

Failure of Protocols and Communication Lead to Death of Neonate

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Introduction

High-reliability organizations in all industries rely on standardized processes and protocols and excellent communication to minimize the risk of misunderstanding and its resultant errors. This case from the West Coast illustrates what can happen when healthcare providers fail to adhere to these same principles.

Facts

The patient was a 19-year-old female, para 0, with no significant medical history. She presented to Dr. A's OB/GYN clinic when she was 9 weeks pregnant. Dr. A oversaw the patient's prenatal care, and she had an unremarkable pregnancy for several months.

In week 32 of her pregnancy, the patient presented to the hospital emergency department with complaints of increased pelvic pressure. Dr. A was summoned,

and she examined the patient. Dr. A documented that the patient complained of intermittent lower abdominal pain of 1 day's duration. Dr. A also noted that the external fetal heart monitor demonstrated some repetitive late decelerations, accompanied by irregular contractions. Prior to admitting the patient, Dr. A ordered an IV fluid bolus, which caused the decelerations to resolve. Because of this, Dr. A decided to send the patient home.

Dr. A was going out of town for a long weekend and "handed off" the patient to Dr. B, although they never directly talked about this patient prior to the handoff. During the weekend, a biophysical profile was ordered (apparently by Dr. B), which scored a 4 of 8. Following this biophysical profile, Dr. B instructed the patient to return the following day so that the test could be repeated.

The patient returned as instructed, and the repeat biophysical profile also produced a score of 4 of 8. Dr. A was never notified that these biophysical profiles

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had been done. Following the patient's second biophysical profile, she was again sent home and instructed to come in 2 days later to see Dr. A; however, she actually saw Dr. A 3 days later.

At that visit, Dr. A noted an elevated blood pressure (122/82 mmHg) and proteinuria, and she sent the patient to the labor & delivery (L&D) unit for evaluation. The patient's other labs were normal, and the external fetal heart tracing was also normal. Dr. A decided to keep the patient overnight for observation, and she was sent home the following day.

The day after the patient went home, she re-presented complaining of pressure all along her abdomen, and Dr. A admitted her to the L&D unit. Dr. A did a vaginal exam, which was not reassuring, and she decided to proceed with a nonemergent C-section. Dr. A left the room while the patient's admission was completed. Some time later, she was paged stat to the patient's room because the patient's condition was rapidly deteriorating. The delivery became emergent and was accomplished very shortly thereafter.

APGAR scores were 0 for the first 20 minutes and rose to 4 after 30 minutes of aggressive treatment. The infant was transferred to a NICU with a diagnosis of status post complete abruption, with severe anoxia. She remained in the NICU for

approximately 5 months, at which time she expired.

Following completion of the delivery, Dr. A learned that, after she had left the L&D unit, the fetal heart rate had begun to decline rapidly. Inexplicably, the external fetal heart rate monitor was disconnected after bradycardia was shown on the strips; there is a 28-minute gap in the tracing before Dr. A was summoned and delivery was accomplished.

Suit was commenced against Drs. A and B, the doctors' professional corporations, and the hospital. A settlement was reached on behalf of all parties in the high range, with expenses also in the high range.

Discussion

As stated earlier, high-reliability organizations promote standardized processes and excellent communication to minimize the risk of errors. Within the healthcare context, breakdowns in communication are a leading cause of medical errors and sentinel events, and many of these breakdowns occur during handoffs.¹

In this particular case, there was not a clear clinical knowledge deficit on the part of any of the healthcare providers. Rather, the failures appear to be related to performance and communication deficiencies.

¹. ECRI Institute. (2009, September). Communication. *Healthcare Risk Control*, Supplement A.

The first issue in this case is the handoff that occurred between Drs. A and B when Dr. A was leaving town for a long weekend. A handoff is defined as *any* transfer of patient care between providers. These transfers most commonly occur during shift changes, patient transfers between units or institutions, or as part of coverage for vacation time or other absences. Handoffs have been identified as a time of exceptional risk in the continuum of healthcare delivery.

In this case, there was a clear understanding between the doctors regarding *when* Dr. B would be covering. However, the doctors had no direct conversation regarding this patient's status or patient-related concerns. It is also noteworthy that Dr. A did not order a biophysical profile throughout the patient's pregnancy, but Dr. B felt one was needed the very first day he was providing coverage.

Especially troubling is the fact that Dr. A never even knew that these tests had been performed until after the conclusion of the medical case — i.e., she learned of them during subsequent review of the file in preparation for litigation.

Upon learning of these scores, Dr. A acknowledged that she would have acted on them. (It is not known why Dr. B did not act on the scores.) In any case, if the doctors had “debriefed” regarding this

patient after Dr. A had reassumed care, it seems unlikely that the biophysical profiles would not have come up in their conversation.

The second major breakdown in this case occurred when the patient was on the L&D unit on the day of delivery. Although, generally, there is no indication that communication between Dr. A and the nurses was anything other than adequate, we know that Dr. A was not paged when the bradycardia was first identified. This was followed by the interruption in the external fetal monitor tracing, a catastrophic error and an obvious deviation from protocol.

From an evidentiary standpoint, this interruption was problematic in two ways: (1) if the fetus's heart rate improved — which is questionable, but not impossible — there was no documentation to prove it, and (2) the interruption in the monitor strips may suggest an attempted cover-up. When defending a case, accurate evidence, *even damaging evidence*, is better than obvious gaps, such as those that occurred here.

At the end of the case, Dr. A felt somewhat like a victim of circumstance. She acknowledged that if she had received critical pieces of information as this case progressed, she would have handled it differently, and a tragedy may have been averted.

Summary Suggestions

The following suggestions may help healthcare providers avoid miscommunication during critical stages in patient care delivery:

- When a physician is going to provide coverage for another physician, the doctors should speak directly about any patients whose conditions may change during the coverage period.
- Similarly, when the coverage concludes, the physicians should speak directly about any patients who experienced significant developments during the coverage period.
- When a physician transitions patient care to other providers, all parties should have a clear understanding of the circumstances in which the originating physician should be

contacted. A formal procedure can help establish specific parameters for this communication.

- Any testing or monitoring that has evidentiary value should continue uninterrupted, or an explanation for the interruption must be documented.

Conclusion

In the practice of medicine, the unexpected will occur, and well-designed systems of care delivery attempt to anticipate as many of these untoward events as possible. Once identified, processes should be developed to minimize the possibility of miscommunication and misunderstanding. Minimizing these opportunities for error can help reduce professional liability exposure and enhance patient safety and satisfaction.

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