MEDICAL MALPRACTICE STANDARDS OF CARE / DEVIATIONS

HOSPITAL STANDARDS OF CARE	CARE THAT WAS GIVEN	DEVIATION
ASSESSMENT:		
1. Assess fetus in distress via continuous electronic fetal monitoring (EFM). Evaluate FMR tracing noting:	Unable to hear Fetal Heart Tones (FHT's) on initial ER assessment. No fetal monitor was used.	*
a. uterine activity: 1) tachysystole - hyperstimulation (>5 UC's in 10 minutes or closer that q 2 minutes) 2) polysystole - coupling, ineffective labor pattern 3) hypertonia - palpate for uterine relaxation following contraction 4) absence of uterine tone - uterine rupture 5) tetanic contractions > 90 seconds long or > 70 mmHg in strength (IVPC)	Uterine activity not checked or at least not documented.	*
b. Baseline FHR: 1) reassuring stable rate between 110-160 BPM 2) fetal tachycardia > 160 sustained > 10 mins 3) fetal bradycardia < 110	Fetal bradycardia present with FHR 20-50 BPM during entire period prior to delivery (1230 until delivery at 1356).	*
c. FHR variability both long and short term: 1) reassuring short term variability 2) decreased or absent variability 3) exaggerated or salutatory variability 4) true sinusoidal pattern 5) response to fetal scalp stimulation	This was not done as EFM was not applied.	*
d. periodic changes: 1) accelerations 2) early decelerations 3) late decelerations of any magnitude 4) variable decelerations 5) prolonged decelerations	Fetal monitor was not used and no signs of active labor were charted.	*
2. Determine factors related to progression and stage of labor.		
a. strength of uterine contractions and resting tone	Contractions were not checked.	*
b. vaginal exam - dilation, effacement, presentation, position, station	Vaginal exam was not performed or at least not documented.	*
c. dystocia, malpresentation, rapid descent of head, imminent delivery, cord prolapse	Not documented.	*
3. Assess:		
a. Maternal vital signs, noting hypotension, hypertension, elevated temperature	Vital signs charted. Hypotension documented but no treatment was given.	*
b. vaginal discharge: meconium, increased bleeding, SROM.	Membranes intact as per Labor room records.	
c. recent medication which may affect fetus, e.g., narcotics, phenergan, terbutaline, MgSo4,	No medications were given.	

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Standard	Deviation	
butaphanol, lebatalol		
d. last epidural dose, noting vasodilation and hypotension	N/A	
e. maternal position - supine- vena caval syndrome	Pt was supine (lying on back) until transfer to Labor Room at 1320 when she was turned to her left side.	*
4. Review current labor status, OB, and medical history for risk factors.	Nothing documented regarding risk factors.	*
INTERVENTIONS:		
5. Select interventions to treat underlying pathophysiology. NOTE: It is not necessary to proceed with subsequent steps if current intervention corrects a non-reassuring FHR pattern.	No treatment was given for hypotension.	*
6. Change maternal position: laterally, then to all fours or knee chest.	Maternal position was not changed until 1320 when she was placed on her left side.	*
7. Correct maternal hypotension: move patient out of supine position, check blood pressure, increase IV rate, elevate legs if not contraindicated. NOTE: For severe hypotension related to epidural, Anesthesiologist may give ephedrine IV.	When hypotension occurred, IV was not in and patients position was unchanged until time of transfer to Labor Room.	*
8. Discontinue oxytocin if infusing.	N/A	
9. Administer oxygen at 8-10 LPM via non-rebreather face mask.	O2 at 5 liters per nasal cannula first documented at 1320 in Labor Room records. This was ordered in the ER at 1245.	*
10. Perform vaginal exam to assess: a. rapid descent of head/imminent delivery b. prolapse of cord c. accelerations due to scalp stimulation NOTE: Elevate presenting part if creating pressure on cord.	No vaginal exam was ever documented.	*
11. Notify physician of fetal heart rate, variability, and pattern.	ER MD notified of inability to hear FHT's on original ER assessment. OB MD was not informed until 25 minutes after initial finding of low FHT's.	*
12. Maintain patient on bedrest until further orders received.	Pt was on bedrest until after the baby was delivered.	

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Standard	Finding	
13. Maintain continuous electronic fetal monitoring with a legible tracing. If unable to record a continuous tracing, or when variability is in question, apply fetal scalp electrode per policy.	No continuous fetal monitoring was performed. No fetal scalp electrode was ever attempted.	*
14. Do not reactivate epidural until fetal distress is resolved.	N/A	
15. Administer tocolytic as ordered for hypertonus, tachysystole, or tetanic contractions.	N/A	
16. Assist physician with fetal scalp sampling if indicated.	N/A	
17. Initiate amnioinfusion to relieve umbilical cord compression.	N/A	
18. Prepare for delivery/cesarean.	Preparations began in labor room after OB was notified.	
19. Notify NICU that resuscitation may be required at birth.	Pediatricians were present at delivery	
20. Send blood specimen to lab on ice.	Surgical labs drawn.	
21. Ascertain whether placenta should be sent to pathology.	Placenta was sent for pathology.	
22. Reassure patient and support persons.	Documented in Intraoperative record.	
EDUCATION:		
23. Explain possible causes of fetal distress and expected plan of care.	Not documented.	*
DOCUMENTATION:		
24. Document on designated forms:		
a. assessment	Assessment was documented by ER RN.	
b. interventions and response	Interventions were documented by ER RN in progress notes and in Labor room record progress notes.	
c. education and response	Not documented.	

KEY:
N/A - Does not apply
* - Deviation from policy