OB Documentation: Knowing the Write Information

Mary Ellen Filbey, RN, BSN, JD, CPHRM
Clinical Risk and Patient Safety Specialist
and MORE® Program Lead Consultant
Objectives/Agenda

- Discuss purposes of medical record documentation
- Recognize documentation errors
- Recognize challenges of using the various medical record formats
- Identify OB documentation best practices for some high-risk presentations
- Discuss your examples and best practices and have some fun!

What Do We Know?

- Frequency and severity of perinatal claims
- Median Obstetrical Malpractice awards
- The Joint Commission’s Sentinel Event Alerts
- Obstetrical claims are studied and studied

What Contributes to OB Claims the Most?

Patterns: Losing Malpractice Cases
Four patterns linked to almost two-thirds of malpractice losses:
• Three are associated with avoidable adverse outcomes:
  – Use of oxytocin, misoprostol and magnesium sulfate
  – Deterioration in fetal status requiring expeditious cesarean delivery
  – Management of VBAC
• Incomplete Documentation:
  – Shoulder dystocia

Frequent Allegations: Documentation
• Inadequate prenatal history
• Incomplete and inadequate physical examination
• Failure to observe and take appropriate action:
  – Poor risk assessment/reassessment
  – Delay in or lack of response to non-reassuring fetal status
  – Delay in performing cesarean

Frequent Allegations: Documentation
• Failure to communicate changes in patient’s condition
• Failure to use/interpret fetal monitoring appropriately
**Polling Question: EFM Certification**

- Nurses?
- Providers?
  - Nationally or other programs
- Consistently using Category Language in documentation?
- Share how you bridged the gap

**Frequent Allegations: Documentation**

- Inappropriate use of Pitocin
- Communication
  - Finger-pointing
  - Assigning blame
  - Disparaging comments

*Documentation is a key communication issue in perinatal services.*
Documentation – at the Center of it All!

Importance of Documentation

Essential Elements - AIR-C²

Communication    Assessment    Response    Changes

Interventions
Attorneys Look at the Basics First

- Date, time and sign each entry
- Draw a line through the empty space at the end of an entry/bottom of page
- Note the patient’s name on each page
- Document at the time of treatment and procedures

Are You Covering the Basics?

- Make sequential entries
- Appropriately add late entries
- Chart personal observations of subjective and objective data
- Make and sign your own entries
- Always chart in ink and legibly

Errors Follow Dangerous Abbreviations

<table>
<thead>
<tr>
<th>High Error Risk</th>
<th>Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>U or IU</td>
<td>Unit or International Unit</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd</td>
<td>daily</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod</td>
<td>Every other day</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)</td>
<td>X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td>0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>morphine sulfate magnesium sulfate</td>
</tr>
</tbody>
</table>
Scrutinizing Your Documentation!

- What is each side looking for in your documentation?
  - Plaintiff?
  - Defense?

Correct Your Errors Consistent with Your Hospital’s Policy

- Hospital policies differ
- Know your hospital’s policy or electronic method to correct an error
- One example:

Are You Being Ambiguous?

- “Squeezing in” some critical information omitted from the record
- Using vague terms such as “fair” or “apparently” or “better” - be descriptive
- Documenting premature conclusions - “probably heartburn” or “most likely fetus sleeping”
Subjective Comments are Easily Misinterpreted

What is the big deal? All I did was document that the doctor looked tired that night.

Are You Implying Bias?

• Referencing anything related to billing/insurance
• Describing a patient in an inflammatory or prejudicial manner

Documenting Provider Unavailable

7/8/11 2100
Dr. Stetrics paged regarding patient’s condition. Mary Ellen Filbey RN

7/8/11 2105
Susy Surgery, RN, from the Operating Room, calls and states Dr. Stetrics in surgery and to call his partner Dr. Wright. Mary Ellen Filbey RN

7/8/11 2115
Dr. Wright called at 2108 with no response. Nursing supervisor, Bessy Body, RN, notified of situation Mary Ellen Filbey RN

2118
Dr. Responsible, Chairperson of OB, called and discussed patient’s condition and request for physician evaluation. Dr. Responsible coming to unit to evaluate patient. Mary Ellen Filbey RN

2121
Dr. Responsible at patient’s bedside to evaluate patient. Mary Ellen Filbey RN
High Reliability Perinatal Units

- Clear Purpose: Safety First
- Clear Language: Fetal well-being
- Clear Organization: Teamwork
- **One Policy:** A physician will come when requested
- Clear operating style


Are You Referencing Confidential QA Documents?

Avoid referring to:
- Occurrence/patient safety event reports
- Risk management
- Quality assurance/improvement
- Peer review activity

Documenting an Adverse Event

If an adverse event occurred with your patient while you were caring for him/her, how would you document it?
Adverse Events – Core Elements

The Facts

Care Provided

Patient Response

Physician Notification

Conversations - Patient/Family

Documentation Tools

• Paper
• Electronic
• Hybrid

Paper – Ambiguous Markings
Electronic Options are Often not Specific Enough

OB examples:
- “RN reviewing tracing”
- “Contraction pattern assessed”

Building Your Electronic Documentation

- Checklist information
- Built in templates:
  - Phase of labor
  - Components to consider for high risk
- Revisit and update checklists and drop-down options

OB is High Risk

Continuum of Care
Emergency Cesarean Section
VBAC’s
Shoulder Dystocia
Vacuum Extraction/Forceps
Prenatal Record Documentation

• Information used for determining dates
• Screening and assessments
• Screening for neural tube defects and genetic testing offered or performed, as indicated
• Patient education and instructions
• The delivery plan with clinical rationale

Fetal Monitoring

Continuum of Care

FETAL MONITORING

Prenatal Labor Evaluation/Triage Transfer Antenatal Post Partum
Good Documentation Counts

Fetal heart tracing has been a Category 1 from 0200 through 0215. I have been with the patient all this time and continually evaluated the fetal status.

Mary Ellen Filbey RN

Labor Evaluation/Triage Transfer

Antenatal
Labor and Delivery Record Documentation

• Initial assessment
  – Maternal and fetal status, status of labor
• Periodic evaluations of labor
  – Emphasis on maternal and fetal status and plans or interventions
• Ongoing documentation during later stages of labor and in lengthy labors
  – Reflect continued clinical evaluation

Labor and Delivery Record Documentation

• Demonstration of thought process
• Discussions with the mother, significant other, and family, as appropriate
• Maneuvers used, in the order utilized
  – Vaginal delivery of singleton breech
  – Shoulder dystocia

Information Flow

Referrals

• PCP should verify that the patient was seen by the specialist
• OB/GYN, MFM, or other specialist should phone the treating physician if the results of the referral are adverse
• PCP, OB/GYN, MFM and other specialists need tracking systems to monitor need for follow-up -- all are responsible!
High-Risk Medication - Pitocin


Emergency Cesarean Section

Consistent terminology and documentation roles


VBACs

Photo source: Matt Williams, http://www.sxc.hu/photo/396692, 03/30/2012.
Shoulder Dystocia – What to Document!


Vacuum Extraction/Forceps – Documentation Considerations


Polling Question

Use of template language or checklist:
• Shoulder Dystoci?
• Operative Deliveries?
• Successes?
Post Partum

Still High Risk – Be Vigilant and Diligent

Know How Your Documentation Supports the Care Your Team Provided

Is Your Healthcare Organization a Safe Place to Receive and Give Care?
What are your communication responsibilities to ensure the safety of patients?
Documentation Strategies to Enhance Communication

- Transmit complete prenatal records to L&D
- Coordinate birth plan of care with interdisciplinary team members, e.g., pediatrics, neonatology, social workers - document
- Ensure effective communication of relevant information - document
- Utilize transfer documentation and follow any established written transfer agreements

Documentation Strategies to Enhance Communication

- Implement NICHD terminology
- Require EFM certification
- Ensure that evidence-based perinatal practice protocols/bundles, order sets are built in
- Ensure consensus on definitions/nursing interventions such as for intrauterine resuscitation

Perinatal Documentation Strategies

- Utilize structured prenatal, labor and delivery forms
- Utilize the forms accurately and completely
- Supplement the forms with progress notes
- Document patient education literature that was provided
- Include a copy of discharge instructions in the patient’s record
Strategies to Enhance Documentation for the team

Print off and audit your records
- Including how late entries look
- Know what your electronic records look like for a deposition or in trial
- Identify opportunities to enhance the electronic record with your IT department

Departing Thoughts

- A good chart defends itself and those who wrote it.
- A chart is a witness that never dies or never lies.

Thank You and Questions