional expressions are critical at this time. Referral to available grief counseling or support groups should be made if indicated.
References


3. Ibid.

4. The American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM), Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives, Approved by the Executive Board of ACOG and the Board of Directors of ACNM February 2011, Reaffirmed by the ACOG Executive Board July 2014.


11. The Joint Commission, Standard EC.02.01.01.


13. Ibid.

14. Ibid.


18. Ibid.
22. Ibid.

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Section 8.5

Samples, Tools, and Resources

The following samples are available in the Coverys Tool Chest:

- EFM Medical Record Audit Tool
- Forceps Vacuum Documentation Tool
- Mock Emergency Cesarean Section Drill
- Perinatal Services Self-Assessment
- Risk Factors to Consider for High-Risk Fetal Monitoring
- VBAC Guidelines

The following resources are available on the ACOG website:

ACOG offers a variety of patient safety checklists at:

ACOG offers “Toolkits for Healthcare Providers” at:
http://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers.

For a list of ACOG’s Committee Opinions, go to:

For a list of ACOG’s Practice Bulletins, go to:
http://www.acog.org/Resources-And-Publications/Practice-Bulletins-List.

For a list of ACOG’s Position Statements, go to:

For a list of ACOG-Endorsed Documents, go to:

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