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Reducing Obstetrical Nurse Liability Related to Documentation

Brenda Henriksen

REDUCING OBSTETRICAL NURSE LIABILITY RELATED TO DOCUMENTATION

By

Brenda K. Henriksen RN

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Abstract

The evolution of nursing practice over the last several decades has caused significant changes in the role of the nurse. Nurses have moved from a role of primary bedside caregiver to educated care coordinator. While this has earned nurses greater autonomy it has also brought a higher level of personal responsibility and liability. Documentation represents an area of nursing that has received increased attention as nurses become increasingly involved in litigation. Nursing documentation is proof of care given. It is therefore important that today's nurses, particularly those who work in the high-risk area of obstetrics, are educated in sound legal charting methods.

Identification of the clinical problem as well as recommendations for practice are derived from a review of the literature. Included is an analysis of findings and how they have been used to develop a nursing education program and protocol to improve documentation on an obstetric unit at a local hospital. The question, "What strategies can nurses working in the obstetric setting implement to decrease liability and lower the risk of malpractice claims related to documentation?" stems from the author's own personal interest in the topic as an obstetric nurse who herself has struggled with defining what actually constitutes "legally sound" documentation. The main findings of the literature include the need for specific protocols for documentation standards as well as staff education programs for unit-specific documentation practices. Nurses must be especially mindful of documentation practices related to electronic fetal heart monitoring, oxytocin administration, the chain of command, and the electronic health record.

Keywords: nursing, obstetric documentation, liability, malpractice

Introduction

The role of the nurse has evolved considerably over the past forty years. Nurses have moved from a secondary role as caregiver to an active member of the healthcare team (Weld & Garmon- Bibb, 2009). Today's nurse maintains the role of bedside caregiver but carries the additional demands of care coordinator, case manager, and patient advocate. The autonomy that nurses have worked to gain over the years adds a great deal of responsibility and accountability that nurses must be mindful of. Nurses are regularly confronted with legal issues and are often faced with the question of whether or not documentation is at a standard which provides adequate proof of care given as well as protects the liability of the nurse (Wong, 2009).

Nurses working in the obstetric setting must be especially mindful of these issues as obstetrics represents an area of healthcare in which financial loss related to malpractice is greatest and nurses are increasingly held personally responsible for adverse outcomes and damages. Litigation in obstetrics results in indemnities in the millions, loss of licensure, and the end of careers (Greenwald & Mondor, 2003). In light of the importance of the issue this paper offers an analysis of documentation and obstetric nursing based on review of the literature as well as implications for practicing nurses.

Purpose

The purpose of this independent study project was to educate staff nurses and to develop an evidence-based protocol for legally-sound obstetric documentation at a Midwestern community hospital.

Significance

Nurses today are held to higher standards of education and personal practice. As such, the role of the nurse has expanded to that of health care professional. As part of this role nurses are expected to question, to act, to intervene, and to advocate for patients and families. Additionally, nurses working in obstetrics are responsible for patient care and the interpretation and reporting of electronic fetal monitoring findings, Oxytocin administration, and utilization of the chain of command (Greenwald & Mondor, 2003).

As a transition from years past, increased responsibilities in practice have caused many nurses to be named personally in malpractice suits. Nurses therefore must approach daily documentation fully mindful of the legal implications of each entry in the patient chart (Wong, 2009). The National Association of Legal Nurse Consultants (NALNC, 2006) reports that from 1990-2003, approximately 16,339 malpractice claims were brought against nurses and nurse practitioners. In obstetrics specifically, litigation related to negligence routinely results in indemnity payments well over $1 million (Greenwald & Mondor, 2003). In addition, the statute of limitations for perinatal malpractice claims is ever-widening. In the state of Minnesota this must not exceed eighteen years. However, exceptions are often made in the case of infancy as the disability can be permanent and non-removable (MN Office of the Revisor of Statutes, 2009).

As part of a discussion of obstetric nurse roles and liability, it is important to note that the patient chart, including nurses notes, are legal documents that are admissible in court. In fact, effective documentation can and has commonly been used as a defense against liability when nurses are involved in lawsuits (Wong, 2009). Cases are won or

lost and licenses are preserved or taken based on the evidence present in the patient chart (Greenwald & Mondor, 2003). Nurses are regularly reminded of these facts as they find themselves inundated with offers for malpractice insurance and news stories of legal suits and loss of licensure. Often lacking however, are education programs and tangible documentation guidelines for nurses working in the obstetric setting. In fact, nurses are often set up for failure in this area from the beginning of practice as nursing program curriculums are often inadequate in preparing nurses for documentation in this current legally-driven healthcare environment (Pappas, Clutter & Maggi, 2007).

In light of the importance of legally-sound obstetric charting practices, this paper offers an analysis of documentation and obstetric nursing based on review of the literature as well as implications for practicing nurses. An obstetric legal documentation protocol and hospital-based nursing education program were developed from information in the literature in an effort to educate practicing nurses and strengthen their skills in this area.

Theoretical Framework

The theoretical framework guiding the work of this study is adult learning theory. According to Knowles (as cited in DeYoung, 2009) adult learning theory dictates that adults, unlike children, learn based on motivation that stems from an understanding of the purpose of the information and its practical implications. The theory also maintains that adults are internally motivated, self-directed, and prefer to take control of their own learning process. Adult learners seek to learn from the context of their own life experiences as well as those of others.

Malcolm Knowles, who is considered the pioneer of adult learning theory, identified six key characteristics of adult learners. First, adult learners are *autonomous* and *self-directed.* The adult learner needs to be free to self-direct personal learning and must be actively involved in the learning process (Lieb, 1991). The adult educator therefore must seek learner input in selection of subject matter that satisfies leaner needs and interest. Adult learners should be allowed to assume responsibility for presentations and group leadership. The effective educator with this group of learners acts as facilitator and communicates with students how the class will help them reach their goals.

The second characteristic of adult learners is that they come equipped with *life experiences* and *knowledge.* As such, these learners have an inherent need to connect learning to this base (Lieb, 1991). The adult educator, according to the theory, must work to relate theories and concepts to this experience and knowledge base in order to engage students and enhance learning.

The third characteristic of this group is that they are *goal-oriented.* Lieb (1991) maintains that adult learners usually know what goal(s) they want to attain prior to any education interaction. These learners therefore appreciate and benefit from education that is organized and makes clear to them how the education will help them reach personal goals. This is best done early in the educator-learner interaction.

The fourth characteristic emphasizes the *relevancy-oriented* nature of the adult learner. Adult learners must see a reason for learning and the information must be applicable to their own work and responsibilities (Lieb, 1991). Theories and concepts must be related to settings and situations that are familiar to participants. These learners do well in choosing projects and activities that reflect their own interests. Related to this

concept is the fifth characteristic which maintains that the adult educator must consider that adult learners are *practical* and are likely more interested in knowledge that is useful for their own work. The adult educator must communicate exactly how the information will be beneficial to learners for their own career (Lieb, 1991).

The sixth and perhaps most crucial characteristic of adult learners is that they need to be shown *respect*. Adult learners desire to be treated as equals in any education experience and to feel that their input and knowledge are valued by the educator (Lieb, 1991). The learner who feels they are not free to express their opinions or offer perspectives from personal experience will be less open to the acquisition of new knowledge.

In light of the unique needs of the adult learner, the role of the educator who approaches the teaching/learning process from the context of adult learning theory is to facilitate rather than impose concepts on learners. Adult learners learn best when allowed input in the development of learning activities, opportunities for self-assessment, and are encouraged to actively participate in learning activities (DeYoung, 2009). This is not to say that all adult learners are completely self-directed and motivated. In fact, there are those that simply desire be led. The responsibility of the educator in these situations is to evaluate the student to determine motivation and develop learning strategies that will work best. For example, some adult learners are motivated by the prospect of career and/or salary advancement or fear of punishment by an employer. Other learners are motivated by a quest for knowledge and a genuine interest in self-betterment. Whatever the case, the educator must teach in context of the situation and the learner.

In the case of the proposed project, adult learning theory suited its purpose. The project involved the education of professional nurses in a group setting where the premise was to learn and gain information that would result in better patient care and career protection. The proposed education was required as part of a staff meeting and was presented from a nursing perspective. This career-relevant approach relates directly to adult motivation and resulted in an effective teaching/learning interaction.

Definitions

After consideration of the topic and an extensive literature review, the author of this paper has created nurse-centered definitions related to legally-sound documentation.

The term *liability* is a traditional legal term with many textbook definitions. For the purpose of this paper and project, *liability* is described as the responsibility of the nurse to provide care that is competent, safe, respectful, patient-centered, and in alignment with unit, institution, nursing, and medical standards of care. In addition, liability is encompassed by proper documentation in that thorough, legally-sound documentation is the proof of care given and can either reduce or increase liability depending on its accuracy and completeness.

Another key term related to nursing documentation is *malpractice*, which can be defined as actions taken (or not taken) by the nurse that lead to physical or emotional damage such that the patient is entitled to compensation. It is important for the nurse to remember that documentation is the link between liability and malpractice in that proper documentation is the only legally admissible evidence of care given and actions taken.

Process

The process of developing the education presentation and protocol that have resulted from this project began with a list of key points and ideas. This helped to provide focus to the literature review process. Expert consultants in the development of the final education presentation and protocol included the nurse manager and clinical coordinator of an obstetric unit at a local hospital as well as an obstetrician who practices at the hospital. Dr. Julie Anderson, the author's academic advisor, also contributed to the process. The development of the presentation, pre and post-test, and protocol were based upon the top high-risk areas of obstetric documentation found in the reviewed body of literature. These include: fetal heart monitoring, oxytocin administration, the chain of command, and the electronic health record.

The original question that began the literature review, "What strategies can nurses working in the perinatal setting implement to decrease liability and lower the risk of malpractice claims specifically related to nursing documentation?" led to the search of several databases in an effort to obtain literature as well as determine how to appropriately focus the subject of the search. The search began with CINAHL and PubMed. During the course of the literature search it was found that the keywords used made a great difference in results found. First, it was discovered that using the word "nursing" led to mainly breastfeeding articles with nearly 400,000 results. The search was therefore refined to use the word "nurse" or by combining words such as "nursing" and "practice". Using the word "malpractice" led to over 6,000 references. Again, this needed to be combined with words such as "nursing" and "perinatal" to narrow results. The advanced search options in CINAHL were found to be very useful in narrowing

search results to peer-reviewed articles. It was noted however, that selecting too many items in the advanced search options made the search so narrow that often no results were found. Terms such as "documentation" and "education" also led to useful results.

During the course of the initial search to answer the proposed question, the need to change or rather, narrow the focus of the search was identified. In the original question the author asked about nursing documentation's impact on perinatal nursing malpractice claims. What was found in this initial literature review was that perinatal nursing encompasses a variety of topics including prenatal care, postpartum care, oxytocin administration, caesarean section, and epidural usage to name a few. The idea of covering all of these topics in a single paper did not seem to leave enough time to thoroughly discuss all aspects of perinatal care related to documentation and malpractice. Because of this, the decision was made to focus the review of the literature on the obstetric setting, specifically, labor and delivery. This includes procedures specific to care during this time and the role of documentation as evidence of care given. This provided a more clearly defined literature base to use in moving forward with the project

In regards to the "deliverable" portion of this project, the information yielded from the search described above was used in the development of an evidence-based education program for staff nurses with the goal of improving nursing documentation from a legal perspective. The main tool used in the proposed program was a PowerPoint presentation providing information gleaned from the literature review as well as case studies and examples from the unit where the nurses work. Collins (2008) supports this approach in maintaining that nurses learn best when education directly applies to their specific work setting.

Review of the Literature

In order to address the question, "What strategies can nurses working in the obstetric setting implement to decrease liability and lower the risk of malpractice claims related to documentation?", the author conducted a review of the literature. From this review four high-risk categories for nurse malpractice claims related to documentation were identified. These categories include: electronic fetal heart monitoring, oxytocin administration, the chain of command, and the electronic health record. What follows is a review and analysis of the literature in these categories as well as suggestions for improving documentation from a legal perspective for each.

Electronic Fetal Heart Monitoring

Electronic fetal heart monitoring was first introduced in 1958 at Yale University and its use became widespread by 1990 (Sweha, Hacker, & Nuovo, 1999). This created the need for research and consideration of nursing's role with this new technology. In 1998 McRae performed a review and meta-analysis of existing data related to the legal implications of fetal heart monitoring. The author found that the use of electronic fetal monitoring caused an increase in nurse liability which made it imperative that nurses have extensive knowledge of the physiology and pathophysiology of labor. McRae (1998) maintained that this advanced knowledge was necessary to effectively document clinical assessment related to the technology.

As electronic fetal heart monitoring become the standard in obstetric care, key administrative groups in nursing began to publish specific guidelines for nursing documentation. The Association of Women's Health Obstetric and Neonatal Nurses (AWHONN) is one such organization. AWHONN was established in 1969 as part of the

American College of Obstetrics and Gynecologists and became an independent organization in 1993. Since its creation, AWHONN has been committed to research, education, and enhancing practice standards for nurses specializing in women's health, obstetric, and neonatal care (AWHONN, 2011). AWHONN impacts a variety of areas of health and nursing encompassed within its key initiatives. These include the Late Preterm Infant Initiative, online education, fetal heart monitoring program, publications in its own award-winning journals, advisory panels for advancement in nursing informatics, and a variety of public health and media campaigns. As such, AWHONN is a respected force in the field of nursing and its recommendations have been widely incorporated into practice.

In 2008 AWHONN published a set of guidelines to be used for fetal heart monitoring that were designed to promote patient safety and to standardize practice. Within the guidelines were several recommendations for documentation. These include documentation of a thorough admission assessment of woman and fetus, ongoing assessments during labor, evidence of interventions provided and evaluation of responses, communication with women and their families, communication with providers, and communication within the chain of authority. Also recommended is the use of standardized terminology for fetal heart tone charting and institutional policies for documentation that are agreed upon and followed closely by all staff. This will help to ensure uniformity of charting practices as well as long-term compliance with legal documentation recommendations (AWHONN, 2008).

Related to the AWHONN recommendations is a literature review by Murray and Huelsmann (2007) who looked at several cases involving malpractice claims against

nurses. The authors found that one of the main issues related to malpractice is incomplete fetal heart tone documentation related to oxytocin administration. Oxytocin is a medication used to induce uterine contractions. Each contraction causes temporarily reduced blood flow and oxygen delivery to the fetus. When contractions are induced by medication, this lack of oxygenation is controlled by the provider who is administering the oxytocin, typically a nurse. Legal issues are encountered when non-reassuring heart tones are seen and actions are taken but not documented in the patient chart. As part of their recommendations, the authors maintain that every intervention done to improve non-reassuring fetal heart tones be documented in the patient chart. Lack of documentation of interventions leaves no record of proper care given by the nurse, a direct source of liability. Also, it is critical to note communication with providers regarding fetal monitoring in the patient chart. Open communication and collaboration with all members of the healthcare team are essential to providing quality care and optimizing patient outcomes (AWHONN, 2008).

The documentation guidelines offered by AWHONN and Murray and Huelsmann can be considered reputable sources of information that can be incorporated into evidence-based practice. This is due to the fact that Murray and Huelsmann is a peer-reviewed reference with an extensive peer-reviewed reference list and is supported by the AWHONN guidelines which come from a respected organization with a foundation in research and practice advancement. Also, strength lies in the fact that Murray and Huelsmann (2007) point out their own limitations, thus giving the reader an indication where further study may be needed before utilizing recommendations as all literature must be looked at with a critical eye prior to incorporation into practice.

Oxytocin Administration

The administration of oxytocin for the induction of and management of labor has brought many legal challenges related to obstetric documentation. In a meta-analysis by Rice-Simpson and Knox (2003), research from many sources, notably AWHONN and ACOG (American College of Obstetrics and Gynecologists) was reviewed and recommendations for documentation were made. Of note is the emphasis placed on complete documentation related to oxytocin administration to include physician order, titration, and maternal and fetal response. The authors point out that common practice faults that may lead to litigation include a failure to accurately assess maternal-fetal status during induction and excessive doses of oxytocin resulting in hyperstimulation of the uterus. In order to avoid malpractice claims related to oxytocin the authors recommend thorough documentation of dosing levels, fetal heart tones at unit-specific intervals, assessment of maternal and fetal response to the medication with each titration, and communication with providers so that ordered dosages are given and titration is made with provider knowledge and consent. The only proof that proper monitoring and interventions have been carried out is the patient chart, a legal document.

Greenwald and Mondor (2003) supported these ideas in their extensive review of the literature and meta-analysis that emphasized the fact that the patient chart represents a minute-by-minute recording of patient status as well as nursing actions. It is a professional document for the purpose of recording factual, pertinent information. Charting that oxytocin or any other medication has been administered "per protocol" is an assumption and does not absolve the nurse from legal responsibility. Rather, exact details of care performed and decisions made must be documented in the patient chart,

particularly as they relate to oxytocin administration. In addition, if a nurse does not agree with a physician order for oxytocin administration that could compromise patient safety the nurse must act appropriately and document the reasoning for not carrying out the order. This reasoning must be evidenced-based and recorded in the patient chart. This is a part of nursing autonomy and the responsibility to think and to act as a professional. The authors went on to state that no single induction of labor follows the exact same pattern and that oxytocin may need to be administered on a case-by-case basis rather than by rigid protocols. The evidence in these resources further emphasizes the care that nurses must take in documentation during oxytocin administration.

While much of the literature related to the topic of oxytocin documentation exists in the form of reviews rather than actual studies, the extensive body of literature utilized in both the Rice-Simpson and Knox (2003) and Greenwald and Mondor (2003) reviews enhances their credibility. This information was used in the formation of the practice recommendations that follow later in this paper.

Chain of Command

Today's obstetrical nurse is more highly educated with a greater level of autonomy than in decades past (Weld & Garmon-Bibb, 2009). Nurses are considered professionals who are an active part of the healthcare team. The input of nurses in care planning and decision-making is taken seriously. As a result, nurses working in higher acuity areas such as obstetrics are expected to be contributing members who are comfortable communicating within the medical chain of command (Greenwald & Mondor, 2003). Evidence of communication within this hierarchy is found through proper documentation in the patient chart.

In a review of the literature Murray and Huelsmann (2007) discussed a 2004 Joint Commission on Accreditation of Healthcare Organizations (JCAHO) report that lists root causes of perinatal death and injury. The authors' summary of this report of widely-gathered data from a reputable source merits its consideration in discussing obstetrical documentation as it relates to the chain of command. Among the eight root causes of perinatal death and injury discussed in the report, communication among caregivers and organizational culture are emphasized as the most responsible for eventually leading to these adverse outcomes. The report goes on to describe documentation strategies to be taken by the obstetric nurse to prevent and work through communication issues. These strategies include being familiar with the unit-specific chain of command and knowing how to properly document movement up the chain as concern for maternal and fetal welfare may arise. This "movement" up the chain must be carefully documented as timelines of team communication are often carefully scrutinized in the litigation process (Murray & Huelsmann, 2007).

Rice-Simpson and Knox (2003) made similar points following meta-analysis of an extensive list of references. One of the key recommendations made by the authors is the use of professional charting and communication practices in obstetric nursing practice. The authors maintain that if these two things are done well, liability and malpractice claims in obstetrics can be reduced or even avoided.

Buppert (2009), upon completion of an obstetric case review stated that nurses need to document provider communication with patients so that proof of an informed decision is present. This relates to the chain of command in that documentation in the patient chart must clearly communicate which patient care actions represent autonomous

nursing interventions and what actions represent provider orders. This documentation provides a tangible record of nursing care and communication within this hierarchy. While this article may be considered to be of lower quality due to the limited number of cases reviewed, its recommendations are in agreement with other reputable resources such as Rice-Simpson and Knox (2003) and Murray and Huelsmann (2007).

Electronic Health Record

The electronic health record, also known as the electronic medical record, represents the face of modern healthcare. It is fast, organized, and helps to standardize medical charting. It allows for easier chart audits and built-in decision support systems help to reduce error and serve to guide clinical practice (Haberman, Rotas, Perlman, & Feldman, 2007). However, compliance in computerized charting varies a great deal in the obstetric setting as Haberman, Rotas, Perlman, and Feldman (2007) found in a quantitative study. The authors performed statistical analysis on documentation in 2,809 (a large sample for such a study) consecutive deliveries and found that when the computerized decision support prompting system was disabled, caregivers were less compliant with documentation and documentation was not as thorough or legally-sound. The authors used these results to emphasize the need for nursing education as to legal documentation practices as well as training in electronic documentation so as to enhance comfort in its use. While the fact that this study was only performed on one unit at one particular hospital may be considered a threat to external validity, it does bring forth some interesting points to be considered when looking at the charting practices on the obstetric unit including the importance of tailoring documentation programs to the specific needs of nurses.

Related to the above information is a qualitative study performed in Norway in which authors tested the KPO model (English translation: quality assurance, problem solving, and caring) for incorporating nursing care into electronic documentation. The model seeks to incorporate nursing documentation needs into the larger health record rather than having this as a separate module (Von Krogh & Naden, 2008). The major goal of the model is to ease nursing comfort with electronic documentation so as to promote more thorough charting practices. Upon analysis the authors concluded that by incorporating nursing-friendly modules and standardized terminology into the electronic health record accuracy in charting increased while liability claims decreased. The study gains validity in that the model was tested over a one year period in several facilities utilizing a large body of data. AWHONN (2008) supports this concept in stating that as a standard, nursing documentation in obstetrics needs to be streamlined, factual, and done at frequent intervals. Electronic documentation initiatives such as that of Van Krogh and Naden (2008) that are efficient and built with nursing needs in mind help to achieve this standard on a daily basis.

From these examples it becomes clear that nurses need to take an active role in the selection and improvement of electronic documentation systems. Greater obstetric nursing involvement in this process could help ensure that electronic documentation programs are nurse-friendly with terminology and categories pertinent to obstetric care incorporated throughout. This would serve to promote compliance with established standards as well as completeness of charting, both key legal standards in documentation and the protection of personal nursing licensure.

Documentation, the Obstetrical Nurse, and Areas for Improvement

In light of the four high-risk areas (fetal heart monitoring, oxytocin administration, chain of command, and the electronic health record) identified in the review of the literature, documentation becomes a high priority in protecting the obstetric nurse against malpractice. Brous (2009) discussed this connection between documentation and litigation stating that the medical record is typically the only tangible evidence used in malpractice cases and that complete, accurate documentation by nursing staff is imperative as it provides evidence of care given and protects the nurse in legal defense. While Brous's article is more of an editorial opinion rather than actual research or literature review, her points are supported by and likely flow from previous works. An example of such a work is a published graduate nursing paper by Cheevakasemsook, Chapman, Francis, and Davies (2006). The paper represented a study that looked at the complexities of nursing documentation and causes of inadequate documentation practices. Qualitative and quantitative data were collected utilizing a variety of techniques including literature review, interviews, observations, and studies of nursing activities to identify three aspects of complexity in nursing documentation: 1) disruption of charting, 2) incompleteness of charting, and 3) inappropriate charting. Disruption of charting relates to the lack of nurse-specific charting due to the fact that there were no nursing diagnoses, care plans, or nursing interventions build into the documentation system. Incompleteness of charting reflects a lack of sufficient information in the patient chart regarding nursing care for patient conditions. Inappropriate charting was defined by the authors as redundancy of documentation in that with no defined nursing area of the documentation system, nursing intervention documentation is often repeated in various

parts of the patient chart. The authors go on to state that these three aspects are related to limited nurses' competence, lack of motivation and confidence, ineffective nursing procedures, and inadequate nursing chart audits. The authors maintain that the complexities result in nursing documentation that is often incomplete. They also found there to be a lack of standardization in charting practices as well as conflict between learned nursing theory and the complexities of actual practice. Strategies for improvement in these areas identified by the authors include effective nursing management, development of new nursing documentation systems, advanced nurse education and training, redesigning of nursing workloads, improved organizing of nursing supervision hierarchies, and regular chart audits.

Collins (2008), in a review of the literature looked at legal issues unique to obstetric nursing care and offered additional suggestions for improvement. A key recommendation involves group training in nursing documentation and communication among various health disciplines (MD, support staff, etc.). This strategy, the author maintains, will help reduce errors that may lead to malpractice claims. Collins (2008) states that group classes serve to unite disciplines and get everyone "on the same page". Professional peers also help hold one another accountable so as not to tolerate a passive attitude that may lead to further problems. This article however loses some degree of validity in that the author adapts training strategies from the aviation industry for use with nurses but has not actually tested the proposed interventions with nurses. While the author's recommendations gain credibility in utilizing strategies from an industry with a long history of standard-setting in regards to training, they do not take into consideration the theories that form or the art that encompasses professional nursing practice.

In a concept-analysis using an established methodology, Walker and Avant's eight-step method for examination of the attributes and characteristics of concepts, Weld and Garmon-Bibb (2009) looked at the practice implications resulting from nursing interpretation of what constitutes malpractice. The authors found that there are many interpretations of the term "malpractice" and that nurses in particular need education as to the meanings and implications of the concept as they relate to documentation in nursing practice. This specific education could be incorporated into group education programs such as those suggested by Collins (2008) as group learning is not only effective, but efficient for the large number that make up the nursing workforce.

Frank-Stromborg, Christensen, and Elmhurst (2001) in a two-part article performed an extensive literature review and meta-analysis and found that in addition to standardizing electronic charting resources, the study of case law is beneficial to practicing obstetric nurses. This includes real examples of how documentation has either supported or refuted nursing defense in litigation. The authors maintain that such study is crucial for responsible, legally-minded nursing practice.

These points are especially important in light of findings of a quantitative study by Coco, Cohen, Horst, and Gambler (2009) which found that as the ratio of high acuity patients increases, nurses, particularly labor and delivery nurses are subjected to more high-liability situations. This qualitative study gains credibility with it large sample size and amount of data collected over a period of seven years. The higher acuity of the labor patient is reflected in the AWHONN (2008) recommendations that nursing care of patients in active labor be at a 1:1 ratio.

Another interesting article regarding patient safety and improvement of nursing delivery of care in the obstetric setting is a summary of a round-table discussion of six nurse executives from around the country. While not a study and likely considered low in terms of validity, ideas for further research and practice interventions can be generalized from the conclusions of these healthcare leaders. One strategy for improvement in care that stands out in the summary by Thorman, Capitulo, Dubow, Hanold, Noonan, and Wehmeyer, (2006) is education for all members of the healthcare team. Specifically, this education would address practitioner liability and help to promote a shared understanding in regards to standardized documentation and communication within the healthcare team. Another strategy offered is the development of a team on the obstetric unit whose role would be to facilitate regular case reviews to allow nurses to learn from past patient cases exactly how documentation played a key role in patient care and determination of nurse liability.

Discussion

Outcome and Dissemination

After a review of the literature related to obstetric nursing and the legal implications of documentation, project plans were made. The goal in project development was to apply knowledge gained in the review of the literature to improve documentation practices and reduce nurse liability on an obstetric unit at a local hospital.

Target audience.

The target audience for the project was a group of staff obstetric nurses. By presenting to nurses as a group, delivery of education is efficient and effective. Studies

have shown that providing education to a group of peers fosters learning and leads to improved retention and incorporation of education into practice (Collins, 2008).

The project.

The project consisted of two components, the first a program to educate obstetric nurses on areas where obstetric nurses are prone to legal liability, the second to introduce an obstetric legal documentation protocol to be utilized on the nursing unit. Nurses were taught strategies to improve documentation in an effort to gain understanding as to what constitutes legally-sound charting. The program, a PowerPoint presentation given to hospital obstetric nurses was based on a tested legal documentation education program designed for undergraduate nursing students. The authors of the program, Pappas, Clutter, and Maggi (2007), discuss nursing legal documentation strategies throughout an entire academic year in the form of seven modules, each with a specific topic. The authors found that by breaking down these legal concepts into specific topics the information was more easily retained and less intimidating to novice nurses. Students also reported that learning as a cohort made them feel supported and confident in their own abilities in carrying forth program concepts into practice. As part of this project a more extensive program with specific modules will be developed for future use pending management approval.

Another key component of the project was in the form of a knowledge assessment prior to the education program to identify basic knowledge level as well as education needs related to legal documentation concepts. Upon completion of the education program the same test was administered to determine retention of information, impact of education on charting practices, and areas where further education is needed. Pre and

post-testing were used because they provide measurable means of determining knowledge level both prior to and following education efforts and can be administered at various intervals to determine retention (DeYoung, 2009). These can be found in Appendix B.

Overall, nurses were very receptive to the education program. Many expressed gratitude in the non-judgmental, relaxed nature of the program as well as interest in the information as a means to improve their own practice. Pre-test responses were correct in nearly 75% of responses, with the most difficulty related to question number three regarding documentation that remains neutral despite disagreement among healthcare team members. Post-test responses were nearly 100% correct. Responses on the instructor evaluation form located in Appendix C were all positive, with most recommendations consisting of requests for further education including case reviews on legal documentation issues for obstetric nurses.

Limitations.

While the premise of the project as well as proposed content was supported by the literature, there are certain limitations that are important to consider. One key limitation is the fact that for the initial project, only one particular obstetric unit was assessed and therefore results are less generalizable to other institutions. However, every initiative to improve practice must start somewhere and hopefully the success of the project will allow its expansion to other units within the particular hospital as well as to surrounding facilities.

Interpretation

Development of the protocol, presentation, and evaluation tests was done based on review of the literature and a consideration of the topic from the adult learning theoretical framework. As a professional nurse, the author has seen the dichotomy that exists between nursing education and actual practice. Nurses are taught the ideals of patient care and care plan development but find often themselves thrust into practice ill-equipped to perform under the weight of a legally-charged healthcare system in which written words carry the burden of proof of care given and decisions made.

The question, "What strategies can nurses working in the obstetric setting implement to decrease liability and lower the risk of malpractice claims related to documentation?" was initially addressed through a review of the literature. After completing this review the author of this paper identified four main high-risk categories of obstetric documentation most often involved in litigation. These include: electronic fetal heart monitoring, oxytocin administration, the chain of command, and the electronic health record. Documentation issues in each of these categories were defined and literature contained in the review was used to determine specific strategies to improve obstetric nursing documentation for each. These evidence-based strategies were then translated by the author into a staff education PowerPoint and testing program for an obstetric unit at a local hospital. A key driving force in the development of this program was an identified gap in the literature regarding applied legal documentation education for practicing nurses. Adult learning theory led the author to approach the evidence from the literature in program development from the standpoint of finding practical, applied nursing interventions for the learning need.

Part of the education program was the development and introduction of an obstetric legal documentation protocol that is to be drafted into unit policy in the near future. Testing methods were employed to evaluate nurse learning as well as identify where improvements in documentation instruction can be made. These initiatives have led to statements by nurses on the obstetric unit regarding increased knowledge of legal documentation practices as well as confidence in the ability to apply these concepts into practice. Future case reviews and chart audits will provide further data for expansion of this project as the evolution of technology and practice dictate.

The interpretation of this project has significant impact for nurse educators. For educators in academia, the responsibilities of nurses in today's workforce necessitate a strong foundation in legal documentation prior to graduation. Navigating the world of nursing as a novice holds new experiences and challenges that easily overwhelm these new nurses. The added factor of developing legally-sound documentation skills can make transition into practice even more stressful. These skills represent another aspect of nursing performance that educators can address to prepare nurses to enter practice confident in their abilities both in documentation and protection of the license they work so hard to attain.

The hospital-based educator carries the task of reinforcing undergraduate nursing education and developing ongoing education that is unit-specific and applicable to nursing practice. Developing staff education programs and protocols such as those discussed in this paper provide specific guidelines for nurses in practice to utilize to build upon their own documentation skills. Periodic updates to protocols and regular education

initiatives will help keep practicing nurses up-to-date on trends and guidelines. This is crucial as healthcare is in a constant state of growth and change.

For the author, the work of this project directly reflects the author's practice. Upon completion of a master's degree in nursing education the author plans to utilize this degree to further improve nursing practice standards through education in her current hospital employment. Additionally, the author plans to begin the transition into academia with a teaching position at a local university. The literature review and project development have taught the author the process of identifying an education need, determining what evidence exists regarding the need, and developing education initiatives with evaluation to address the need. This will allow the author to utilize her advanced degree to expand her own knowledge and contribute to the nursing profession both in education and practice.

Implications for Nursing

After review of existing literature on the topic of obstetric nursing malpractice related to documentation several implications for nursing in the areas of practice, research, education, and policy have been identified.

Practice

In regards to nursing practice, it becomes clear from discussion that nurses today are held to high personal and professional standards. The level of responsibility that accompanies this role necessitates the education of nurses as to legal issues related to documentation and litigation. Today, nurses are responsible for providing care that is evidence-based and in line with practice and institutional standards. Documentation is

the proof that such care has been given. In light of these facts practicing nurses must keep current on practice standards, particularly as they relate to legally-sound documentation in high-risk areas of nursing such as obstetrics.

A key practice recommendation mentioned by Thorman, Capitulo, Dubow, Hanold, Noonan, and Wehmeyer, (2006) is the employment of a full-time nurse-educator on the obstetric nursing unit who is responsible for the creation of practice protocols and staff education programs. This educator role would include regular literature reviews in an effort to update unit protocols and provide continuing nursing education as updates in practice and new concepts arise. Additional roles involve regular unit case reviews and chart audits to ensure that protocol standards such as documentation intervals are being adhered to by staff. Continuing staff education represents a practical method of keeping nurses up-to-date on current practices and in the process helps to reduce nurse and in effect, institution liability. The unit-based nurse educator could also set up an orientation to the obstetric legal documentation process for new employees and graduates to help ensure that nurses have the right "tools" for legally-sound documentation from the beginning of practice on the unit.

Education

With the wide range of the legal and practice implications related to documentation, it is prudent that nurses have knowledge of proper documentation practices prior to entrance into the nursing field. This education begins in the undergraduate nursing program and should continue throughout one's nursing career. The undergraduate education program described by Pappas, Clutter, and Maggi (2007) is designed to provide nursing students with education regarding legal issues faced by

nurses in today's healthcare environment as well as how to chart responsibility so that those issues do not result in malpractice claims.

As an implication for nursing education it appears beneficial, according to the literature, for all undergraduate nursing programs to implement a legal documentation program as part of their curriculum. The large number of institution and state standards that nursing programs are responsible for meeting make it difficult to find the time to add legal content. However, from the review of the literature and project findings it becomes clear that nursing programs need to work to build legal documentation into the curriculum as an integral part of each nursing course. Creation of a separate course on the topic may not be practical for time and credit constraints and students may be overwhelmed with the information were it presented only during one intensive course. Students therefore would likely benefit from incorporation of the concepts throughout the entire curriculum so that concepts can be applied to and practiced with relation of material to specific nursing education material. This practice-applied approach satisfies the basic tenants of adult learning theory and will likely result in successful learning outcomes.

The education of new nurses in the practices of legally-sound documentation benefits students, healthcare institutions, and the profession as a whole. Nurses trained in this area are more marketable for employment, are less likely to engage in unsafe legal charting practices, and therefore less likely to be named in malpractice claims. Should a nurse be called into the courtroom, a foundation of strong, legally-sound documentation will serve as proof of care given as well as protection of the nurse. In today's healthcare

environment where acuity, stress, and responsibility are high it is crucial that nurses have a working understanding of these concepts prior to and throughout professional practice.

Research

Despite the large amount of information found relating to this topic, additional research needs have been identified. It seems agreed-upon within the nursing and legal fields that nurses need to engage in peer-based continuing education to ensure the use of standardized terminology and charting standards that are within the boundaries of legally-sound documentation. A review of the literature however did not yield any specific program for nursing-led peer education to educate nurses on unit-specific legal documentation practices. Also lacking is a significant database of results of staff education programs in for form of testing or chart audits to offer proof of program success. It would also be of benefit to compare various types of staff education teaching strategies such as PowerPoint, case studies, group work, gaming, etc. to help staff educators determine what strategies would work best with their own nursing populations. In a time where funding for programs is often not allocated without research showing documented benefits, it may be difficult to implement these programs until further work is done to advance this area of research.

Health Policy

In addition to an understanding of legal issues in nursing care, as practicing professionals today's nurses are also encouraged to be actively involved in health policy and reform. One particular area or health policy that directly affects nurses is the introduction and widespread use of electronic documentation as a tool not only for charting but for audits and financial management. The advanced applications of these

systems make it ever more prudent that nurses take the practice of legally-sound documentation seriously. The American Nurses Association (2010), in a document addressing nursing documentation practices calls for the advocacy of nurses for electronic documentation that is easily accessible and is designed to reflect the needs of practicing nurses so those concerns do not get lost in bureaucracy. By advocating for nursing-centered electronic documentation systems nurses benefit from the implementation of systems that address nursing documentation needs to promote completeness and leally-sound documentation practices.

It may also be of benefit for nurses to lobby to gain additional legal protection in the form of malpractice insurance that is employer-funded. While this is a step aside from the issue of improving obstetrical nurse legal documentation skills, a review of the literature has shown that malpractice claims and litigation are real threats to nurses and it is to their own advantage to be as prepared as possible should the occasion arise.

Conclusion

After consideration of the topic of nurse liability related to documentation in the obstetric setting including an extensive literature review and development of a staff education presentation and protocol, certain conclusions have been made. First and foremost, it has become clear that sound legal documentation is an essential component of obstetrical nursing practice. While much of the information that exists on this topic is in the form of literature reviews and meta-analyses, certain themes have been found. These include the identification of high-risk legal areas of obstetric documentation, the need for staff education regarding legally-sound documentation strategies for these areas,

and the effectiveness of practice-based adult education. Since the idea of legally-sound documentation does not carry one single all-encompassing definition, it becomes necessary that introduction of documentation strategies and protocols be done via an interactive educational endeavor.

As discussed in this paper, today's nurse carries the responsibilities of care coordinator, patient advocate, and professional expert in addition to primary bedside caregiver. The increased autonomy and liability that come with such responsibilities make it essential that all nurses, particularly those practicing in the high-acuity obstetric setting take the initiative in continuing education. Nurses need to have a working understanding of current legal issues, nursing malpractice, and how documentation plays a critical role in each. By developing and implementing a unit-specific education program to increase awareness of legal issues and improve skills related to documentation a dual purpose of both safeguarding nurses and optimizing patient care outcomes was achieved.

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