Failure to communicate (or effectively communicate) fetal status and/or obtain a consult regarding abnormal fetal status or concerns arising during labour is a frequent occurrence in HIROC obstetrical claims. While practitioners are accountable for their decisions to hold-off on notifying or escalating medical management concerns/disagreements with the most responsible practitioner (MRP), long standing negative interdisciplinary and/or leadership dynamics and instability can present barriers to effective team communication during clinical situations. In cases where communication or consultation did take place, lack of documentation makes the case particularly challenging to defend.

**COMMON CLAIM THEMES**

- Significant delays notifying/requesting MRP attendance following patient arrival at obstetrical triage and/or admission to the labour/delivery unit.
- Different definitions/terms to describe fetal status resulting in treatment and communication delays.
- Delay in communicating abnormal fetal heart rate (FHR) patterns identified in obstetrical triage to the labour floor nurse and MRP.
- Delay in communicating (including calling for assistance) due to:
  - Perceived/actual power and control imbalances, hostility, conflicts and trust issues within the interdisciplinary team including long standing negative leadership dynamics and instability;
  - Cumbersome, impractical and non-specific chain of command/escalation protocols;
  - On-call practitioners participation in elective procedures and/or clinic;
  - Misinterpretation of fetal heart rate patterns and/or decreased vigilance over time to atypical and abnormal patterns (e.g. clinically significant changes to baseline and variability, prolonged second stage of labour, oxytocin-induced fetal tachycardia or uterine tachysystole and FHR abnormalities);
  - ‘Wait and see’ approach (i.e. wait until the situation is emergent);
  - Poor patient handover practices (e.g. staff breaks and shift changes).
- Informal communications/consultations later disputed by the consultant/MRP (e.g. nurse to nurse, midwife to physician, nurse to physician).
- Lack of documentation of paging efforts to on-call physician and level of urgency communicated.
- Lack of clarity as to who can call the second on-call physician and/or activate the obstetrical emergency contingency plan when the on-call obstetrician, anaesthesiologist or paediatrician is unavailable or does not attend in a timely manner.

**CASE STUDY 1**

A maternal patient presented to the obstetrical triage unit for monitoring. An abnormal FHR pattern was identified by the triage nurse just before the patient was transferred to the labour floor. Late decelerations and minimal variability were identified by the labour floor nurse shortly after admission to the floor and were communicated to the MRP. An emergency C-section was performed. Long-term neurological sequelae were not ruled out. Expert review was not supportive of the nurses’ management or communication practices, in particular the 90 minute delay notifying the MRP from the onset of loss of variability in the triage unit. The triage nurse recalled advising the labour floor nurse of the abnormal tracing and need to notify the MRP prior to the transfer, a recollection which was disputed by the labour floor nurse.

**CASE STUDY 2**

Nurses encountered periodic atypical and abnormal FHR patterns throughout the patient’s second stage of labour. The FHR findings were constantly communicated; however, the obstetrician dismissed the nurses’ concerns and believed the FHR patterns to be ‘normal’. Worried about the obstetrician’s lack of concern, the charge nurse was notified. The nurses elected not to escalate the matter further (e.g. to the Department lead/chief) despite their reservations about the patient’s medical management. Following a prolonged and abnormal active labour, the infant was diagnosed with moderate brain damage. Review of the case indicated the labour floor lacked a chain of command policy, and nursing leadership for the unit was reluctant to go over and above the attending obstetrician with regard to care.

**Canadian Case Examples**
**REFERENCES**

- HIROC claims files.
- CRICO. (2014). *Clinical guidelines for obstetrical services at CRICO-insured institutions*.
**Failure to Communicate Fetal Status: Maternal/Newborn**

### MITIGATION STRATEGIES

*Note: The Mitigation Strategies are general risk management strategies, not a mandatory checklist. Please refer to the following Risk Reference Sheets: 1) Failure to Interpret/Respond to Abnormal Fetal Status; 2) Failure to Monitor Fetal Status; 3) Mismanagement of Induction/Augmentation Medications.*

### Reliable Communication Processes

- Implement processes to ensure effective communication of fetal status to the MRP/physician consultant, including:
  - Adopting standardized Canadian nomenclature for communicating and documenting fetal status findings (i.e. normal, atypical and abnormal);
  - The need to specify the level of urgency and require the on-call physicians to clearly specify their anticipated response/attendance time;
  - Ensuring the physician/consultant recognizes the discussion as a formal ‘report’ or consult;
  - Communicating abnormal (or worsening) FHR findings once a call for a C-Section has been made (including assessments performed in the OR and/or during preparation of the patient for surgery).

- Ensure timely notification to the MRP:
  - Following patients’ presentation to the obstetrical triage and/or labour/delivery floor;
  - When patients declines some/all fetal assessments during labour (including EFM where indicated by hospital/health region guidelines).

- Adopt a standardized and effective communication process to/between nurses during patient handovers (i.e. following the transfer of care of a midwife’s patient to a physician, obstetrical triage to labour/delivery floor and during breaks and shift changes).

- Adopt a maternal/newborn program-specific:
  - On-call/second on-call contingency plan (i.e. specific action to be taken when the on-call obstetrician, anaesthesiologist or surgical team does not respond/is unable to respond in an appropriate timeframe);
  - Chain of command (‘escalation’ process), including the names, titles and current phone numbers of the obstetrical team members in the line of authority.

- Adopt standardized and evidence based classification for communicating non-elective C-Sections (e.g. category 1 or emergency - immediate threat to life of woman and/or fetus; 2 or urgent – no immediate threat to life of woman and/or fetus; 3 or scheduled – requires early delivery; 4 or elective – at a time to suite the woman and/or maternity team).

- Maintain an environment which supports:
  - Questioning and challenging of care provided;
  - Zero tolerance of bullying and intimidation.

### Training

- Offer interdisciplinary initiatives to enhance team communications, collegiality and to minimize and manage conflict in the workplace (e.g. MOREob).

- Offer leadership and patient safety training/education to maternal/newborn program leaders (e.g. team work, decision making, conflict resolution, just culture, assertive communications, etc.).

### Documentation

- Ensure complete and timely documentation of each attempt to page/call/contact the on-call/second on call/contingency plan physician including the name of the physician, time called, level of urgency communicated and the physician’s anticipated response/attendance time.

### Monitoring and Measurement

- Implement formal strategies to monitor:
  - On-call physicians’ attendance/response times to requests for consults, attendance and births, including their attendance/response times if participating in electives, clinic or off-site when on call;
  - Effectiveness of the on-call/second on call contingency plans (obstetrician, anaesthesiologist and surgical team);
  - Compliance with communication and chain of command protocols (e.g. chart/e-chart audits, analysis of reporting incidents/events, learning from medical-legal matters).