Lessons Learned

OPTIMA HEALTHCARE INSURANCE SERVICES

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When Time Matters: Lessons in Obstetric Escalation and Response

Introduction

Obstetric claims may occur less frequently than many other medical professional liability events, but their severity can be extraordinary when maternal or neonatal injuries are catastrophic and lifelong. This closed claim demonstrates how labor management, fetal monitoring interpretation, provider responsiveness, escalation, documentation, team communication and organizational culture can converge to create an indefensible outcome.

Key Takeaways

Safe maternal and neonatal care depends on reliable assessment of labor progress and fetal status, timely bedside response, clear escalation expectations, structured communication, decision-focused documentation, emergency readiness, and a culture that supports speaking up.

Case Summary

A 21-year-old primigravida at 39 weeks presented to the hospital emergency department with pelvic pressure and back pain. Vaginal examination showed 2 cm cervical dilation, 70% effacement, and no membrane rupture. Electronic fetal monitoring (EFM) was documented as reassuring/Category I, with a fetal heart rate (FHR) baseline of 140-150 beats per minute. She was discharged home.

Approximately six hours later, at 8 p.m., she returned to the hospital and was sent directly to the obstetrics unit. Evaluation confirmed rupture of membranes. She was experiencing mild contractions, and cervical examination showed 2 cm dilation, 75% effacement, and fetal station of -3. EFM was again documented as reassuring/Category I, with a baseline FHR of 130-140 beats per minute. There was no documented change overnight.

Oxytocin was initiated at 8 a.m. the following morning and increased per protocol. Epidural anesthesia was placed at 2 p.m. By 8 p.m., the patient was 5 cm dilated, 100% effaced, and at -1 station. The FHR tracing continued to be documented as reassuring. At 11 p.m., she was fully dilated at 0 station and began pushing.

Nursing documentation reflected repeated telephone and text notifications to the obstetrician between 11 p.m. and 1:30 a.m. These communications included requests for bedside assessment, updates regarding the FHR tracing, and reports that the patient was exhausted, struggling to push effectively, and requesting a cesarean delivery (C-section). The obstetrician arrived at the bedside at 2 a.m. At that time, documentation noted an FHR of 130 beats per minute and fetal descent with pushing.

At 4:30 a.m., the patient was taken to the operating room (OR) for a C-section due to failure to descend. The epidural was ineffective, and spinal anesthesia was initiated. The FHR was documented as 140 beats per minute; no further FHR assessment was documented before delivery.

C-section procedural documentation described the fetal head as "firmly engaged deep in the pelvis" and stated that the head was manually extracted "fairly easily." A vacuum was applied to the fetal head to assist with delivery. The infant was delivered at 4:55 a.m., limp and unresponsive, with the umbilical cord wrapped loosely around the neck. The initial and only documented Apgar score was 2 for heart rate. The infant was resuscitated, intubated, and transferred to the NICU.

Negligence Allegations

- Negligent management of labor and delivery.
- Negligent maternal and fetal monitoring.
- Failure to escalate and/or follow the chain of command.
- Delay in performing C-section delivery.

Damages and Outcome

The child sustained severe cerebral palsy with spastic quadriplegia and is dependent on all activities of daily living. The child is non-verbal, has hearing and visual impairment, is incontinent, and is dependent on feeding tube, tracheostomy, continuous oxygen, and ventilator support. Due to the extent of the child's neurologic and medical needs, the child requires 24-hour care.

The hospital contributed $8 million toward the settlement and the physician settled for the $1 million policy limits.

Expert Review and Key Issues

There were no supportive defense expert reviews in this case. Experts opined that the nursing staff lacked adequate EFM interpretation training, failed to follow escalation protocols, and were not prepared to respond to an obstetric emergency. Experts further concluded that absent variability and persistent late decelerations were not recognized or acted upon and that the infant should have been delivered several hours earlier.

Labor-management concerns included the prolonged second stage and delayed bedside assessment. The patient remained fully dilated at 0 station for more than five hours before the decision to proceed with cesarean delivery, and the obstetrician did not arrive at the bedside until approximately three hours after pushing began. The record reflected repeated nursing requests for assessment, but the chain of command was not activated.

The circumstances of delivery also raised questions. Procedural documentation described the fetal head as deeply engaged in the pelvis, and vacuum assistance was used during cesarean delivery. Low-frequency, high-risk procedures require defined privileges, current competency, appropriate preparation, and complete documentation.

Records also reflected prolonged rupture of membranes, and a white blood cell count of 14,100/mm³ two days before delivery. Experts questioned whether these findings were reviewed and incorporated into the plan of care given concern for intraamniotic infection. Documentation did not clearly demonstrate the clinical assessment or decision-making related to these findings.

Finally, nurses described the obstetrician as dismissive and intimidating, and testimony indicated these concerns were well-known before the event. Behavior that undermines psychological safety can delay communication and escalation. Combined with the clinical deviations, catastrophic injury, and documentation weaknesses, the claim was considered indefensible.

Lessons Learned and Risk Mitigation Strategies

This case highlights how delays in recognition, communication, escalation, bedside assessment, and delivery decision-making can compound risk and contribute to catastrophic outcomes. The following strategies are offered as considerations for strengthening obstetric safety through standardized processes, clearly defined roles and expectations, documented education and competency, timely recognition and escalation of concerns, effective interdisciplinary communication, leadership accountability, and a culture in which all team members are expected and supported to speak up for maternal and fetal safety.

1. **Standardize Evidence-Based Labor-Management Practices and Expectations.**
    - Medical and nursing staff should collaboratively develop and maintain written policies, procedures, protocols, guidelines, and orientation materials.
    - Align materials with current evidence-based practices and recommendations from professional organizations, including ACOG and AWHONN.
    - Establish clear clinical criteria for provider notification, bedside assessment, escalation, reassessment of the labor-management plan, and timely intervention when maternal or fetal concerns arise.
    - Review and approve materials regularly through established medical staff and organizational governance processes.

2. **Define OB-Specific Education, Training, and Competency Expectations.**
    - Establish role-specific orientation, education, training and competency requirements for all obstetric staff and providers.
    - Require initial and ongoing competency validation and annual review of required competencies.
    - Provide continuing education related to high-risk, time-sensitive obstetric conditions and procedures.
    - Ensure education reflects current organizational policies, professional guidance, and identified performance-improvement needs.

3. **Validate Fetal Monitoring Competency.**
    - Require all obstetric providers and nurses to complete EFM interpretation education and demonstrate competency before independently caring for obstetric patients.
    - Conduct ongoing education and competency validation at defined intervals to confirm continued proficiency.
    - Incorporate multidisciplinary fetal heart rate tracing rounds, or "strip rounds," into ongoing education to promote shared learning and consistent interpretation.
    - Reinforce timely recognition of concerning patterns, appropriate escalation, and use of standardized terminology when interpreting, documenting, and communicating FHR patterns.

4. **Conduct Multidisciplinary Emergency Drills and Simulations.**
    - Conduct regular multidisciplinary drills and simulations to strengthen emergency readiness, team coordination, communication, role clarity, and timely response during high-risk obstetric events.
    - Include scenarios involving preeclampsia, obstetric hemorrhage, shoulder dystocia, trial of labor after cesarean, induction and augmentation of labor, operative vaginal delivery, and anesthesia-related emergencies.
    - Include nursing, obstetric providers, anesthesia, neonatal or NICU personnel, and surgical teams as applicable.
    - Debrief simulations and actual high-risk events to identify strengths, opportunities for improvement, assigned follow-up actions, and lessons to incorporate into education and practice.

5. **Hardwire Escalation and Closed-Loop Communication.**
    - Develop or revise escalation and chain-of-command policies to include obstetric-specific clinical triggers.
    - Define expected provider response timeframes, criteria for provider nonresponse, and required next steps when concerns are not acknowledged or resolved.
    - Require closed-loop communication and documentation of the concern communicated, the provider's response, the agreed plan of care, and any additional escalation.
    - Incorporate structured communication tools such as SBAR, CUS, and Stop the Line to reduce ambiguity, promote shared understanding, support assertive communication, and empower team members to speak up and escalate concerns when maternal or fetal safety may be at risk.

6. **Address Professionalism, Communication, and Psychological Safety.**
    - Investigate and address reports of intimidating, dismissive, disruptive, or nonresponsive behavior that may interfere with teamwork, communication, escalation, or patient safety.
    - Support all members of the care team in speaking up and escalating unresolved maternal or fetal safety concerns.
    - Use medical staff leadership, human resources, and organizational accountability processes as appropriate.

- Consider incorporating behavioral concerns, provider response delays, and communication failures into OPPE/FPPE review when they may affect the quality or safety of patient care.

7. Strengthen Documentation Practices and Expectations.

- Document the clinical decision-making process clearly and accurately.
- Include maternal and fetal assessments, labor progress, relevant laboratory and diagnostic findings, and changes in clinical condition.
- Document patient requests and preferences, provider communications and responses, informed consent discussions, and escalation steps.
- Clearly identify the clinical rationale for decisions and the evolving plan of care.

8. Enhance Quality Monitoring and Performance Improvement.

- Use ongoing quality monitoring, obstetric dashboards, case review, and focused audits to identify trends and opportunities for improvement.
- Evaluate adherence to established standards and protocols.
- Monitor provider response times, escalation reliability, fetal monitoring concerns, and maternal and neonatal outcomes.
- Review findings promptly and use them to guide education, peer review, process improvement, and risk mitigation efforts.

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References and Resources

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