THE DOCTORS COMPANY

PATIENT SAFETY

Interactive Guide for Obstetrical Practices

Minimize your practice liability
with a loss prevention checkup.

FOR MORE THAN 35 YEARS, THE DOCTORS COMPANY HAS BEEN FIERCELY COMMITTED TO ADVANCING, PROTECTING, AND REWARDING THE PRACTICE OF GOOD MEDICINE. OUR COMMITMENT EXTENDS TO DELIVERING PRACTICAL TOOLS AND SERVICES THAT CAN HELP YOU IDENTIFY POTENTIAL RISKS AND STRENGTHEN PATIENT SAFETY.

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This interactive guide is not a standard of care. Any guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any action or treatment must be made by each health care practitioner in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

How to Use This Interactive Guide

This review is not a test. It is an interactive guide designed to help you uncover areas in your practice that could create liability risks.

There is no scoring system. The options for responding to the statements are **Always/Yes**, **Sometimes**, **Never/No**, and **N/A**. The ideal response to every statement is **Always/Yes** or **N/A**. Any other response indicates an area of potential malpractice exposure in your practice that should be addressed and resolved.

Respond to the statements as objectively and honestly as you can. The effectiveness of this interactive guide depends on how candid you are.

The guide is divided into 13 sections. These sections reflect the most frequent patient safety/risk management issues identified in our closed claims.

You can evaluate your practice and systems as a whole or focus only on the sections that are areas of concern.

Effective risk management is a team effort. To gain a range of perspectives, we suggest that the physician, office manager, and staff complete this assessment. Any significant variations in the answers among those taking the risk assessment should be discussed and addressed.

Knowledge Center

Our extensive online library of articles is considered to be the industry's definitive resource on today's most pressing patient safety/risk management and health care policy issues. We invite you to explore our content at www.thedoctors.com/knowledgecenter.

Expert Team of Trained Specialists

Our patient safety program is led by an expert team of trained medical and patient safety professionals who work tirelessly with members to implement strategies tailored to their specialty and practice.

Our specialists operate regionally and are available to our members for consultation nationwide. E-mail us at patientsafety@thedoctors.com, or call us at (800) 421-2368, extension 1243, and we will connect you with your regional patient safety/risk manager.

If you have an urgent patient safety or claims issue, our specialists are available 24 hours a day, 365 days a year on our nationwide hotline at (800) 421-2368.

Communications

Always/ Yes	Sometimes	Never/ No	N/A	
				ACCESS
☐	☐	☐	☐	1. Each hospital is given after-hours call schedules in a timely manner and knows how to reach each covering physician immediately.
☐	☐	☐	☐	2. Each hospital has a defined policy on ACOG's "immediately available" recommendation, and providers are aware of each institution's interpretation and requirements for obstetric physicians overseeing vaginal birth after cesarean (VBAC) patients.
				DIRECT COMMUNICATIONS
☐	☐	☐	☐	3. When taking a phone call from a patient, front office staff always ascertains whether the patient is pregnant.
☐	☐	☐	☐	4. When taking phone calls, non-licensed staff has a written list of specific patient complaints and the corresponding physician-approved instructions that may be given to the patient. When one of the complaints is received over the phone but the standard physician instructions do not suffice, staff members have immediate access to licensed personnel to help advise the patient, or they know to direct the patient to report to the hospital.
☐	☐	☐	☐	5. Handoff communication between covering providers follows a specific format, such as SBAR (Situation, Background, Assessment, Recommendation), in order to ensure that a complete report is passed in a logical manner.
☐	☐	☐	☐	6. Labor and Delivery (L&D) Unit staff members are trained to use SBAR or a similar format when giving the provider a report on a patient.
☐	☐	☐	☐	7. L&D staff members use universal language when interpreting fetal heart rate patterns (e.g., NICHD terminology or a color-coded interpretation system).
☐	☐	☐	☐	8. Nutrition counseling and appropriate weight gain guidelines are provided to all pregnant patients.

Lab Tests, Procedures, Referrals to Specialists, and Results

Always/ Yes	Sometimes	Never/ No	N/A	
				PRENATAL TESTING
☐	☐	☐	☐	1. There is a reminder system in place to prompt on-time second trimester laboratory and ultrasound testing for pregnant patients.
☐	☐	☐	☐	2. Patients with borderline or abnormal quadruple/multiple marker screen or ultrasound findings are given the option of referral to genetic counseling.
☐	☐	☐	☐	3. If formal ultrasounds are performed in the office, providers are trained according to the ACR/ACOG/AIUM joint guidelines, or a radiologist reviews all in-house formal ultrasound films.
☐	☐	☐	☐	4. Current CDC guidelines for Group B Streptococcal (GBS) screening of pregnant women are followed carefully, and office protocols are updated with any published changes.
☐	☐	☐	☐	5. There is a care plan in place to prompt regularly scheduled reevaluation of laboratory values for patients diagnosed with or at risk for preeclampsia.
				BREAST AND CERVICAL CANCER SCREENING
☐	☐	☐	☐	6. Patients who are not compliant with recommended mammogram and cervical cancer screening tests are reminded periodically via mailers or phone calls that detail the risks of forgoing the tests.

Scheduling and Follow-Up

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. There is a scheduling triage system, with only licensed personnel or the provider deciding when to see a pregnant or high-risk patient who is requesting an immediate appointment.
☐	☐	☐	☐	2. No patient is scheduled for an elective/nonmedically indicated induction or cesarean delivery prior to a gestational age of 39 weeks.

Medical Records

Always/ Yes	Sometimes	Never/ No	N/A	
				PERSONAL HEALTH INFORMATION
☐	☐	☐	☐	1. A patient history questionnaire is completed and signed by the patient with each new pregnancy.
☐	☐	☐	☐	2. Screening for domestic violence is included in the initial intake questionnaire.
☐	☐	☐	☐	3. There is documentation of pregnancy screening for tobacco, alcohol, and drug use.
☐	☐	☐	☐	4. Screening for a history of depression or postpartum blues is included in the initial pregnancy visit and in the postpartum visits.
				PATIENT EDUCATION
☐	☐	☐	☐	5. Any written materials that are given to the patient are documented in the prenatal record.
☐	☐	☐	☐	6. Discussions regarding prenatal laboratory screening results, ultrasound reports, and any recommended further testing are documented in the prenatal record.
☐	☐	☐	☐	7. Discussions with applicable pregnant patients regarding smoking/ drug/alcohol cessation, VBAC policies, and/or shoulder dystocia risks are conducted and documented at least once each trimester.
☐	☐	☐	☐	8. If a patient wants a formal birth plan, the plan is discussed in the office during the third trimester, and a copy is placed in the prenatal record.
☐	☐	☐	☐	9. Instructions that are given to the patient over the phone are always documented in the medical record, including after-hours instructions (e.g., "patient was directed to go to L&D" or "patient was instructed to lie down and count fetal movements, then call back in one hour").
				CONTINUITY OF CARE
☐	☐	☐	☐	10. A copy of the prenatal record is sent to the L&D Unit when the patient reaches 36 weeks gestation.
☐	☐	☐	☐	11. Copies of the birth plan and all existing informed consents for induction, augmentation, shoulder dystocia, operative vaginal delivery, cesarean section, etc., accompany the patient's prenatal record to L&D.
☐	☐	☐	☐	12. A prenatal record updated with any significant changes is sent to L&D at 39 weeks gestation or when the patient presents to the hospital.

Medical Records

Always/ Yes	Sometimes	Never/ No	N/A	
				MEDICATIONS
☐	☐	☐	☐	13. Over-the-counter medications that are approved by the provider per a pregnant or lactating patient inquiry are documented in the medical record (e.g., "patient called to inquire if it was OK to take Benadryl for allergies, OK per Dr. Smith to take as directed on package").
				DOCUMENTATION
☐	☐	☐	☐	14. A standardized prenatal documentation record, such as the ACOG Antepartum Record, is used for the prenatal record.
☐	☐	☐	☐	15. All areas of the prenatal record, whether electronic or paper, are appropriately completed, with an indication such as "N/A" being used rather than leaving a section blank.
				DELIVERY NOTES
☐	☐	☐	☐	16. All delivery notes contain thorough gross placental exam observations, including unusual umbilical cord length or abnormalities.
☐	☐	☐	☐	17. If operative vaginal delivery is performed, notes include indications, fetal station at application of the instrumentation, duration of application, estimated fetal weight before delivery, pelvic adequacy, problems or pop-offs during use, and patient agreement/consent of use.
☐	☐	☐	☐	18. Notes on a shoulder dystocia delivery include precise documentation of maneuvers used in the order implemented, amount of traction (gentle, moderate, firm), time of delivery of head, and time of completion of delivery.
☐	☐	☐	☐	19. Following any difficult delivery, a note is made with general observations of the neonate, including any marks or bruising, any lack of movement of extremities, and notification to the nursery care team of the observations.
				RETENTION
☐	☐	☐	☐	20. Medical records for obstetrical patients are retained until 10 years after the child reaches the age of majority or 28 years after delivery.

Medication Management

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. The FDA-assigned pregnancy category for a drug is noted in the chart for prescriptions written for pregnant patients (e.g., "Zofran, FDA category B drug, was e-prescribed for Mary Jones").
☐	☐	☐	☐	2. Any risks, benefits, alternatives, and patient informed consent to FDA pregnancy category C through X drug prescriptions are noted in the chart.

Physician/Patient/Staff Relationships

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. When a patient has an infant being cared for in the Neonatal Intensive Care Unit (NICU), you attend NICU rounds with the neonatologist in order to remain updated on the infant's status and to facilitate an open rapport and connection with the parents.

Informed Consent and Refusal

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. An informed refusal discussion and form are implemented for patients who decline second trimester quadruple/multiple marker testing, genetic testing, or routine ultrasound screening exams.
☐	☐	☐	☐	2. Informational discussions are initiated and documented regarding quadruple/multiple marker laboratory testing (example: a normal test does not equal a guarantee of a healthy baby).
☐	☐	☐	☐	3. State-specific waiting periods and notification policies are strictly followed for consent of termination of a pregnancy.
☐	☐	☐	☐	4. During a third trimester prenatal visit, the patient signs a Consent for Delivery form that lists common complications and includes a discussion of operative vaginal delivery, episiotomy, and the possibility of emergency cesarean section.
☐	☐	☐	☐	5. During a third trimester prenatal visit, the patient signs a Consent for Augmentation of Labor form in order to facilitate discussion of the issue, if needed, once the patient is already in labor.
☐	☐	☐	☐	6. If misoprostol (Cytotec) is planned for cervical ripening, an additional consent is obtained for off-label use of the drug.
☐	☐	☐	☐	7. If any risk factors for shoulder dystocia are present (e.g., previous history, suspected macrosomia, maternal obesity, or diabetes), an informed consent discussion and Shoulder Dystocia Consent form are presented to the patient early in the third trimester to discuss the possible dystocia-relieving maneuvers, risks, benefits, and alternative delivery options.
☐	☐	☐	☐	8. If VBAC is a consideration for the patient, a thorough and specific informed consent discussion is conducted and documented at least once each trimester, with a formal consent form signed and placed in the chart.
☐	☐	☐	☐	9. The VBAC Consent form includes the discussion of emergency cesarean section.
☐	☐	☐	☐	10. Patients are made aware of and understand the level of nursery services available at their chosen hospital and the possibility of neonatal transfer, if applicable.
☐	☐	☐	☐	11. Postpartum tubal ligation decisions by the patient are discussed early in the pregnancy and again in the third trimester for consent. Consent for the procedure is confirmed after delivery of the infant.
☐	☐	☐	☐	12. In adoption situations, the patient's wishes are clarified, and copies of appropriate paperwork are sent with the prenatal record to the L&D Unit prior to hospital admission.

Clinical Procedures

Always/ Yes	Sometimes	Never/ No	N/A	
				LABORATORY
☐	☐	☐	☐	1. Quality controls are run on urine dipsticks and nitrazine test paper/ swabs at least once per week.
				FETAL MONITOR TESTING
☐	☐	☐	☐	2. Fetal monitor testing is overseen only by staff members who are certified with fetal monitoring courses every two years and receive ongoing competency evaluation.
☐	☐	☐	☐	3. A patient undergoing fetal monitor testing has the ability to notify staff in attendance with a call bell or other device.
☐	☐	☐	☐	4. Fetal monitor tests in progress are viewed on a central monitoring system, or monitor strips are physically checked every five to seven minutes.
☐	☐	☐	☐	5. Staff members who oversee fetal monitor testing are trained on what to do if an adverse fetal heart rate pattern is detected.

Confidentiality and Privacy

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. The patient's wishes for confidentiality in front of visitors in the delivery room are discussed ahead of time, and, if applicable, a note is included on the prenatal record for L&D staff.

Emergency Procedures

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. An emergency delivery kit is available in the office.
☐	☐	☐	☐	2. Basic infant resuscitation equipment (including an ambu bag and infant and preemie oxygen mask) is available in case of an emergency delivery.

Credentialing and Staffing

Always/ Yes	Sometimes	Never/ No	N/A	
☐	☐	☐	☐	1. Obstetric providers and staff who perform fetal monitoring receive updated training on interpretation of fetal monitor strips every two years.
☐	☐	☐	☐	2. All providers, including midlevel practitioners, are certified in the Neonatal Resuscitation Program (NRP) every two years.
☐	☐	☐	☐	3. Providers or technicians who perform ultrasounds have formal training and up-to-date certification.
☐	☐	☐	☐	4. Standardized procedures for nurse practitioners and/or certified nurse midwives are updated annually.
☐	☐	☐	☐	5. Certified nurse midwives do not attend VBAC or trial of labor after cesarean (TOLAC) patients in L&D; instead, the OB physician cares for them directly.

Building Reliable Systems to Reduce the Impact of Human Factors

Always/ Yes	Sometimes	Never/ No	N/A	
				LABOR AND DELIVERY SYSTEMS
☐	☐	☐	☐	1. To help facilitate communication with labor nurses over controversial tracings, providers have remote access to electronic fetal monitor tracings that are in progress on the L&D Unit.
☐	☐	☐	☐	2. Instead of training separately, providers participate in training with L&D staff to ensure common understanding of fetal monitor terminology, SBAR communication guidelines, OR and unit protocols, and team training.
☐	☐	☐	☐	3. Providers participate in hospital-based emergency simulation exercises with the L&D staff (e.g., emergency cesarean section drills and shoulder dystocia drills).
☐	☐	☐	☐	4. You insist on and fully participate in time-outs and counts for both the delivery room and the operating room.

Miscellaneous Risk and Loss Control Issues

Always/ Yes	Sometimes	Never/ No	N/A	
				PATIENT TERMINATION
☐	☐	☐	☐	1. Termination of third trimester patients is avoided in lieu of direct transfer of care to an accepting provider.