IN THE COURT OF COMMON PLEAS OF RICHLAND COUNTY, OHIO

LISA YATES, Administrator for the Estate of Dylon John King, Deceased, : Plaintiff, : versus : Case No. 01-389-D : MEDCENTRAL HEALTH SYSTEMS, et al, : Defendants.

DEPOSITION OF SUSAN MORGAN,

a witness for the Defendants herein, called by the Plaintiff for cross-examination pursuant to the Rules of Civil Procedure, taken before me, Catherine Lee Boyer, a Registered Merit Reporter, Registered Professional Reporter, and Notary Public in and for the State of Ohio, at the offices of O'Donnell, Boyer & McGhee located at 44 Park Avenue West, Mansfield, Ohio, on Friday, March 8, 2002, beginning at 9:30 a.m.

APPEARANCES

For the Plaintiff: Ms. Donna Taylor-Kolis
FRIEDMAN, DOMIANO & SMITH CO., LPA
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1370 Ontario Street
Cleveland, OH 44113-1704

For MedCentral: Mr. Gregory D. Rankin
LANE, ALTON & HORST, LLC
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For Women's Care: Mr. Lawrence S. Huffman
GOODING, HUFFMAN, KELLEY & BECKER
137 North Pierce Street
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INDEX OF PLAINTIFF'S DEPOSITION EXHIBITS

SUSAN MORGAN,
having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS-EXAMINATION

BY MS. TAYLOR-KOLIS:

Q. Mrs. Morgan . . . It is Mrs. Morgan?
A. Well, Ms., actually, but . . .
Q. All right. I am an old-fashioned girl, so unless you tell me to say "Ms.," I will probably say Mrs. --
A. That's fine.
Q. I have been retained by Lisa Yates to represent the estate of Dylon King. Undoubtedly, you must be aware that she is the plaintiff in that case. My purpose today is to find out what might not be contained in the medical records in terms of your thought processes during the delivery of Dylon and just sort of test some of your medical knowledge and see what your practices and procedures are. Believe it or not -- I am sure your attorney has counseled you prior to the deposition -- it really is not my intent to trick you. My job is to try to get the facts as they existed at the time this incident occurred.

If at any time I ask a question that you do not understand, I would like to secure an agreement from you that you are going to say to me, I don't know

what you are asking. Can I secure that agreement from you.
A. Certainly.
Q. The reason is, just so you know why I have that rule, is we attorneys tend to rely upon the transcript. So if I ask a question and you answer it, I am going to presume that there was some meeting of the minds on it. Okay?
A. (The witness nodded.)
Q. Each and every question must be answered orally. Are you aware of that requirement?
A. Yes.
Q. We definitely don't want to put the court reporter in the position of trying to interpret the answer. Okay?
A. No problem.
Q. If at any time you need to take a break for personal reasons or you just get exhausted, I don't have anything else to do today, so you can tell me you need to take a break.
A. (The witness nodded.)
Q. Additionally, most attorneys are not happy with this arrangement, but if for some reason you need to personally confer with your attorney, if I ask you a question and your brain starts imploding and you say, gee, I would like to talk to my attorney, say, on the record, I would like

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to confer with my attorney. And the procedure we will use is I will leave the room. You do not need to leave the room. I will leave the room.

Do you have all of these procedures down?

A. Yes. I understand. Yes.

Q. The first question I have to ask you is: Have you ever given a deposition before?

A. Yes.

Q. Okay. We will get into that briefly. You have given a deposition on how many occasions?

A. Two previous occasions.

Q. On the two occasions you previously were caused to give testimony, were you a named defendant in those matters?

A. In one matter, yes. In the other matter, no.

Q. Okay. In the matter in which you gave a deposition as defendant, I am assuming that is the case that is reflected in your Answers to Interrogatories?

A. I am not sure what --

Q. There was a case filed against you that was dismissed?

A. Okay, yes, that case, yes, James.

Q. Your attorney has disclosed that?

A. Yes. I wasn't sure 100 percent what you were talking about.

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Q. That is okay. What was the allegation of negligence in that matter?

A. Uhm, briefly, that the patient had a breech presentation in labor, and that the breech presentation wasn't diagnosed until late in the patient's labor, and then she precipitously delivered the baby, and I was unable to completely deliver the baby, because it became lodged, wedged in the mother's pelvis.

Q. Based on general practices of . . . And I was corrected by the head of midwifery at the University Hospitals. You want me to call it midwifery, I take it?

A. Yes.

Q. Based on the general practices of midwifery in the face of a situation, if you had known there was a breech, would you under MedCentral's policy and procedures for nurse midwives have been required to call a physician in?

A. I was and I did.

Q. Okay.

A. But he didn't arrive until after the baby had been partially born.

Q. So there came a point where you recognized there was a breech presentation, and pursuant to the policies and procedures, which I just received this morning, you would have called in a physician. Correct?

A. I did do so. He didn't arrive because of the very

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precipitous nature of the lady's labor and delivery. He wasn't able to get there before the baby did.

Q. Okay. You and I just had a little interactive dialogue. And I guess that is one of the other rules I should tell you. I tend to be conversational in my depositions. You need to wait until I am completely done speaking, and I need to do likewise, because she won't be able to take crossover speaking. So I need to try hard to be sure that you answer a question completely. Okay?

Okay. A deposition was taken in that case, and the case has been voluntarily dismissed?

A. That is correct.

MR. RANKIN: Donna, that case has now been refiled since we answered interrogatories.

MS. TAYLOR-KOLIS: I will put the request in the depo, but don't do it. I do it. When I read the transcript, I will send you a letter. All I would request is the case name and number on that matter. Thank you.

Q. All right. You gave a deposition in another matter which you were not a defendant. Is that correct?

A. That's correct.

Q. Were you giving a deposition as an expert witness or as a person who was an attending health care professional?

A. As an attending health care professional.

Q. Okay. What were the facts and circumstances in that

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matter to the best of your recollection?

A. Okay, we had a patient who was pregnant that presented with a mass on the back part of her wrist, hand sort of area. And when I observed this, we thought -- I thought that it was a -- possibly a cyst of some sort. I spoke with my consultant physician at that time, and he agreed that it looked possibly like a ganglion cyst. So we referred the patient to an orthopedic surgeon to have it evaluated.

The patient and the surgeon jointly agreed to defer the removal of the cyst until after her baby was born. And then when it was removed, it turned out to be a cancerous lesion, a carcoma, I believe, if my recollection is correct. And, as a result of that, that patient had to have surgery and subsequently, actually, died as a result of the cancer. And there was a lawsuit against the orthopedic physician for failure to diagnose the cancer and treat the cancer in a timely manner. And I was deposed in regards to what -- what we did to refer her to that physician. And that is all that it -- that I was involved as far as the deposition in that matter.

Q. Okay. So no other depositions?

A. No.

Q. Have you ever done a medical legal review for anyone in your capacity as a nurse midwife?

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A. No.
Q. Okay. I would like to briefly go through the background and training that led you to your profession as a certified nurse midwife.
A. Uhm-hum.
Q. Thank you for providing your CV today. I will quickly have the court reporter mark this Plaintiff's Exhibit A.
(Deposition Exhibit A was marked for identification.)
Q. All right. It is Susan?
A. Susan.
Q. At the time, you delivered Lisa Yates, your last name was Beach. Is that correct?
A. That's correct. Uhm-hum.
Q. B-E-A-C-H?
A. Uhm-hum.
Q. Obviously, you are a high school graduate?
A. Uhm-hum.
Q. Then you obtained your BS in nursing in 1981 from West Virginia Wesleyan College?
A. Uhm-hum.
Q. Following 1981, I take it you were working prior to going into a master's program?
A. That's correct.

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Q. Okay. Where did you work from '81 to '85?
A. I would have to look.
Q. You can cheat. Not a memory contest at all.
A. In 1981, I started to work at the Charleston Area Medical Center and at -- and when I first took the job, I worked as a nurse in the intensive care nursery, newborn intensive care nursery; then after approximately 6 months, I took a job in labor and delivery and worked in the labor and delivery unit for about 9 months before I moved to Florida.
Q. Okay. Was your move to Florida precipitated by the fact you wanted to go into a nurse midwifery program, or you just relocated?
A. I just decided to move to Florida.
Q. Okay. Once down in Florida, you took a job, I see?
A. Memorial Medical Center and worked there around two years.
Q. As a registered nurse?
A. As a registered nurse in labor and delivery there.
Q. Okay. Then you left that area, not the physical area, but --
A. I left that hospital to take . . . The job I had at Memorial was a night shift 11:00 to 7:00, and I wanted a daytime job, so I went to work for Good Samaritan Home Health Services and did home visits primarily with elderly

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people at that time. I did that for several months. And then an opportunity for another labor and delivery job came up at Riverside Hospital, which was in the same town, and so I took that.
Q. Okay. And at Riverside, you began working as a registered nurse in labor and delivery and newborn again?
A. Uhm-hum.
Q. Okay. Somewhere between '84 and '88 at Riverside, it looks like you developed an interest in the midwifery program?
A. That is right. I started the nurse midwifery program in 1985. I started first as a part-time student, then finished it full-time the last 2 years in '86, '87.
Q. Okay. I see you are certified by the American College of Nurse Midwives?
A. That's correct.
Q. Okay. Do you subscribe to their publications?
A. Yes, I do.
Q. Do you -- I was going to ask, do you read them religiously, but your attorney is going to object.
Do you obtain any of your ongoing educational credits through their programs?
A. Yes, I have done so.
Q. Okay. When is the last time you participated in an ACNM credit program?

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A. Probably about two years ago.
Q. Okay. Are you current in your educational requirements?
A. Yes.
Q. Okay. Are you the kind of person who keeps files on their continuing education credits?
A. I do have a file, yes.
Q. Okay. How far back does your file go?
A. I am not sure exactly how far back but I have -- for the state licensing, I have to keep it for two years, so I have it at least that far back.
Q. Okay. I would ask at a minimum that you provide your attorney with copies of the course descriptions, or however you are maintaining that record, that you have taken within the last two years. And I would ask you to also provide any past that, if you have kept them as a matter of course. Sometimes people don't. But I would be interested in seeing what you have taken in the past two years.
A. Okay.
Q. All right. When you finished your program in 1988, I see that you were a CNM to a personal physician. Is that correct?
A. That's right. In single private practice. Wasn't a group practice.

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Q. Okay. So Dr. George L. Mayer?
A. Uhm-hum.
Q. How did you meet Dr. Mayer?
A. Actually, he worked, he had privileges at Riverside Hospital, so I had met him through that. Then a friend of mine that was a midwife worked at another hospital where he actually did most of his deliveries; and she sort of recommended him to me and me to him and set up a sort of a meeting; then we decided to go into practice.
Q. All right. So the two of you went into practice together?
A. Uhm-hum. Uhm-hum.
Q. I gather from '88 to '92 when you were with Dr. Mayer, that you had some sort of a practice agreement? I am not talking about financial. I mean --
A. Okay.
Q. -- parameters of what you were to do for him as a certified nurse midwife?
A. There wasn't really anything written down. It was more of a verbal agreement between the two of us, but, yes, we did have a verbal agreement.
Q. Out of curiosity -- and you correct me if I'm wrong, because I am not always accurate on my dates, although I try -- wasn't there a requirement through the American College of Nurse Midwives by 1988, to keep your

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credentials, that you enter into practice agreements in writing?
A. I am not familiar with that.
Q. Okay. Fair enough. Were you delivering at that time?
A. At . . . Yes.
Q. Okay. What hospitals did you and Dr. Mayer have privileges at?
A. Okay, I had privileges at St. Vincent's Medical Center, and Dr. Mayer had privileges at not only at St. Vincent's but also at Riverside. But we didn't do really very many births at Riverside, so we decided not to have my credentials at Riverside. Primarily, the deliveries that he did at Riverside were ones where patients wanted a tubal ligation. St. Vincent's was a Catholic hospital and wouldn't allow that. So since I wasn't normally involved in the tubal ligation procedures anyway, we decided that it was not necessary that I have privileges at Riverside.
Q. Did you have a standard practice agreement with Riverside?
A. No. I didn't ever go to Riverside and work there as a nurse midwife. I worked there as an employee before I started to working for Dr. Mayer, but I never worked there as a nurse midwife.

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Q. Let me take that back. I meant to say St. Vincent's. I already knew you weren't at Riverside.
A. At St. Vincent's, there was a written policy and procedure about what the midwives were allowed to do and under what sort of like supervision and that kind of a thing was necessary, yes.
Q. Okay. From 1988 to 1992, when you were doing nurse midwifery services at St. Vincent, were you a participant in the annual committee to outline the parameters of what the certified nurse midwives could do?
A. No.
Q. So you were simply a person that was -- you were presented with, here is the protocol, sign it, keep it and know them. Correct?
A. Right.
Q. Okay. You left that, it looks like, in 1992 and relocated back to Willard, Ohio?
A. Uhm-hum.
Q. You were in Willard for five years?
A. Uhm-hum.
Q. Working for W. H. Paik?
A. Paik.
Q. Okay. Full scope nurse midwifery services?
A. Uhm-hum.
Q. What hospitals did you guys have privileges at?

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A. Mercy Hospital in Willard and also at the MedCentral Hospital in Shelby.
Q. Okay. Once again, was this a private practice?
A. Yes. Uhm-hum.
Q. Doctor Paik's?
A. Yes. Although I was an employee of the Mercy Hospital at that time.
Q. That is what I was going to ask.
A. Rather than Dr. Paik's personal employee, there was an agreement between Dr. Paik and the hospital that I wasn't like directly party to, I suppose, that allowed me to work for the hospital but also to work in Dr. Paik's office and do midwifery care there.
Q. If you delivered a baby between 1992 and 1997 . . . And let me take a wild guess. You did. Right?
A. Yes. Several.
Q. Okay. All right. During that 5-year period of time, by whom would the patient be billed for the delivery? By the hospital?
A. No, by Dr. Paik's office.
Q. Okay. You were actually, however, an employee of Mercy Hospital?
A. Yes. Right.
Q. That is who paid your salary?
A. That is who paid my salary.

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Q. Once again, asking you the same question, 1992 to 1997, were you on an annual basis presented with a scope-of-services contract or protocol by Mercy Hospital?
A. Yes.
Q. Okay. At any time from '92 to '97, were you involved in formulating those protocols?
A. When they were initially formulated in '92, I was involved at that time.
Q. Okay.
A. And then I do not recollect there being any significant modifications of it after that.
Q. It leads me to the next logical question. You are saying when they were formulated in 1992. When you went with Dr. Paik, can I assume that is when these hospitals you are discussing decided to initiate a nurse midwifery program?
A. That's correct.
Q. Okay. So that is how it is going around the state. So that is why I asked you. So you and the doctor came together and put together a rather comprehensive -- because I am going to assume it met certain criteria -- a set of standards, then on an annual basis probably looked at them to see if they needed modifications?
A. Yes. Uhm-hum.
Q. Why did you leave that employment situation in 1997?

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A. Primarily, I was offered a better position at Women's Care. They had expressed interest in developing a nurse midwifery practice with multiple midwives, as well as they were in that, at that time, investigating the idea of opening a birthing center.
Q. Okay.
A. And they were interested in . . .
Q. Let me ask you a couple of questions, because that is how we get to the present is going through the past.
What physician approached you, if it was a physician indeed, to join Women's Care, Inc.
A. The initial contact that I had was actually with Dorinda Strang, who was at that time the personnel -- excuse me -- not personnel -- the office administrator. Subsequently, I met with her and Dr. Ed McMillan. Those were the initial contacts.
Q. Okay. Miss or Mrs. Strang, how did she become aware of your existence?
A. Uhm, I am not really sure. I mean, I practiced in the community. Mercy Hospital actually had made quite an effort to market my presence at Dr. Paik's office and at Mercy Hospital, so there were like advertisements in the newspaper and that kind of a thing. And I would expect that is probably how, uhm, they found out about me at first. And then they, like I said, initially just asked

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me to meet with them to talk about what nurse midwives do and how that might be something that they would be interested in in their practice.
Q. Okay. So you interviewed them. They interviewed you. Thought it was a good match. Obviously, had been developing programs since 1988. Is that correct?
A. Yes, that's correct.
Q. Then you were hired by Women's Care, Inc. Is that correct?
A. That's correct.
Q. That is who has been your employer from 1997 to the present?
A. That's correct.
Q. I am just asking, because sometimes I forget and later I go, What? It says 1997 to 2002. You are still working for them, but you just printed this today?
A. At this point, I am still employed there, although they decided that they no longer wish to have midwifery services as a part of the practice, so at the end of this month, I will not be working there anymore.
Q. If you are at liberty to disclose it, do you know why they decided to discontinue midwifery services?
A. Because of the economic situation in the practice. The number of -- the volume of births has decreased, significantly. They also found theirselves in

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considerable financial straights as a result of the failure of the birthing center to be economically successful and lost a considerable amount of money with that.
Q. Okay. Even though it may seem to everybody in the room like it has nothing to do with this lawsuit, you are indicating to me, A, you came on as a nurse midwife?
A. Uhm-hum.
Q. B, were you and Dr. McMillan the person or persons who formulated this Certified Nurse Midwife Guidelines that I have been handed this morning?
A. Actually, those guidelines were formulated by, I guess, the hospital administration prior to my employment with Women's Care. And they were presented to me in their entirety for review. And I didn't have anything that I found unacceptable about them, so I agreed to them. That has been the guidelines I have been practicing under since I have been at . . .
MS. TAYLOR-KOLIS: All right. Could we have this marked Deposition Exhibit B, please.
(Deposition Exhibit B was marked for identification.)
A. I didn't formulate them specifically myself.
Q. All right. So these are the hospital guidelines which you were handed by somebody at the hospital,

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presumably?
A. Uhm-hum.
Q. You reviewed them?
A. Uhm-hum.
Q. Separate and apart from this, to be in compliance with the Ohio Administrative Code, I am assuming that you and Women's Health -- well not --
A. Women's Care, Inc.
Q. I shouldn't use that word. -- have a Standard Care Agreement?
A. That's correct.
Q. All right. Where are your standard care agreements on file?
A. At the office.
Q. Okay.
A. And I think the hospital probably has a copy of them, too. I am pretty sure they do.
Q. Okay. I am going to assume you would have executed one each and every year since 1997?
A. Uhm-hum.
Q. Does that comport with your recollection?
A. Uhm-hum. That's correct.
MS. TAYLOR-KOLIS: I am going to request of Attorney Huffman here today representing Women's Care that Women's Care, Inc. produce each of the standard care

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agreements for 1997, '98, '99. And I don't need to see past '99 since it would not be relevant, unless you just want to throw them my way. But I would request those three years.
MR. HUFFMAN: Okay.
Q. Okay. All right. Now we are right into the heart of the matter.
All right. We will get in the heart of the matter in one second. I did lose my train of thought.
You were brought on to perform nurse midwife services for this group. Did you also, at that time, did they bring anybody else in as a nurse midwife?
A. Initially, no. I was the initial employee as a nurse midwife.
Q. In 1999, how many nurse midwives did you have in your group?
A. In 1999, there were two.
Q. Okay. Yourself and . . . ?
A. Sue Serovick.
Q. R-O-V-I?
A. C-K.
Q. Okay. All right. Now, in addition to performing delivery services at the hospital as nurse midwife, were you going in office examinations of patients?
A. That's correct.

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Q. Okay. Counseling them?
A. That's correct.
Q. Okay. Doing interim pregnancy visits? And I call them "interim." They come in, find out they are pregnant, then you were following them, measuring fundal heights, blood pressures, fetal heart tones, things of that nature?
A. That's correct.
Q. In the office setting, under what circumstances would the physicians at Women's Care examine the patient?
A. I am not a hundred percent sure I know what you are asking.
Q. Okay. I could ask another question.
A. If you could clarify a little what you mean.
Q. Sure. In your practice . . . I think everybody in this room knows you are not an MD. But under, I guess we are going to call them the policies of ethics or guidelines, if you will, for the American College of Nurse Midwives, you were capable of examining patients to determine the well-being of their fetus during pregnancy?
A. Uhm-hum.
Q. Is that a fair statement?
A. That's true.
Q. Okay. How was it determined what your patient load in the office would be through Women's Care?
A. Okay. There was a sort of an -- or still is a sort

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of a standard number of appointment slots for myself as well as the physicians. Some of the appointment slots are delineated for OB patients, some for GYN patients, some for working patients, like might have problems, and some for postpartum patients. When a patient calls for an appointment, she is asked when she would like to come and why she is needing to come, and then she is offered the option of usually a couple of appointment slots that meet what the criteria of what she needs to be there for. And then the patient generally chooses which provider and which day and time she would like to come.
Q. Okay. So you and the physicians were sharing patient visits, and you would be excluded only based probably on GYN. You are not going to --
A. Well, I did GYN and I do do GYN care there. But this particular patient is a pregnant patient. But, yes.
Q. Okay. So you are treated as a member of the corporation and you do basic exams and are expected to know and understand what physical findings mean, just like the physicians would be. Correct?
A. Exactly. Exactly.
Q. They don't come in and check your work. Is that correct?
A. That's correct.
Q. Okay. Fair enough. In anticipation of today's

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deposition, can you tell me what materials you have reviewed?
A. The patient's office chart and the patient's hospital chart.
Q. Okay. Do you have the patient's office chart separate from that notebook?
A. Yes.
Q. Okay. Could I see it for a second?
A. Yes, certainly.
MS. TAYLOR-KOLIS: I have a sneaking suspicion I haven't seen the complete patient chart.
MR. HUFFMAN: Really?
MS. TAYLOR-KOLIS: Yeah. And it is not your fault.
THE WITNESS: I am reasonably sure you saw the whole office chart, because when I looked through it, I didn't see anything there that wasn't in the notebook. But there is a possibility, I guess.
MS. TAYLOR-KOLIS: Can I ask you, do you have the ability to photocopy?
COURT REPORTER: Yes.
MS. TAYLOR-KOLIS: I am not going to do it now, but before we leave at the end of the deposition, I would like for you to photocopy this for me, because my office made a mistake in record obtaining, so a lot of

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this I have seen and some I haven't.
MR. RANKIN: While we are at it, we should also have a copy of the guidelines, too.
MS. TAYLOR-KOLIS: All right.
Q. Mrs. Morgan, you signed the death certificate in this matter, didn't you?
A. That's correct.
Q. Okay. Do you have a copy of that?
A. Not . . . I don't know if we have that or not.
Q. Okay. Don't stress yourself. We are going to mark this Deposition Exhibit C. But as you sit here, you don't know if you or your counsel have --
A. I don't recall. But since I signed it . . .
Q. I have a top part and bottom part. I can give you the top part. This is the original, if you would like it.
I did not know that . . . The death certificate customarily is not a part of the medical record. I didn't know if you had one in your office chart.
A. No, we don't, ordinarily.
Q. All right. Is it customary for you to be the person to sign a death certificate?
A. If I am the one that delivers the baby, yes.
Q. Prior to signing Dylon King's death certificate, did you ever sign any other death certificates?
A. Well, certificates for fetal death as that one is,

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yes.
Q. About how many?
A. I really don't have any absolute figure on that. I would say probably fewer than five.
Q. Okay. I am going to give you the original, at least the top part. Unfortunately, that is how it comes from the health department.
A. Uhm-hum. Uhm-hum.
Q. You would agree with me that you signed this on December 7th. Correct?
A. That's the date that is on here.
Q. And, at that time, you were aware an autopsy was being performed?
A. That's correct.
Q. Okay. Would it be a fair statement that on December 7th, you did not, in 1999, you did not know the results of the autopsy?
A. That's correct.
Q. Okay. Is there a reason that you chose to go ahead and list the cause of death and sign a death certificate without knowing what the autopsy results were?
A. The family had requested the baby's body be buried or in some fashion disposed of. I am not sure whether they cremated it or buried it. But they wanted the baby's body to be released to the funeral home. And it is

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generally the policy that can't happen until the death certificate is completed.
Q. Who told you that is generally the policy?
A. The people at the funeral home, as far as I recall, indicated that they couldn't like take -- like dispose of the body or take care to bury it or cremate it or whatever they were going to do to it until the certificate was signed.
Q. Are you aware that you are able to, under the laws of the State of Ohio, sign a death certificate, even a fetal death, as pending autopsy?
A. I wasn't aware of that.
Q. Okay. So you just didn't know that?
A. I didn't know that.
Q. Can you tell me why you listed "cardiac asystole" as the cause of death?
A. Because, at that time, that is all we knew is that the baby had died.
Q. You conferred with no physician in your group in terms of what to list as the immediate cause of death in this matter?
A. I don't recall.
Q. Okay. Fair enough.
MS. TAYLOR-KOLIS: I will take that one back.

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MR. HUFFMAN: Can I take a peek at this?
MS. TAYLOR-KOLIS: You sure can.
Q. It is my understanding that after the autopsy was completed, that you called Lisa Yates. Do you have a recollection?
A. Actually, Lisa called me first, wanting information about the autopsy.
Q. All right.
A. And I returned her telephone call.
Q. Do you have some sense of when that dialogue occurred between the two of you?
A. Uhm, I can look in the chart, actually. I think there is a note about when she called me. Yeah. I think it was probably -- well, it says here the autopsy report was received on the 5th of January, so it was probably in the early part of January.
It looks as if on January 13th we tried to contact the patient to schedule a postpartum appointment and were unable to do so and a letter was sent to her.
My recollection is that she called outside of the office hours to -- wanting information about the autopsy report. I indicated to her that I didn't have the information that she wanted in front of me and that I didn't want to just sort of talk about it without having it available to me. And so I asked her to make an

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appointment.
So it was probably the early part of January. Other than that, I don't know the exact date.
Q. Okay. To be responsive to the question, and maybe you are being, is it your testimony that you never had a conversation with Lisa explaining to her what you thought the autopsy meant?
A. I am not clear on what your question is asking me.
Q. If Lisa Yates testifies today by deposition that you and she had a conversation after you had the autopsy results, would she be accurate?
A. We had a conversation. My recollection of the conversation was she wanted some information about what the autopsy said. And while I don't remember the exact words that I used, I think I indicated to her that it was -- that I needed to really have the autopsy report to be able to kind of give her a full sort of a discussion of it and that she probably should make an appointment to come in and talk about it. It is possible -- but I don't have a direct recollection of it -- that we did discuss in general what we thought the -- that I thought the autopsy . . . Because I think I had seen the autopsy report at that point.
Q. Okay. That is the question. Very specifically, she is going to testify she spoke with you after you had seen

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the autopsy results.
A. Yes. But I think I told her at that point what I thought that I remembered about the autopsy report was that it showed that the baby had died as a result of the cord around the neck, but that I really did not feel comfortable or feel like I should be going into a lot of detail with her about it until I actually had an opportunity to sort of go over the materials with her. And I didn't have them with me at the time because it was outside of the office hours.
Q. How would she get you outside of the office hours?
A. She paged me through the answering service.
Q. Okay. I was curious. I don't know how your office works.
Referring you back, once again, to the death certificate which you signed in this matter. Just so you have it in front of you. Towards the bottom of the middle section.
A. Okay.
Q. That is the section below where it says "immediate cause of death."
A. Uhm-hum.
Q. Number 17.
A. Uhm-hum.
Q. On these items --

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A. I am sorry.
Q. If you want to uhm-hum, that is okay. You indicated that the death occurred during labor or delivery. That is your handwriting?
A. Yes, that is my handwriting.
Q. How did you draw that conclusion?
A. Well, the baby was alive at least during a part of the labor, because we had fetal heartbeats; and that at the time then when the baby was born, there wasn't -- didn't have any heart beating and no breathing.
Q. So the record is clear, I guess you are answering what I need you to answer. Based upon your training, education, and certification as a nurse midwife --
A. Uhm-hum.
Q. -- you can freely testify to the fact that on presentation, Mrs. Yates had a viable fetus. Is that correct?
A. When I first saw her, it was alive, yes.
Q. Okay. All right. Enough about that.
In December of 1999, what OB/GYNs were a member of Women's Care, Inc.?
A. Okay. Uhm, Dr. Thomas Croghan, Dr. Larry Feichtner, Dr. Stewart Ryckman, Dr. Michael Gunzenhaeuser, Dr. Guy Capaldo, Dr. Hunter Wilson and Dr. Edroy McMillan.
Q. Okay. I gather that as part of your -- I don't want

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to call them practice protocols -- a part of your Standard Care Agreement, if it is not in here, there was a method for you, while you were at the hospital . . .

And you only delivered at one hospital. Is that correct?

A. At that time, yes.

Q. At all times you had the ability to be in contact with one of the physicians in the group?

A. That's correct.

Q. Either by telephone?

A. That's correct.

Q. Radio?

A. Uhm-hum.

Q. Fax?

A. Uhm-hum.

Q. Some way.

A. Some way, yes. Primarily telephone.

Q. Okay. Someone was always available to you. Is that correct?

A. Yes, either by telephone or in person, yes.

Q. Okay. Under the CNM guidelines I have just been handed -- and I know that everybody else is disadvantaged, since they can't see them -- but I am not a cheater and try to read verbatim -- on page 2, although these are not paginated, "Approved Privileges" . . .

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And this relates to MedCentral Health Center. Correct?

A. Uhm-hum.

Q. The second approved privilege for a certified nurse midwife is supervision of an uncomplicated laboring patient. Would you agree with that?

A. Yes, that's correct.

Q. Are you going to describe Lisa Yates as an "uncomplicated laboring patient"?

A. Yes.

Q. You are?

A. (The witness nodded.)

Q. You have had an opportunity to review all of the documentation and in the chart and the fetal strips?

A. Uhm-hum.

Q. Do you have a recollection that at approximately 5:10 a.m., in the morning, on December 2, 1999, Lisa Yates passed a large quantity of meconium?

A. That was reflected in the record, yes.

Q. Okay. You have been a nurse midwife for, well, 12, 13 years?

A. Uhm-hum.

Q. Okay. What does the presence of meconium aspiration at that phase of a person's labor mean to you?

A. Okay, well, first of all you used the word "aspiration." And that is not what happened.

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Q. Okay. I did. What does the presence of meconium at this stage in this particular patient's labor indicate to you clinically?

A. Uhm, well, there could be a variety of reasons the baby passes meconium. Sometimes the meconium is not apparent in the fluid prior to the later labor, just because it doesn't leak down enough. There can be sometimes meconium present there earlier and there is not enough fluid leaking out initially for it to show. Other times it can be a new finding. And then it just tells us that the baby has -- has passed meconium.

Q. Medically, what is the significance of the presence of meconium?

A. There can be meconium passed simply because the baby is postdate. Meconium can pass because of presentation or it can pass because of some type of asphyxiation.

Q. Okay. Lisa Yates was not postdate, was she?

A. Well, I think her due date was . . .

Q. December 4th of 1999, I believe.

A. This is the first, so she wasn't significantly postdate.

Q. Well, she wasn't postdate. Correct?

A. I mean . . . Correct.

Q. The second thing you said, I didn't write it fast enough, but my brain is pretty awake. Presentation?

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A. Uhm-hum.

Q. What presentation could cause the --

A. If the baby was breech, for example, there would be meconium.

Q. This baby was not breech?

A. This baby was not breech.

Q. And the last thing you clearly stated was asphyxia. Correct?

A. It could be. Not always because of that. But it could be.

Q. That is absolutely correct. It is not always. But if you eliminated the other two possibilities, the third possibility left on the table is fetal asphyxia. Is that true?

A. That's true.

Q. So there was a general diagnosis at 5:10 in the morning of fetal asphyxia. Is that correct?

A. Yes.

Q. Did you call a physician at that time?

A. No.

Q. Why?

A. Because the fetal heart tones on the monitor strip didn't show any evidence of nonreassuring pattern and the patient was progressing in labor.

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Q. Would you say she had an abnormal course of labor based on her progression?
A. She progressed slowly in her labor, but I wouldn't necessarily say it was abnormal, no.
Q. Do you have a definition of abnormal progression of labor either in your Nurse Midwife Guidelines as submitted by the hospital or in your Standard Care Agreement as written by your group?
A. I don't believe so.
Q. There is no definition in either one of these documents, documents I don't have?
A. I would have to review the document to see what it says. I don't recall.
Q. We will ask the question two ways. First of all, as you sit here today, you are telling me although you have been affiliated with MedCentral since 1997, you don't have a recollection of there being a definition of abnormal labor?
MR. RANKIN: I will object to the form of the question. I think the form is argumentative.
You may answer.
A. Well, I don't look at the midwifery guidelines that frequently. It is not like I look at them everyday. So I can't recall exactly what the papers say.
Q. Well --

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A. I have a sort of a general guideline about what we would consider abnormal labor progress, but that can be highly variable according to the individual patient and an individual patient situation. Generally speaking, if the patient makes progress in dilation, in descent of the baby, then over time, that is considered adequate labor, I guess, and adequate progress. If there is a time when the patient does not make progress, then that would be considered abnormal.
Q. Okay.
A. But I don't -- I mean, it is kind of -- it would be variable, I would say, according to the patient and her situation; in other words, her first baby or second baby or 10th baby, other factors that might come into play.
Q. A part of your responsibility as a certified nurse midwife, once again -- and it is contained in the guidelines -- application and interpretation of indirect and direct fetal monitoring equipment and tracings. Would you agree with that?
A. That is true. Uhm-hum.
Q. And you have been reading fetal tracings for how long?
A. Since 1981 when I first became a labor and delivery nurse.
Q. And your testimony, if I heard it correctly, was

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that you eliminated the possibility of fetal hypoxia?
A. Uhm-hum.
Q. Based on the fetal heart tones or the tracings?
A. Well, the tracing. Use those words interchangeably, I suppose. It is a little imprecise.
Q. Well, nomenclature is rather important, I suppose, and I just want to be sure that we are talking about the same thing. When is the last time you looked at the chart?
A. Yesterday. And this morning.
Q. Okay. Did you rereview the fetal monitoring strips?
A. I looked at them briefly, yes.
Q. Okay. In the last 64 minutes of Lisa Yates' delivery . . . And feel free to look at the strips.
A. Uhm-hum. Here it is. Okay. Okay.
Q. Well, first, let's deal with the last 64 minutes prior to delivery. You record delivery at what time?
A. I would have to look that up.
Q. Okay.
A. Looks like it was at 7:16.
Q. Okay. Would you agree with me that there are minimal heart tracings contained in that chart?
MR. RANKIN: Object.
You may answer.
A. I don't know what you mean by "minimal."

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Q. Well, do you know what the fetal heart rate is during that last 64 minutes?
A. Yes.
Q. Okay. Tell me what that was.
A. Okay. Well, it was being monitored externally, and the patient was being like auscultated with the monitor in between her contractions. And it looks like it was running primarily about 152, 160 at one point, and later on maybe between 130 and 150.
Q. Where is her documentation that there was maternal or fetal ausculatation?
A. In the Nurses' Notes, it shows the baby's heartbeat was written down by the nurses. Then I was standing there the whole time.
Q. Okay. We are going to get to where that is in the Nurses' Notes in a minute.
A. There is also some showing on the strip. But there were other times it was monitored it wasn't necessarily printed out here.
Q. Well, isn't there a point in time in those strips -- and I can pull mine out -- where it says "fetal monitor off"? I think it is about 6:15.
A. They took -- I think they took a part of it off, yes.
Q. What part did they take off?

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A. I think they took the contraction part off at that point. And then the external monitor we would just -- instead of -- it wasn't picking up continuously, so we were listening in between contractions with the actual transducer.
Q. Why wasn't it picking up continuously?
A. Mostly because of the amount of descent the baby had made into the mother's pelvis.
Q. Okay. In reviewing -- and, once again, we have as much time as you want to take.
A. Uhm-hum.
Q. -- the two hours prior to that time period, okay, going back two hours before delivery so to speak?
A. Uhm-hum.
Q. Would you agree that there are, in fact, on those strips, variable decelerations with late components?
A. There are variable decelerations.
Q. Do you see any with late components?
A. There are.
MR. RANKIN: I am sorry. What time frame did that question encompass?
MS. TAYLOR-KOLIS: Within the two hours before delivery. Taking it basically from the 5:15 documentation of "thick meconium" through the time of delivery.

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A. It looks like I can see possibly . . . There is one there at approximately . . . I am not sure what the time on that is.
Q. Times are cut off on some of the strips.
A. I was going to say, times are cut off on a lot of them. But probably about . . . Assuming that . . . Looks like there is one at 5:45 or 5:50 or something like that. And then it looks like there is another one in around 5:55 or so. And then other than that, the rest of them just look pretty much like what we consider the head compression-type decelerations where the baby's head is being pushed down in the mother's pelvis and the baby has a response in relation to that.
Q. Based upon your training and experience as a certified nurse midwife as being required to be able to read these tracings, what is the significance of a variable deceleration component?
A. Well, variable decelerations can occur any time during a mother's contraction. That is why they are called variable. There are decelerations in the strip that show it happening earlier in the contraction stage as well as the middle of the contraction stage and at the late. So they are sort of all three present in this strip.
Q. Okay. My question was, separate and apart from how you are interpreting that strip at this point: As a certified nurse midwife, what to you is the significance of a variable decel with a late component?
A. As I said, variable deceleration is -- can happen at any point in the mother's contraction cycle. It . . . In most cases, if this is later in the cycle, it probably does have to do with cord compression.
Q. Okay. That is a fact you would have known on December 2, 1999, I gather?
A. That's correct.
Q. Not new medicine, is it?
A. No, it is not.
Q. Okay. Did you ever consider a scalp gas in this case?
A. Huh-huh.
Q. I am sorry?
A. That is not a procedure I would personally perform.
Q. Okay. If it wasn't one that you would personally perform, you know what a scalp gas is?
A. Uhm-hum.
Q. I am not being facetious, of course.
A. Hum-uhm.
Q. When is it under your purview to call in a certified physician and say, I think we should have a scalp gas in this situation?

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A. Ordinarily that is what I would do is I would call my back-up consultant physician and say that I felt that there was some degree of concern about the baby's well-being and that a scalp pH and arterio blood gas should be performed. I would certainly do that in the situation where I felt there was a loss of the baby's heartbeat or significant and persistent variable type decelerations.
Q. Could you have received --
Let me see if I am going to ask it this way.
During the last 64 minutes before delivery where -- I used the form "minimal tracings," which your attorney didn't like. But you and I are in agreement there is not a continuous monitoring of the child's heart status by description in that last 64 minutes?
A. Well, I am not sure that I would say that it -- there wasn't any . . . I am not sure of what you are saying.
Q. There was not a continuous fetal monitoring strip during the last 64 minutes, the strips themselves?
A. There is not a strip, but there was monitoring of the fetal heart tones all of that time.
Q. All right. My question is, are you aware of any adjustments that you could have made to provide a continuous strip in that last 64 minutes?

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A. Well, I could have placed an internal monitor on her.
Q. Is there a reason you did not consider that?
A. Mainly because I felt that the previous strip had been normal enough and that with what we were hearing with the auscultation in between the contractions and during the contractions was normal enough that that didn't seem indicated.
Q. Okay. That was a decision that you made?
A. That's correct.
Q. Are you the person who makes the decision on whether or not to place an internal monitor?
A. Generally speaking, yes.
Q. Okay.
A. Though the nurses do have latitude of placing them, too.
Q. Okay. In looking at the chart that was submitted by the hospital, I found it difficult to ascertain what portions of the chart you were recording notes in. So, first of all, let me ask a couple of questions about the team, or as best you remember it.
A. Uhm-hum.
Q. What I could make out from the records is that you came on duty at about 7 p.m. on December 1. Am I reading it right or wrong?

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A. Around, well, actually, I think it starts at 6:30. I probably came in someplace around 7 o'clock.
Q. Do you have a --
A. I start at 6:30, and it runs until 7:30 or so the next morning. There is a certain amount of flexibility as to what time the morning personnel comes on.
Q. Okay.
A. But, generally speaking, if you have been with somebody at -- all night, like I was with her, this birth was happening sort of right at the -- sort of a changeover time, I would be the one that usually would stay with the patient and deliver the baby.
Q. If a person was close to delivery, you are not just going to --
A. No, I wouldn't say, it is time to go, and walk out. My recollection is that the person coming on for the morning hadn't yet arrived at the hospital when this baby was born anyway.
Q. Okay. When you came on service on the evening -- Well, that is what I call it, "came on service." Is that okay with you?
A. Yes. That's okay.
Q. -- on December 1, 1999, did you receive a report about the patient?
A. Yes, from the nurses, yes.

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Q. From the nurses. What nurses did you speak with?
A. That I cannot directly remember.
Q. Well, your ability to read their names is better than mine, I am going to guess.
A. Possibly. Let's see. This is a little confusing, certainly.
Q. Probably no more so than the way I indexed it.
A. Well, the way this is indexed is not the same way I am used to looking at it in the charts.
Looks like "SS" is here. And those initials usually . . . I would say is . . . Well, it says her name at the bottom, Sharon See, RN. Then there is a "PL" here, which I think probably refers to Peggy Long, although she did not sign her name at the bottom. So those were the nurses there when I first came on at like, you know, at 6:30, 7 o'clock.
Q. What was your understanding of the circumstances under which Lisa Yates was admitted to the hospital?
A. That she came in in early labor and had been making progress, slow progress through the course of the day. She was receiving Pitocin for augmentation of her labor. And she had been checked, I guess, around 5 -- looks like maybe at 4:30 or 4:45, something like that, and she was 5 centimeters.
Q. A physician from your group had seen her that day.

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Is that right?
A. That's correct.
Q. Okay. That was Dr. McMillan?
A. Actually, Dr. Ryckman.
Q. Oh, was it Dr. Ryckman?
A. Well, actually, I think maybe very early in the process, Dr. McMillan had seen her. What happened, I think, when the patient first came in, I think it was during the nighttime of the night before, and she wasn't initially admitted. They just were monitoring her. I am trying to see. It is in the Nurses' Notes one place and then in the flow sheet another place. So I have to . . .
Yeah. It looks like she came in at 5:35 in the morning of December 1st. And Dr. McMillan examined her and found she was having contractions about 4 to 7 minutes apart and there was a -- and she was sort of in prodromal labor, and he gave her medication for sedation. Then subsequent to that, around looks like maybe 8 o'clock or so, Dr. Ryckman examined her and then he ruptured her membranes at 8:38.
Q. Did you speak with either one of those physicians before you came on to manage Lisa's delivery?
A. I don't recall having done so. Ordinarily I wouldn't, unless there was something they were specifically or particularly concerned about with the

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patient situation. And her situation was not particularly untypical.
Q. Do you have a recollection of ever actually having met or rendered any services to Lisa prior to December 1st?
A. I had seen her when she came into the office -- or, excuse me, to the hospital once around the middle part of October.
Q. In the emergency room admission?
A. Well, actually, I guess they call it . . . She came to the labor and delivery unit about some concern of abdominal pain. I reviewed that part of the chart the other day.
Q. When you took over management of her delivery, were you aware she was a VBAC?
A. Yes.
Q. Okay. In your practice, what are the criteria for a VBAC? Do you have criteria?
A. Well, there are criteria that --
MR. HUFFMAN: Can we get straight what you are referring to, for the record, as a VBAC?
MS. TAYLOR-KOLIS: Yes. I am sorry. Vaginal birth after cesarean. I am sorry. You get this way when you are not in front of a jury. Make it quick. Okay.

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A. Patients are qualified for a VBAC if they have a low transverse cesarean section and we have documentation of that information, they agree to having a try of labor, and that there is not any other indications that they absolutely need a cesarean section.
Q. Okay. Are there risks to counseling in favor of vaginal birth after cesarean?
A. There are risks to any medical procedure, obviously. We review with the patient what the risks and benefits are of labor and presumably vaginal delivery versus scheduling a repeat C section. Generally, that happens during their prenatal visits.
Q. You recently reviewed her office chart?
A. Uhm-hum.
Q. Was there counseling provided to her?
A. There is not anything that I saw documented.
Q. Okay. I didn't either, but I don't always read everything correctly.
A. No, I didn't see any documentation to reflect that, although I would . . . I didn't see her for prenatal visits in question, so I can't say what was stated there.
Q. Okay.
A. But, generally speaking, that would be pretty much of a routine part of her prenatal care is to review that.
Q. Okay.

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A. Patients aren't . . . Actually, I think even when they are initially -- when the initial intake history is done, they are asked if they have a particular preference, because some patients know even when they first come in pregnant whether they want to have a trial of labor and attempt a vaginal delivery or if they absolutely don't want to do that and just absolutely want to have a repeat C section.
Q. Based on their prior experience?
A. That's right. And we, in almost all cases I can think of, do honor the patient's request in regards to that, unless there is a strong medical reason that we shouldn't honor their request.
Q. And based upon the history she had, as you know it to be, were there any strong reasons she couldn't have tried?
A. No.
Q. Okay. Based upon your reading of the chart, or your recollection, whichever it is --
A. Uhm-hum.
Q. -- at any time between 7 . . .
Well, is it okay if we say you got there at 7:00 at night?
A. Yes, that's fine.
Q. I am not worried about 6:30 to 7:00. So from then

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to the time Lisa delivered the following morning, did you speak with any doctor in your group?
A. About anything?
Q. About this patient?
A. About this patient?
Q. Yes. I am sorry. Should have made that more clear.
A. Well, I mean, because that does mean . . . I don't have a specific recollection of a conversation regarding Lisa with Dr. Wilson or any of the other physicians. I had some other patients through the night there. And I believe that I did speak to Dr. Wilson about one of the other patients, concerns that I had about the other patient. And, uhm, I might have at that point mentioned that she was there and she was making, you know, slow progress. But other than that, I am not sure exactly what time that might have been. I can't recall the exact -- I mean, I didn't actually make a note about the exact timing and contents of the conversation, because it was a pretty routine sort of a situation.
Q. Okay. So that the testimony is clear -- and sometimes this happens because I don't ask very precise questions when I am looking around pieces of paper -- you did not go to any physician from your group and express any concern about this particular patient, Lisa Yates?
A. Not that I recall.

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Q. Okay. You may have mentioned her in passing to -- and your mind is telling you it is Dr. Wilson. Correct?
A. Well, I know that Dr. Wilson was the person on call with me that night.
Q. Okay.
A. So if there would have been anybody that I would have called, it would have been Dr. Wilson.
Q. Okay. Was Dr. Wilson physically in the hospital that night?
A. At any time or just . . . ?
Q. Yes.
A. He was there in the hospital in the morning; but he wasn't through the course of the night, no.
Q. What time does he customarily come in or --
A. He comes early in the morning and sometimes as early as say 6:30 or so to do rounds on his patients that he has --
Q. Okay.
A. -- already on the postpartum floor.
Q. Okay. All right. How many patients were you attempting to deliver that night?
A. Well, at the time Lisa's delivery was occurring, I think she was the only one. But I had had, I think, two other patients or three other patients during the course of the night.

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Q. Yeah, I guess that was the way that I . . .
How many people were in labor that you were involved with that night?
A. Okay, I don't remember exactly. But my recollection is probably two or three. I think there was . . . It wasn't like dozens or anything like that.
Q. Okay. Going backwards, someplace we were way earlier, where do you chart notes in this chart?
A. On the progress note sheets.
Q. The progress note sheets?
A. Which, uhm, the nurses put right on the Nurses' Notes and on the progress notes sheets, and then I dictated in this case a history and physical and delivery note for her.
Q. Okay.
A. Well, actually, it was more of a -- more of a history than an actual physical. They just call it history. And I guess that is what the dictating people call it. But it was more of a history than a delivery note, actually.
Q. Okay. You are referring to . . . Let's just make sure that we have the same document. I want to make sure.
First of all, history and physical delivery note, this one?
A. Yes. That is what they call it. Uhm-hum.

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Q. This one?
A. Oh, wait a minute. Let's see.
Q. Because I -- if there is something different than that, I haven't seen it. That is not necessarily your fault.
A. Okay, yeah, it is the same. It just looks different because it is printed on a different print. But it is the same document.
Q. At the top, it indicates the physician is Dr. Hunter Wilson?
A. Actually, I think they made a correction on that, because mine says Dr. McMillan, but . . .
MS. TAYLOR -KOLIS: Can we take two minutes? Everybody stretch their legs. I want to make sure that it is the exact same document with the exception of name.
(A short break was had.)
A. What happens is generally when a patient is admitted to the hospital, they are admitted to the doctor that is on call.
Q. Okay.
A. And so that is how come Dr. McMillan's name is on there. But Dr. Wilson was the one that was on call with me at the time the patient delivered. So they may have made a correction about that.

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Q. You are right. Even though the print looks incredibly different, it appears to be the exact same report with the exception of a name insertion. The wonders of computers.
A. Yeah, it has to do with the computers, because everything at the hospital is . . . They don't actually have real charts for these dictations. They are all just stored on the computer and they just print them out as they need it.
Q. All right. So you are actually the person who dictated --
A. I am the one that dictated this, even though it has . . . That is just the way that the hospital does it.
Q. Okay. Because you were the person who was there, so you are supposed to recall all of the events?
A. Uhm-hum. Yeah. Right. But as far as why they have Dr. McMillan or Dr. Wilson's name at the top versus mine, it is the way that the hospital computer system works, basically.
Q. Okay. Not a problem. So that document is yours.
Now you are telling me you have notes in what you are calling the progress notes?
A. Uhm-hum. Which --
Q. If you can show me what your progress notes look like, because they are not labeled "progress notes." I

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have things labeled "Nursing Notes."
A. Well, there is progress notes labeled, too, under this section here. It says "MedCentral Health System Progress Record" actually is, I guess, what it is called.
Q. Okay. Because I tabbed a second Progress Record, but I don't have any notes in it.
A. That there. That paper you have in your hands there.
Q. These are your progress notes?
A. This is a brief note, brief delivery note, then I dictated also a sort of a summary note.
Q. Okay. So that I am clear, this is the dictation summary?
A. Uhm-hum.
Q. And this note, which --
(Deposition Exhibit C was marked for identification.)
Q. Ms. Morgan, here is Deposition Exhibit C. That is the brief note that you wrote. Is that correct?
A. That's correct.
Q. Just so we are all clear later and I don't go back and make up words, can you read your note into the record?
A. Okay. "Brief delivery note," then "(See also dictated note)" unquote.
MR. RANKIN: Parenthesis.

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A. Parenthesis. Whatever. Yes, I guess that quote is not the right word.
It is "SVD" --
Do you need me to interpret the abbreviation?
Q. No.
A. Okay. -- "stillborn male at 0716 - Apgar 0/0. Attempted CPR by CRNA and pediatrician with no response. Placenta delivered intact - lower uterine segment intact. Fundus firm with massage and Pitocin with IV unit. Family given opportunity to see and hold infant. Discussed autopsy." Then my signature.
Q. Okay. You discussed autopsy and obtained a signature from them to allow an autopsy to be performed. Is that correct?
A. That's correct.
Q. Okay. Why was the autopsy performed at Akron's Children's Hospital?
A. That is just where they perform the autopsies. I mean, I don't think that we have a pathologist at our facility that does pediatric autopsies. But I am not familiar with the exact reason why it was Akron Children's versus Columbus or Cleveland.
Q. You wouldn't involve your county corner in a case of fetal demise?
A. Ordinarily not.

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Q. Okay. I was just curious.
A. Ordinarily not, no. Not under this circumstance.
Q. Okay. So with the exception of this dictated note and this brief note, you weren't charting anything?
A. Generally I don't.
Q. Okay. How does that work on your service, or how did it work on your service in December of 1999?
A. (The witness did not respond.)
Q. Who was doing the charting, is the better question.
A. Well, the nurses do sort of a narrative kind of a note and keep track of the vital signs and that kind of a thing in the Nurses' Notes. There is a Delivery Summary Record, which you had there just a minute ago -- you flipped over it -- that I dictate -- or, excuse me -- write on along with the nurses.
Q. Is it this way?
A. That one there, yeah.
Q. Okay.
A. Then the progress notes that I write . . . Generally, the only progress note that is really written is when a procedure is performed; in this case, the delivery of the baby.
Q. Okay.
A. Because there was exceptional circumstances here, I felt that it was a good idea and I did dictate a longer

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note just reviewing the patient's situation.
Q. Ms. Morgan, why would you call these "exceptional circumstances"?
A. Because the baby died.
Q. Okay. On the Delivery/Infant Data Sheet, that is what it was called in here?
A. Uhm-hum.
Q. That is why I labeled it that way. So I was confused. It is a two-page document, I think?
A. No, it is just a one page.
Q. Okay.
A. That other document you have in your hands, if I can look at it --
Q. Sure.
A. -- I believe has to do, yes, that is a part of the baby's chart. Although it is stamped with the mother's name on there, it is actually a part of the baby's chart.
Q. Okay. On the Delivery/Infant Data Sheet, is there anything on this particular sheet -- we won't mark it unless the answer is yes -- that was recorded by yourself?
A. Yes.
Q. Okay.
(Deposition Exhibit D was marked for identification.)
Q. All right. Handing you what has been marked

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Deposition Exhibit D. Here. There is yours.
A. Okay. You want me to look at this one? We have a copy too.
Q. That's okay. We will mark it an exhibit for the deposition.
Tell me what on this particular Delivery/Infant Data Sheet is recordation made by yourself.
A. Up under physical exam, those two arrows indicating all of those physical areas were normal, I made those marks there. Under the area where it talks about the placenta, I marked that it was expressed. And I marked the estimated blood loss at 400. Then my signature is below that.
In the next column over under "Delivery Data" I marked the "vaginal," "spontaneous" and "VTX"; the "ML" for "episiotomy"; and the "none" for "laceration"; and then the "nuchal times one tight," I wrote that in that column. Then in the column past that where it says "Intrapartum Problem List," I marked "late passage of meconium" and "stillbirth." Then I put the comment that the "Infant's nose and oropharynx suctioned with deelee prior to birth of baby - cord tight, double clamped and cut before birth of body."
Q. Ms. Morgan, how long did the second stage of labor last in this case?

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A. Approximately two hours.
Q. Okay. Do you have any protocols to address at what point in the second stage of labor a physician ought to be called in?
A. I would say there is probably not a hard-and-fast rule about it. But, generally speaking, if it is significantly in excess of two hours, we would consult with -- I would consult with one of the physicians, at least to just let him know what was happening.
Q. To clarify what you just said, are you not aware of any national standards promulgated by your organization that indicate a time line about second stage of labor and when an attending physician should be called in?
A. I am aware that there is some, I guess, ongoing controversy about the management of second stage of labor as opposed to sort of an active management of it versus a more passive or laissez faire, or whatever term you want to use; in some cases, that there is disagreement as to whether the patient ought to begin to push as soon as she is completely dilated versus when she begins to feel some urge to push. And there can be a lengthy time between the two of those.
Q. In this case, the patient had an urge to push at about 1:30 a.m. Is that right?
A. Oh, no. I --

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Q. All right. I might be misquoting it. We will go and find it.
A. The patient had the urge to push and began to push at around . . .
Q. 1:10 a.m.?
A. Okay. Well, she didn't start pushing at that point.
Q. Right. But we are discussing the issue of the urge to push and what you are --
A. Well, and it would have to be -- well, I guess I should clarify perhaps.
Q. Let's take a look in the Nurses' Notes.
A. That you would have to be completely dilated and have an urge to push would be the beginning of the second stage.
Q. Okay. She was completely dilated at what time?
A. Let me look at the notes.
Q. Now I am asking you a bunch of questions at once. Withdraw everything I asked except for what time, based upon the documentation of the chart, was she completely dilated?
A. Based on what this paper here says, 4:50.
MR. RANKIN: AM.
A. AM, yes. Since they use 24-hour time, it would be 1600 or something if it was 4:50 p.m.
Q. Okay. I accept that is what is documented. Because

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there is a note that the patient is complete at 4:50 in the narrative portion of the notes.
A. Yeah. I am looking back here.
Q. But in the written portion of the nursing notes, at 1:10 a.m., 0110, do you see that she is feeling increasing pressure and an urge to push?
A. At that point, it does say, yes.
Q. Okay. Were you informed of that?
A. (The witness did not respond.)
Q. First of all, this is a nurse that is recording these notes?
A. That's correct.
Q. Okay. The nurses report to you. Correct?
A. That's right.
Q. Okay. Do you have any criticism there is anything about this labor that any of the nurses at MedCentral failed to report to you?
A. No, I don't.
Q. All right. What did that imply to you that your -- that your client -- your client -- that your -- my client, your patient -- the patient had this urge this early on before she was completely dilated? Did that mean anything to you?
A. Generally it means the baby is moving down in the pelvis. It can also mean, depending on the patient, that

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she is . . . It is not untypical for there to be a lot of pressure as the baby moves down into the pelvis and the cervix dilates more. This patient had an epidural anesthetic, so she was pretty numb. And it may just also have meant that she wasn't getting as much analgesia from the epidural as she previously received.
Q. What time did you finish running the Epidol during this?
A. She had it during the point of the delivery.
Q. At what point was the oxytocin stopped?
A. When the baby was born. I don't recall. Probably at the time when the baby was born.
Q. Okay. You were aware, I gather, based upon the report you received, that the patient did have a temperature on presentation?
A. She had a temperature during part of the labor, yes. She always had a temperature; but, I mean, an elevated temperature.
Q. An elevated temperature?
A. They always have a temperature.
Q. It looks like it was closer to midnight the elevated fever was noted. She was given Ampicillin. Is that right?
A. That's correct.
Q. Would you have an idea of what would have caused the

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elevated temperature? You don't know at that time. But as the nurse/midwife factoring that, what could possibly cause that elevated temperature?
A. Whenever you have someone in labor, there is risk of infection.
Q. Chorea? Or some other?
A. Chorea would be one possible infection. And also, certainly, some type of like maternal urinary tract infection or an upper respiratory. But some type of infection in the mother's body. Also, patients sometimes become slightly febrile. When it goes up a low amount like this, it is because of dehydration or lots of coverings and things on them or just the epidural anesthetic itself.
Q. Okay. And did the physician order the Ampicillin?
A. Uhm, it is a part of our sort of standing orders that if the patient has an elevation of temperature, that she can receive Ampicillin, or if they are allergic to that, another antibiotic.
Q. So you did not have to personally call a physician and bring to their attention she had an elevated temperature. Is that correct?
A. That's correct.
Q. And do you have any knowledge one way or another as to if one of your -- I don't know to call them your

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partners -- if one of the attending physicians in your group was advised of the elevated temperature?
A. I am not aware of that. I didn't specifically do that.
Q. What nurses, based upon the handwriting or the Nurses' Notes section, were present and helping you out with this delivery?
A. Uhm, there is a . . . I can't read her writing here, but I know her name is Ralene. I can't read the last part of her signature. Her -- the first name is Ralene.
And then there is a Sheryl Bammann. I believe it is S, is the first initial, and I believe the first name is Sheryl.
Q. So the Sheryl part is at the top part, if we are on the page starting 1900 and goes to . . . ?
A. Yeah. That is right.
Q. So that is Sheryl. And starting at 2220, you think that is Ralene?
A. Yeah, at 2220, that is Ralene. I don't know what the last name is, actually. It may be more easy to read . . . I can't read it from here. I don't recall what her last name is.
Q. Okay. I would like to ask you a couple questions. After Dylon was delivered and you went back to write your

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dictation or to dictate your dictation, however . . .
Do you dictate it?
A. I dictated it.
Q. Or hand write it?
A. I dictated it.
Q. Do you go back and look at the Nurses' Notes as well as the charting?
A. I look at the Nurses' Notes and what the delivery record said, this Delivery/Infant Data Sheet.
Q. Had you worked closely with these two nurses previous to this particular delivery?
A. Actually, my recollection, if it is correct, they were both reasonably new nurses within the unit.
Q. Okay. So I am going to ask you something that I saw that I was confused by and wondering if you have an explanation. If you don't, that is fine. There are two continuous pages of nursing notes that now have been written by a person whose handwriting you have identified as Ralene. Do you see where the first one starts? 1900 at the top and 0705 at the bottom. Do you have that page?
A. Uhm-hum.
Q. Then there is another page that starts at 710 and goes through 717 also Ralene's handwriting. Do you see that?
A. Yes. But that is not here.

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Q. Is it in your book?
A. It is here but it is not in this place. I am going to have to flip to another.
Q. Not in the Nurses' Notes?
A. Well, they have got the Nurses' Notes sort of . . .
For some reason, that is with the newborn records, but I don't understand why that is.
Let's go back here.
Yes, okay.
MR. RANKIN: That is . . . Should that be . . .
THE WITNESS: Actually, this paper here ought to be . . .
Can we just move this one up there? Because that is really where that one ought to be in my mind. Because it is not really directly a part of the baby section. Which, actually, this one here is a part of that, too.
And this is the mother's monitor strip, not the baby's heartbeat strip. Do you want me to take that one out too?
MR. RANKIN: Yes.
THE WITNESS: All right. Then that is about the baby.
So this one we will stick here, because

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that is the only place to put that. Then just so we have everything in some order. Okay.
Q. Okay. Is there yet a third person charting within these two pages?
A. (The witness did not respond.)
Q. Sheryl, Ralene, and then towards the bottom of that first sheet there is another looks like a different name, but that could just be because I don't know how to read.
A. I think the only people --
Q. Bammer? Something?
A. Oh, yeah. That is the Bammann girl, the lady that she just . . . This is just how she sort of scrunched her name in there.
Which line are you talking about?
Q. Wish we had a Bate stamp copy. The one that starts at the top.
A. Yeah, but which page? Where are you saying somebody's writing is at?
Q. Right there.
A. The same person's writing. She has just written it a little differently. But that is her.
Q. She has been writing since when?
A. Well, she started to writing here.
Q. At 0649?
A. Yes. And then she wrote 0659, 0701, 0705, and

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then --
Q. What was her job?
A. She was one of the labor and delivery nurses.
Q. So you had three labor and delivery nurses in there?
A. Well, there were two present at the time of the delivery. That is the routine thing. Ralene was one, and Sheryl was the other one.
Q. Okay. Well, let me show you the reason I am asking is we have got charting here. Okay?
A. Uhm-hum.
Q. Okay. Starting here and goes through 705, written by Ralene for 1, 2, 3, 4, 5, 6, 7, 8 lines. Then this one starts writing, on the next page, after the delivery, at 7:17 when the baby is no longer with us, we have got charting again starting at 0515.
A. Uhm-hum.
Q. Do you know when this charting was written into the chart? Was it after the baby died someone came in and wrote these notes?
A. It says "out of sequence," so I am not sure exactly when they were written.
Q. Show me where that is.
A. "OOS" on this page here.
MR. RANKIN: 17.
A. It says after this sticker is placed there, then

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this initial "OOS" means out of sequence.
Q. Okay. I did not know that.
A. So that is what these --
Q. Who wrote these out-of-sequence notes?
A. That is Ralene's handwriting.
Q. Do you know if Ralene wrote out-of-sequence notes after the baby was born?
A. I have no idea. I didn't tell her to and she didn't share with me any reason she might have written that. She wrote on the next page here, a new page it looks like.
Q. I see it. Goes all of the way up through the time of delivery?
A. Uhm-hum.
Q. Okay. Now, there is a question I want to ask you. On the last page that Ralene writes.
A. Uhm-hum.
Q. Okay? That second page where it says, I guess it says "over," and this ends up being the over?
A. Right. This is the over.
Q. Continue?
A. Continue.
Q. It says 6:30?
A. Uhm-hum.
Q. "Dr. Wilson at nurses' station inquiring about patient's condition. Given update about patient's

condition and failure to progress." Do you see where it says "failure to progress"?
A. Yes. That is what she wrote there, yes.
Q. Okay. Would you agree this patient, based upon that second stage and then her attempts to deliver, was having a failure to progress?
A. No, I wouldn't agree with that statement at all.
Q. Okay. So you wouldn't agree with that statement?
A. No.
Q. You didn't talk with Dr. Wilson. This nurse did. Is that right?
A. Well, apparently she did, yes.
Q. Okay. And, once again, I think you have answered it, but I want to make sure that the record is clear, since I am doing this without assistance of my associates today. You never called Dr. Wilson to tell him there was a finding of meconium at 5:10 in the morning?
A. No, I did not.
MS. TAYLOR-KOLIS: Okay. I don't have any further questions for you.
THE WITNESS: Okay.
MS. TAYLOR-KOLIS: You have the right to read the deposition. And I am going to insist that you do.
THE WITNESS: Okay. Well . . .

MS. TAYLOR-KOLIS: I never let people waive their signatures.
THE WITNESS: That is fine.
MR. RANKIN: Me either. We can agree on that.
THE WITNESS: I want to read it.
(This deposition concluded at 11:27 a.m.)
* * * * * * * * * * *

ERRATA SHEET

STATE OF OHIO :
: ss:
COUNTY OF RICHLAND :

I, the undersigned, SUSAN MORGAN, do hereby certify that I have read the foregoing deposition and that, to the best of my knowledge, said deposition is true and accurate with the exception of the following corrections listed below:

PAGE	LINE NO.	CHANGE/CORRECTION	REASON FOR CHANGE

_____
SUSAN MORGAN

Sworn to before me and subscribed in my presence this _____ day of _____, 2002.

_____

NOTARY CERTIFICATE

STATE OF OHIO :
: ss:
COUNTY OF RICHLAND :

I, Catherine Lee Boyer, Registered Professional Reporter, Registered Merit Reporter, and Notary Public in and for the State of Ohio, hereby certify that there came before me SUSAN MORGAN, who first duly swore to tell the truth, the whole truth, and nothing but the truth in the case aforesaid; that the testimony was recorded by me in stenotypy and was afterwards transcribed using a Computer-Aided Transcription System; that the deposition is a true record of the testimony given by the witness; and that the transcript has been prepared for the witness' review and signature.

I further certify that I am neither attorney for, nor related to or employed by, any of the parties to the action in which this deposition is taken; that I am not a relative or employee of any attorney employed by the parties hereto or financially interested in the action; and that I am not, nor is the court reporting firm with

which I am affiliated, under a contract as set forth in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and seal at Mansfield, Ohio, this 20th day of April, 2002.

Catherine Lee Boyer, RPR, RMR
Notary Public, State of Ohio
My commission expires 7-17-03.

Certified Nurse Midwife Guidelines

Certified Nurse Midwives (CNM) with privileges at MedCentral Health System may practice according to the guidelines and protocols established by Department of Obstetrics/Gynecology, at MedCentral Health System.

Definition - Certified Nurse Midwife means a registered nurse who holds a valid Certificate of Authority issued by the Ohio Board under Section 4723.42 of Ohio Revised Code.

Scope of Practice - Section 4723.43 - of Ohio Revised Code.
A nurse authorized to practice as a Certified Nurse Midwife in collaboration with physicians, may provide the management of preventive services and those primary care services necessary to provide health care to women antepartally, intra-partally, postpartally and gynecologically consistent with the nurse's education and certification, and in accordance with rules adopted by the Board.

No certified nurse midwife may perform version, deliver breech or face presentation, use forceps, do any obstetric operation, or treat any other abnormal condition, except in emergencies. Division (A) of this section does not prohibit a certified nurse midwife from performing episiotomies or normal vaginal deliveries, or repairing vaginal tears.

Qualifications

- Licensure as a registered nurse in the State of Ohio.
- Graduation from a nurse-midwifery education program approved or recognized by the American College of Nurse-Midwives.
- Certification in nurse-midwifery from the American College of Nurse-Midwifes, signifying successful passage of the national examination.
- Licensure in nurse-midwifery from the Ohio State Medical Board.
- Liability coverage.

Approved Privileges -

- Uncomplicated prenatal care.
- Supervision of uncomplicated laboring patients.
- Application and interpretation of indirect and direct fetal monitoring equipment and tracings.
- Spontaneous vaginal delivery of singleton infants in vertex position.
- Episiotomy and repair.
- Amniotomy.
- Repair of vaginal laceration.
- Repair of periurethral laceration.
- Repair of 1st and 2nd degree perineal lacerations.
- Repair of 3rd degree perineal lacerations with approval of attending physician.
- Uncomplicated postpartum care.
- Childbirth education.
- Childcare education.
- Screening of GYN & OB patients in the E.D.

All orders written by the (CNM) will be written as verbal orders/telephone orders from their supervising physician.

Any questions or concerns related to practice issues should be addressed with the (CNM). If unable to resolve the issue, contact the supervising physician. If question remains unresolved, the Chief of Obstetrics should be consulted.

The Certified Nurse Midwife will adhere to the policies and procedures, and requests for changes in policies and procedures will go through correct channels and be approved before implementation.

Approved 8-19-97 by O.B. GYN Section Committee.

Standard Care Agreement - A Standard Care Agreement between each certified nurse midwife and the collaborating physicians will be retained on site at MedCentral Health Care System.

A physician listed with whom the certified nurse midwife has entered into a standard care agreement must be continuously available to communicate either in person, or by telephone. The designated physician (by plan) must be readily available in instances of emergency.

MEDCENTRAL HEALTH SYSTEM
POLICY/PROCEDURE MANUAL

TO: ALL NURSING PERSONNEL	SUBJECT: ADMISSION OF PATIENT IN LABOR	
POLICY DESIGNATED: [ ] SYSTEMWIDE [X] MANSFIELD [ ] CRESTLINE [X] SHELBY		
PREPARED BY: MEDCENTRAL NURSE EXECUTIVES	FILE: A PAGE 1 OF 5	NURSING MANUAL __ VOLUME 1 (ADM) __ VOLUME 11 (CLINICAL) _X_ SPECIALTY: MATERNAL CHILD HEALTH
APPROVED BY: VICE PRESIDENT OF NURSING J Plaster		
DATE WRITTEN: 11/7/80	REVIEWED:	REVISED: 4/96 11/97 2/00

I. PURPOSE:

A. To insure a safe environment and safe delivery for the laboring woman and infant.

II. GENERAL INFORMATION:

A. When a prospective patient presents herself to the Delivery Unit, a few pertinent questions and observations by the admitting nurse can usually determine if the patient should be admitted or merely examined on an out-patient basis.

III. POLICY;

A. Nursing assessment to determine whether a patient is in labor is to be done by a nurse well equipped with the skills and experience necessary to perform this task.

B. If STD profile has NOT been done during pregnancy, do it prior to using K-Y Jelly with a vaginal exam.

C. Vaginal examination should be done by an R.N. on admission. If patient states her membranes are ruptured and she is obviously not in labor, call the physician before vaginal exam. If patient states membranes are ruptured and she is obviously in labor, examine before calling physician. Vaginal exam should be deferred if excessive vaginal bleeding or premature labor is present.

D. Nursing personnel will wear protective disposable gloves when in contact with body fluids.

E. See procedure for use of Perinatal Forms.

MATERNAL CHILD HEALTH MANUAL	SUBJECT: ADMISSION OF PATIENT IN LABOR	PAGE: 2

IV. EQUIPMENT:

A. Patients prenatal record (kept in designated drawer at nurses' station in Labor & Delivery)
Assembled chart for Labor and Delivery
IVAC (Thermometer)
Fleets enema, prn
Fetoscope or doppler
Stethoscope and B.P. cuff/Vital Signs Monitor
Sterile glove for vaginal exam
Lubricant
Fetal monitor
Nitrazine paper (to assess rupture of membrane)
Physician's routine order card (in file at desk)
Protective Disposable Gloves

V. PROCEDURE:

NURSING ACTION	IMPLEMENTATION
1. Greet patient and support person	a. Convey a feeling of welcome and security. Assume a relaxed attitude.
	b. See procedure for support person.
2. Orient patient to room	a. Explain use of Birth Room/Labor Room to patient and support person.
	b. Explain procedures to be done during laboring process.
3. Request prenatal blood tests for patients who have had no lab tests done	a. Request CBC, serology, HB_sAg, Rh factor and blood type STAT through HIS computer and notify lab by phone.
	b. Do STD profile and send to lab.
	c. Chart in Nurses' Notes.
4. Direct support person to Admitting Office (or E.D. Receptionist)	a. Explain necessity for going to Admitting Office or Emergency Department receptionist to obtain admitting information.
	b. Send with support person, an admission information slip with labor room number, patient's name, physician's name and signed hospital permit. (Shelby Hospital - post-partum room number)
	c. During hours from 2400 to 0700, direct support person to Emergency Department Receptionist with above information.

MATERNAL CHILD HEALTH MANUAL	SUBJECT: ADMISSION OF PATIENT IN LABOR	PAGE: 3

NURSING ACTION	IMPLEMENTATION - cont'd
5. Assist patient	a. Assist patient in getting undressed.
6. Direct support person to car patient's clothing and valuables	a. Explain that placing these items within the car and with locking it on admission will prevent the loss of items when patient is transferred from the Delivery Unit to the Mother/Baby Unit.
7. Complete nursing assessment	a. An assessment of E.D.C. gravida, para, membrane status and U.C. status will be completed immediately upon admission. Completion of the written assessment shall take place within 30 minutes of arrival to Labor and Delivery, as condition allows.
8. Determine and record cervical dilatation (see Policy Statement)	a. Explain procedure to patient. b. Remove sterile glove from wrapper, place on hand, maintaining sterility, and lubricate index and second fingers with sterile lubricant. c. Perform vaginal examination to determine dilatation while keeping patient draped with sheet. d. Record on Perinatal flow record, dialation, station and effacement.
9. Determine if membranes are ruptured, if indicated	a. Explain the procedure for test to patient. b. Place a strip of nitrazine paper between index and second finger of sterile gloved hand and insert fingers into vaginal opening. Do not use lubricant. c. A change in the nitrazine paper from yellow to blue is positive. d. Explain the "test" to patient.
10. Obtain and record FHR; apply fetal monitor as ordered	a. Apply monitor as ordered by physician, adjusting toco and phono until adequate tracing obtained. Explain monitor to patient and support person. b. If unable to maintain FHR, use doppler or external monitor, again listening in each quadrant of abdomen. c. Record FHR on Perinatal flow record.

MATERNAL CHILD HEALTH MANUAL	SUBJECT: ADMISSION OF PATIENT IN LABOR	PAGE: 4

NURSING ACTION	IMPLEMENTATION - cont'd
11. Take blood pressure, temperature, pulse, and respirations.	a. Take blood pressure, temperature, pulse, and respirations. 1. Vital Sign monitor may be applied. b. Record on Perinatal flow record.
12. Notify physician of admission	a. Notify doctor of admission, relating all observations and findings and transcribe orders. b. Transcribe orders from file card, if ordered.
13. Administer Fleets	a. Administer Fleets enema if enema, prn ordered by physician and/or at patient's request. b. Record in Nursing Notes.
14. Notify Nursery and Maternity	a. Notify Nursery of patient admission and pertinent history (i.e. RH, breast/bottle feeding, pediatrician, positive group B strep, substance abuse). b. Notify post partum if patient is to have Cesarean Section, is hypertensive, has herpes or other infectious processes.
15. Determine if information on identification bracelet is correct	a. Ask patient if spelling and information on patient's bracelet is correct before addressographing chart.
16. Prepare chart	a. Record time and mode of admission on Nurses' Notes. b. Describe any vaginal discharge, patient's response to labor and physician notified on Nurses' Notes. c. Record observations and patient's statements on narrative Nurses' Notes. d. Addressograph chart and arrange in order.
17. Complete Nursing Office Report and census sheet	a. Write patient's name, gravida & para, time of admission, and time & type of delivery if applicable on Nursing Office Report. b. Write patient's name, physician's name and time of arrival on census sheet.
18. Support people may stay with patient	a. When support people return from Admitting Office, they may stay with the patient. b. Support people should keep other visitors informed of patients progress.

MATERNAL CHILD HEALTH MANUAL	SUBJECT: ADMISSION OF PATIENT IN LABOR	PAGE: 5

NURSING ACTION	IMPLEMENTATION - cont'd
19. Initiate patient classification	a. Enter patient's name on Patient Classification Sheets.
20. Patients with no prenatal care or less than four prenatal visits	a. Enter date, patient hospital number, race, and no or little prenatal care in Data Collection Sheet, for state statistics.

Approved by C. Kaple & D. Rinehart - October 28, 1997
Approved by Carolyn Kaple RN 2-18-00

MEDCENTRAL HEALTH SYSTEM
POLICY/PROCEDURE MANUAL

TO: ALL NURSING PERSONNEL	SUBJECT: CARE OF PATIENT IN LABOR	
POLICY DESIGNATED: [ ] SYSTEMWIDE [X] MANSFIELD [ ] CRESTLINE [X] SHELBY		
PREPARED BY: MATERNAL CHILD HEALTH DEPARTMENT	FILE: L PAGE 1 OF 4	NURSING MANUAL __ VOLUME 1 (ADM) __ VOLUME 11 (CLINICAL) _x_ SPECIALTY: MATERNAL CHILD HEALTH
APPROVED BY: VICE PRESIDENT OF NURSING J Plaster		
DATE WRITTEN: 10/87	REVIEWED:	REVISED: 11/97 2/99 2/00

I. PURPOSE:

A. To ensure the optimal level of comfort and safe environment for the laboring woman as well as a safe delivery of the infant.

II. NURSING POLICY:

A. R.N.'s and L.P.N.'s may care for laboring patient.
L.P.N.'s, however, may not perform vaginal exams.

B. Wear protective gloves when in contact with body fluids.

III. EQUIPMENT:

FLOOR STOCK
- Chart
- Monitor (EFM/IFM)
- Sphygmomanometer
- Stethoscope
- Fetoscope (prn)
- IVAC thermometer
- IV equipment
- Ice water pitcher
- Paper sack
- Foley Catheter PRN
- Sterile examining gloves
- Sterile lubricant (surgilube)
- Nitrazine (prn)
- Amnihook (prn)
- Fetal scalp lead (prn)
- Intrauterine pressure catheter (prn)
- Protective gloves
- Space Lab Monitor PRN

ADMITTING
- Identification bracelets for mother and newborn

IV. PROCEDURE:

NURSING ACTION	IMPLEMENTATION
1. Assessment	a. TPR q 4 hrs and prn, blood pressure q 1 hr. Notify physician if not in normal limits.

NURSING ACTION	IMPLEMENTATION
	b. Record fetal heart rate (FHR) q 15 minutes during first stage. If not on a monitor, auscultate q 15 minutes in first stage, q 10 minutes in second stage. If FHR obtained by ausculatation it should be done contraction, et. el., for 1 minute after contraction. Apply internal fetal monitor (IFM) if rupture of membranes (ROM) prn. Notify physician of FHR changes, if warranted.
	c. Assess monitor strip for uterine activity q 30 minutes and determine intensity by abdominal palpation.
	1. If monitor not available, determine uterine activity by palpation.
	NOTE: If monitor unavailable, the physician decides which patient has priority.
	d. Determine cervical dilatation, effacement, and station of presenting part as indicated by signs of labor per procedure.
	e. Assess FHR and amniotic fluid with SROM or AROM. Take FHR q 5 minutes X 3 and document.
	f. Completion of the written assessments shall take place within 30 minutes of arrival to Labor and Delivery. An assessment of E.D.C. gravida, para, membrane status, VBAC, and U.C. status will take place immediately upon arrival to Labor and Delivery.
2. Physical care	a. Encourage ambulation in early labor per physician's order. Instruct patient to remain within obstetric area.
	b. Provide perineal care and oral hygiene prn.
	c. Encourage to void frequently - check for bladder distention, catheterize prn. Insertion of #16 foley catheter is preferred for patients with epidurals. Inflate bulb with 5cc of sterile water.
	d. Provide privacy.
	e. Assess pain level and, depending on status, suggest diversional activities: effleurage, pelvic rock, back massage, position changes, give pain medicine if indicated, visual imagery, Lamaze breathing techniques.
	f. Call CRNA or anesthesiologist to initiate epidural anesthesia per physician's order.

NURSING ACTION	IMPLEMENTATION
	g. Provide atmosphere adjustments as needed, i.e., dim lights, lower sound in TV, etc.
	h. May offer vaseline for chapped lips.
	i. Offer comfort measures i.e., cool washcloths and lines changes prn.
	j. Use side rails as needed.
3. Emotional and psychological care	a. Inform patient and support person of labor progress.
	b. Encourage and praise patient's efforts.
	c. Reassure patient and support person that efforts of labor are effective.
	d. Relieve support person if needed.
	e. Remain with patient and support person as needed.
	f. Inform patient of reasons for request of position changes, O_2 etc., whether for progress of labor or FHR changes.
	g. Instruct on pushing techniques and use of labor bar when needed.
4. Provide nutrition and hydration	a. Offer ice chips. Explain why only ice chips.
	b. Maintain IV fluids.
	c. Be aware of patient's urinary output, increase IV as appropriate.
5. Appropriate documentation locations TPR & BP	Labor Flowsheet.
Dilatation, Effacement Station	Labor Flowsheet.
Uterine frequency, duration and intensity	Labor Flowsheet
FHR	Labor Flowsheet
Patient Activity	Nurses' Notes; fetal monitor strip
Voiding	Nurses' Notes: I&O Sheet

MATERNAL CHILD HEALTH MANUAL	SUBJECT: CARE OF PATIENT IN LABOR	PAGE: 4

NURSING ACTION	IMPLEMENTATION
IV	Labor Flow & MAR
Analgesic/Anesthesia	Labor Flow
ROM (date & time) with FHR x 3	Labor Flowsheet; Delivery/Infant Data Sheet; Fetal monitor strip; Nurses' Notes.
Emesis	Nurses' Notes; fetal monitor strip; I & O Sheet.
Complete dilatation	Labor Flow & Delivery/Infant Data Sheet; fetal monitor strip.
Time of Delivery	Labor Flow & Delivery/Infant Data Sheet, Newborn Record, fetal monitor strip.
Apgar Score	Delivery/Infant Data Sheet; Newborn Record, Birth Assessment.

REFERENCES:

Olds, Sally; London, Marcia L.; Ladewig, Patricia A. "Maternal-Newborn Nursing - A Family-centered Approach", 2nd edition, 1984, Addison-Wesley Publishing Company

Approved by Carolyn Kaple - November 13, 1997
Approved by Carolyn Kaple - February 10, 1999
Approved by Carolyn Kaple RN 2/9/00

Guideline of Care for the Labor and Delivery Patient:

Admission Nursing Intervention:

Complete admission assessment
Record information in appropriate spaces on Cleveland Perinatal Forms 4, 5, 6, 8
Perform vaginal exam
Obtain vital signs
Notify physician of admission status

Ongoing Labor Care Interventions:

Keep physician aware of patient status

VS - TPR q4h, BP at least q1h and prn

FHR - See page 2
Obtain q 15 minutes and prn on patients on Pitocin, $MgSO_4$ infusions
Obtain immediately following ROM (spontaneous or artificial) and q 5 minutes x 2
Notify physician of ominous or non-reassuring FHR patterns

Vaginal Exam -
Note cervical dilation, effacement, station of presenting parts, and any abnormal findings (i.e., large amount bloody discharge, unusual ordor, change in color of vaginal discharge, etc.)

Hydration -
Provide fresh ice chips
Initiate and maintain base IV line and observe site, rate and solution q 2h as long as IV is needed
Bolus with up to 1000cc L/R per order for pre-epidural hydration, increased temperature or FHR decels

Elimination -
Encourage voiding q2h on bedpan or toilet (may be ambulator as condition warrants)
Catherize prn if unable to void and bladder is distended
Insert foley catheter if has received epidural anesthesia

Emotional Support -
Provide for support person and patient
Keep patient and support person informed of labor progress
Inform of procedures the patient can expect

Pain Control -
Provide comfort measures (positioning, cool wash cloths, ambulation, and chair sitting as condition warrants, review and encourage appropriate breathing techniques)
Administer analgesics and sedatives as ordered
Notify CRNA's of patient desire for epidural
Assist CRNA with epidural administration
- Apply EKG monitor, NIBP cuff, pulse oximeter
- Obtain and interpret pre and post-epidural EKG strips

MEDCENTRAL HEALTH SYSTEM
POLICY/PROCEDURE MANUAL

TO: ALL NURSING PERSONNEL	SUBJECT: DELIVERY ROOM PROCEDURE	
POLICY DESIGNATED: [ ] SYSTEMWIDE [X] MANSFIELD [ ] CRESTLINE [X] SHELBY		
PREPARED BY: MATERNAL CHILD HEALTH DEPARTMENT	FILE: D PAGE 1 OF 6	NURSING MANUAL __ VOLUME 1 (ADM) __ VOLUME 11 (CLINICAL) _X_ SPECIALTY: MATERNAL CHILD HEALTH
APPROVED BY: VICE PRESIDENT OF NURSING J Plaster		
DATE WRITTEN: 3/26/81	REVIEWED: 7/95	REVISED: 6/96 11/97 2/00

I. PURPOSE:

A. To prepare patient for delivery.

B. To administer nursing care to the patient.

C. To assist the physician.

D. To care for the infant and transport to the Nursery.

II. POLICY:

A. This procedure is carried out by a registered nurse with assistance of L.P.N. and unit clerk.

B. All personnel entering the Delivery Room during a delivery are to be appropriately garbed in scrubs or cover gown, cap, mask.

C. Protective gloves should be worn throughout care of mother and newborn.

D. **Mansfield** - Patient may be delivered on Stryker bed or delivery table, if requested by physician.

III. EQUIPMENT:

Delivery Room set up
Infant warmer
Medications
Patient's chart
Labeled monitor tracing envelope
Protective gloves
Delivery charge sheet
Infant charge sheet

MATERNAL CHILD HEALTH DEPARTMENT MANUAL	SUBJECT: DELIVERY ROOM PROCEDURE	PAGE: 2

IV. PROCEDURE:

NURSING ACTION	IMPLEMENTATION
1. Provide privacy	a. Close door to delivery room.
2. Transfer patient from cart to Delivery Room table if requested by physician	a. Do not leave patient alone at any time.
	b. Record time of transfer on Delivery/Infant Data Sheet as per guidelines.
	c. Keep all monitor tracings in envelope. Place in designated area.
	d. **Mansfield** - If epidural anesthesia initiated in last 15 minutes, move SpaceLab monitor into delivery room with fetal monitor and resume monitoring of mother and infant.
	e. Record FHR q 10 minutes if not monitored.
3. Admit support person into Delivery Room	a. Admit support person in suitable attire.
	b. See procedure for Support Person in Birthing Suite.
4. Prepare patient for delivery	a. Explain procedures progressively to patient and support person.
	b. **Mansfield** - If patient has epidural catheter in place, call CRNA to give loading dose and to stand by for delivery.
	c. If patient is to have a Pudendal Block, add medication of physician's choice to Pudendal Tray.
	d. Line stirrups with terry cloth pads. Place legs in stirrups, being careful not to cause any undue pressure or strain on legs when positioning stirrups.
	e. Instruct patient as to sterile fields and caution her not to touch these areas.
5. Circulating for the delivery	a. Remove cover drapes from instrument table and bipod pans. Place one of these drapes over the infant warmer so that sterile side is up.
	b. Break the table/bed (Handles are at the top end of delivery room table).

MATERNAL CHILD HEALTH DEPARTMENT MANUAL	SUBJECT: DELIVERY ROOM PROCEDURE	PAGE: 3

NURSING ACTION	IMPLEMENTATION
	c. Scrub perineum with Betadine Scrub and sterile water. Change gloves for further care.
	d. Tie physician's gown.
	e. Adjust overhead light.
	f. Adjust overhead mirror for patient and support person.
	g. Prepare oxytocin drugs (see wall chart for physician preference) and/or give as ordered by physician.
6. Document	a. Chart time of birth on intrapartum problem list, perinatal flow record, and time and sex on intrapartum data and newborn record.
	b. Chart medications, time given and site of injection on medical record.
	c. Cord blood - See Cord Blood Collection procedure for RH negative mothers.
	d. Chart necessary information as called for on the medical record.
	e. Circulating R.N. will assign apgar scoring at one (1) and at five (5) minutes after birth. Record on medical record.
	f. It is the physician's responsibility to chart duration of labor, admission physical examination at designated areas on Delivery/Infant Data Sheet.
7. Care of infant	a. Depending on condition of the infant, the physician will either place the infant on the mother's chest for skin-to-skin contact or place in the infant warmer for closer observation. If infant needs closer observation, institute a narrative Nursing Note to reflect evaluation and care. Do not cover with a blanket when under radiant warmer. If infant in warmer for extended length of time, check temperature every 15 minutes.
	b. Should there be any respiratory problems with an infant, institute neonatal resuscitation as indicated. Call Respiratory Therapy for assistance as necessary.

MATERNAL CHILD HEALTH DEPARTMENT MANUAL	SUBJECT: DELIVERY ROOM PROCEDURE	PAGE: 4

NURSING ACTION	IMPLEMENTATION
	c. To avoid chilling and/or loss of body heat, make sure that infant has been thoroughly dried and place cap on infant's head and place pre-warmed blanket over infant when placed on mother's chest.
	d. Obtain bulb syringe from physician. Aspirate infant as needed.
	e. Observe infant for anomalies.
	f. If condition of infant permits, support person may hold infant wrapped in blanket at this time.
	g. Identify infant (see procedure for Infant Identification).
	h. Document infant's condition q 15 minutes until transfer to Nursery as follows: - Fifteen (15) minutes after birth, note on newborn data, the infant's condition. (TPR) - Within thirty minutes after birth, take axillary temperature, HR and respirations of infant. Document on newborn record. Observe gross appearance of infant and document on newborn record, the color, cry and tone of infant. - Forty-five minutes after birth, note on newborn record, the infant's condition, Ax. & T, PR.
	i. Prepare infant for transfer as follows: - Note quality of Mother-Infant interaction on newborn record. - Note any pertinent information about infant on newborn record. Include special procedures to the infant while in Delivery Room (drugs, O_2).
	j. Document time of transfer, mode of transfer and condition of infant at time of transfer on newborn record.
8. Care of mother after delivery	a. After physician has removed drapes, return table to proper position.

MATERNAL CHILD HEALTH DEPARTMENT MANUAL	SUBJECT: DELIVERY ROOM PROCEDURE	PAGE: 5

NURSING ACTION	IMPLEMENTATION
	b. Remove legs from stirrups and/or foot supports.
	c. Cover patient with a blanket.
	d. Transfer mother to designated recovery area or continue recovering in delivery room. Do not leave patient on delivery table unattended.
	e. Follow procedure for Recovery of Patient - Vaginal Delivery.
9. Transfer infant to Nursery	a. Wrap infant in blanket and place in crib/radiant warmer. Support person may assist by pushing the crib to the Nursery.
	b. Report to Nursery nurse any pertinent information concerning infant (PROM, assisted ventilation, etc.)
	c. The Nursery nurse will identify infant before removing it from crib/radiant warmer.
	d. She will then weigh infant, telling the Birthing Suite personnel and parents the weight.
	e. Infant's weight is recorded on medical record.
	f. **Mansfield** - The Birthing Suite personnel will then call Admitting Office from the Nursery and give the following information: name, sex, birth weight, time of birth, Pediatrician, and to which nursery the baby is admitted (Nursery or Special Care).
	g. Chart infant's hospital number on Delivery/Infant Data Sheet newborn record.
10. Transport mother to Maternity	a. The nurse in charge of Birthing Suite may designate someone to transport mother and infant to their respective areas.
	b. Document time of transfer, mode of transfer and condition of mother at time of transfer on Delivery/Infant Data Sheet.
	c. Mother's chart to accompany patient.
	d. Assist in transferring patient to postpartum bed.

MATERNAL CHILD HEALTH DEPARTMENT MANUAL	SUBJECT: DELIVERY ROOM PROCEDURE	PAGE: 6

NURSING ACTION	IMPLEMENTATION
	e. Report to Maternity nurse the following information: voiding, B.P., pulse, respirations, fundus check, amount of bleeding, any information pertinent to patient's labor, delivery or recovery, medications given, etc. Leave patient's chart with postpartum nurse.
11. Record delivery with infant's weight in Log Book	
12. **Mansfield** - Mark mother as a transfer out on census sheet	
13. Complete delivery information on Nursing Office Report	
14. Complete charging information on charge sheet	a. On charge sheet, enter all charge items used (monitor, cath. trays, medications).
	b. Fill in admission time.
	c. Fill in transfer time.
	d. Enter information in appropriate charge screens of H.I.S.
15. Complete Infant Charge Sheet	a. Note all charge items used for care of infant prior to infant transfer to Nursery.
	b. Enter information in appropriate charge screens of H.I.S.
16. Compile patient classification	a. Complete the Patient Classification form.

REFERENCE:

Standards for Obstetrics - Gynecologic Services, 6th edition, 1985

Approved by Jo Plaster - July 9, 1996
Approved by C. Kaple - December 31, 1997
Approved by Carolyn Kaple RN 2/9/00

MEDCENTRAL HEALTH SYSTEM
POLICY/PROCEDURE MANUAL

TO: ALL NURSING PERSONNEL	SUBJECT: CEPHALIC VERSION - NURSE'S ROLE IN	
POLICY DESIGNATED: [ ] SYSTEMWIDE [X] MANSFIELD [ ] CRESTLINE [X] SHELBY		
PREPARED BY: MATERNAL CHILD HEALTH DEPARTMENT	FILE: V PAGE 1 OF 4	NURSING MANUAL __ VOLUME 1 (ADM) __ VOLUME 11 (CLINICAL) _X_ SPECIALTY: MATERNAL CHILD HEALTH
APPROVED BY: VICE PRESIDENT OF NURSING J. Plaster		
DATE WRITTEN: 7/1/88	REVIEWED: 6/95 1/00	REVISED: 12/96 11/97

I. PURPOSE:

A. To convert a less favorable presentation to vertex in order to avoid breech delivery or Cesarean section.

II. GENERAL INFORMATION:

A. Criteria: External version should only be attempted under the following conditions:

1. No marked disproportion between fetus and pelvis.
2. The presenting part is not engaged.
3. There is sufficient quantity of amniotic fluid to permit easy movement of the fetus. The membranes must be intact to prevent prolapse of the cord.
4. Abdominal and uterine walls must not be highly irritable.
5. The fetal heart rate must be monitored.
6. Anesthesia should never be used lest undue force be applied.
7. The procedure must only be done in a labor/delivery unit where a rapid Cesarean birth can be performed if fetal distress develops.

B. Contraindications:

1. Cephalopelvic Disproportion
2. Third trimester bleeding
3. Low implanted placenta

C. Possible Complications:

1. Placental separation - partial or complete
2. Cord compression
3. Rupture of membranes with or without possible cord prolapse
4. Uterine rupture
5. Rh sensitization in Rh negative moms

III. EQUIPMENT:

FLOOR STOCK
Utility Room - 1000cc D5LRS, 500cc NS, IV blood administration Y set; IV solution set, IV start tray

Medication Cart - Ritodrine 150mg (Yutopar)

LABOR ROOM
Fetal monitor

BIRTH SUITE NURSES' DESK
OB outpatient records
OB inpatient chart - nurses notes, labor flow record, and intrapartum data sheet

IV. PROCEDURE:

NURSING ACTION	IMPLEMENTATION
1. Have patient void prior to procedure	
2. Apply external fetal monitor	a. Explain procedure to patient. b. Obtain baseline FHR and reactive NST prior to procedure.
3. Obtain baseline vital signs	a. T, P, R, FHR, and BP.
4. Prepare and start base IV as ordered by physician	a. Label IV bag and tubing. b. Start the IV with #18 angiocath, base IV rate 125cc/hr.
5. Place portable ultrasound where immediately available	a. Place unit in patient's room or just outside door.
6. Prepare IV Ritodrine solution	a. Mix according to Ritodrine Administration Procedure. b. Place tubing on Travenol pump. c. Using standard set and #21 needle for piggyback into mainline at closest portal to IV site. d. Start only when physician orders.
7. Place patient in Trendelenburg position	a. Position patient with head of bed lowered and foot of bed elevated.
8. Document fetal position by ultrasound	a. Assist physician by placing ultrasound near the patient's bed and supply gel.

NURSING ACTION	IMPLEMENTATION
9. Start IV Ritodrine	a. Administer IV Ritodrine via IV pump per Ritodrine Administration Procedure. Increase rate until maternal heart rate increases over 100.
	b. Continue continuous fetal monitoring - VS and FHR q 15 minutes and breath sounds q 1 hr.
	c. Physician will assess uterine relaxation prior to procedure.
10. Prepare for external version	a. When the uterus is relaxed, the fetal monitor transducer and Toco are removed and the fetus is rotated externally to vertex by the physician.
11. Assess fetal status	a. Position is confirmed by ultrasound by the physician.
	b. EFM is reapplied to monitor the fetal status.
12. Discontinue Trendelenburg	a. Return bed to horizontal position or reverse Trendelenburg per physician preference.
13. Discontinue IV Ritodrine	a. Discontinue Ritodrine infusion but maintain mainline IV at 125cc/hr rate until physician orders discontinued.
14. Assess uterine activity and fetal well being	a. Continue EFM, observe fetal well being and observe for any uterine activity for a minimum of 30 minutes.
	b. Vital signs should be taken and recorded immediately after procedure and q 30 minutes until discharge.
15. Discharge	a. Give patient homegoing instructions - inform physician if uterine contractions begin, if presence of vaginal bleeding, rupture of membranes, sudden increase or decrease in fetal activity or sudden pain.
	b. Discontinue monitor and IV only on physician's order.
16. Documentation	a. If patient is an in-house patient, record on nurses' notes, labor flow record, and intrapartum data sheet; for IV's and medications, charge on HIS system.
	b. If patient is an outpatient, record on OB record and charge through HIS system. Use homegoing instruction sheet for homegoing instructions.

MATERNAL CHILD HEALTH MANUAL	SECTION:	PAGE: 4

REFERENCES:

Olds-London-Ladewig, Maternal Newborn Nursing, A Family Centered Approach, Addison-Wesley Publishing Co., 2nd Ed., 1984 pp 585-586.

Pritchard-McDonald-Gant, Williams Obstetrics, Appelton-Century-Crofts, 17th Ed., 1985, pp 864-865.

American Journal of Obstetrics and Gynecology, External Cephalic Version of the Breech Presentation Under Tocolysis, April 1986, pp 900-903.

Obstetrics and Gynecology, Antepartum External Cephalic Version Under Tocolysis, Vol. 67, No. 1, Jan. 1986, pp 63-68.

Approved by Nicole Jung RN 10-8-97
CAK

MEDCENTRAL HEALTH SYSTEM
POLICY/PROCEDURE MANUAL

TO: ALL NURSING PERSONNEL	SUBJECT: USE OF PROSTAGLANDIN GEL (PgE-2) FOR CERVICAL RIPENING	
POLICY DESIGNATED: [X] SYSTEMWIDE [ ] MANSFIELD [ ] CRESTLINE [ ] SHELBY		
PREPARED BY: MEDCENTRAL NURSE EXECUTIVES	FILE: P PAGE 1 OF 3	NURSING MANUAL __ VOLUME 1 (ADM) __ VOLUME 11 (CLINICAL) _X_ SPECIALTY: MATERNAL CHILD HEALTH
APPROVED BY: VICE PRESIDENT OF NURSING J Plaster		
DATE WRITTEN: 9/88	REVIEWED: 1/00	REVISED: 9/96 9/97

I. PURPOSE:

A. To achieve cervical ripening (softening, effacement, and early dilation) prior to induction of labor.

II. GENERAL INFORMATION:

A. Prostaglandins are hormones which cause cervical ripening by enzymatic breakdown and solubilization of the collagen fibrils, changes in the biochemical composition, and increase of water content. Indications for use include: post maturity, pregnancy induced hypertension, IUGR, diabetes, anencephaly, and intra-uterine death. Tonic effect of Pg E-2 can be negated by the subcutaneous administration of Terbutaline or IV Ritodrine.

B. Requires an R.N. with expertise in use of FHR monitor and knowledge of effects and side effects of prostaglandins. The attending physician must evaluate the degree of physical ripening prior to use and q6h before repeating dosage. A qualified physician should be available to manage any complications.

III. PRECAUTIONS:

A. Do not use if have ROM, grandmultip, non-cephalic lie.

B. Gel must be refrigerated until used.

C. Gel may be inserted q6-12 hrs., with at least 6 hours between doses.

D. Do not start Pitocin induction till at least 6 hours from last dose of prostaglandins.

E. Complications may include uterine hypertonus resulting in fetal distress and uterine rupture, diarrhea, shivering, backache, and vomiting. All may be avoided by adjusting the volume of gel and application technique.

IV. EQUIPMENT:

Exchange Cart
- Sterile gloves
- Sterile speculum, if desired
- IV extension tubing (**Mansfield only**)
- 5cc syringe
- K-Y jelly

Pharmacy
- Prostaglandin Gel
- 2 mg per syringe

Birthing Suite Equipment
- Fetal monitor

Forms
- Observation chart
- Labor Flow Sheets (**Mansfield only**) and Nurses' Notes, as needed

V. PROCEDURE:

NURSING ACTION	IMPLEMENTATION
1. Instruct patient and procedure	a. Explain rational for procedure steps.
2. Apply Fetal Monitor	a. See procedure for "Application of Fetal Monitor".
	b. Monitor at least 20 minutes prior to medication with gel and then monitor continuously.
3. Prepare patient	a. Collect equipment at bedside.
	b. Position patient in lithotomy position, with clean underpads. Keep patient covered as much as possible.
	c. Give physician supplies as requested.
	d. Provide emotional support with appropriate breathing or relaxation technique.
	e. After procedure, reposition patient for comfort.
4. Activity	a. Bedrest as ordered, usually at least one (1) hour in flat position, then BRP or ambulatory if no regular U/C pattern.
5. Assess FHR, uterine contractions q 15 min., BP q 30 min. x 1 hour after Gel. Then BP, FHR & Uterine contractions q 1 hr. TPR q 4 hr.	a. FHR - report to physician any late decelerations, or significant changes in FHR pattern.
	b. BP - report to physician any significant change from admission BP.
	c. Palpate U/C's frequently. If uterine hypertonus, notify physician and have Terbutaline or Ritodrine available.
	d. If active labor or side effects from prostaglandin becomes evident (N/V, diarrhea, fever, chills), start baseline IV D$_5$LR at 125cc/hr.

NURSING ACTION	IMPLEMENTATION
6. Assess vaginal bleeding	a. If any unusual bleeding, notify physician.
7. Document	a. Fetal monitor application per procedure.
	b. **Mansfield** - Administration of Prostaglandin gel, including amount, route, time on Intrapartum Data Sheet. **Shelby** - Administration of Prostaglandin gel, including amount, route, time on Nurses' Notes and Med Kardex. Also on Nurses' Notes any side effects experienced and patient's reaction to procedure.
	c. BP, P, R, and FHR and U/C's on Labor Flow Record.

RESOURCES:

Sandy, Edward and Zuspan, Frederick, "The Use of Prostaglandins for the Induction of Labor," Region IV, OSU Perinatal News, Winter 1988, No. 27.

Glazer, G. "Prostaglandin Gel for Cervical Ripening", *MCN*, Jan-Feb 1987.

"Advances in Care", *Nursing Mirror* 159 21 (December 5, 1984).

Approved by Jo Plaster,R.N. - January, 1997
Approved by Nicole Jury RN - 10-8-97
CFK 10/22/97
Darlene Richardson 10/21/97

MEDCENTRAL HEALTH SYSTEM
POLICY/PROCEDURE MANUAL

TO: ALL NURSING PERSONNEL	SUBJECT: ADMINISTRATION OF OXYTOCIN (PITOCIN)	
POLICY DESIGNATED: [ ] SYSTEMWIDE [X] MANSFIELD [ ] CRESTLINE [X] SHELBY		
PREPARED BY: MATERNAL CHILD HEALTH DEPARTMENT	FILE: O PAGE 1 OF 4	NURSING MANUAL __ VOLUME 1 (ADM) __ VOLUME 11 (CLINICAL) _X_ SPECIALTY: MATERNAL CHILD HEALTH
APPROVED BY: VICE PRESIDENT OF NURSING		
DATE WRITTEN: 2/3/81	REVIEWED: 2/95	REVISED: 9/96 12/97

I. PURPOSE:

A. Intravenous oxytocin is used in the induction of labor, the augmentation of labor, the management of incomplete or missed abortion and during the immediate post-partum period to control bleeding or hemorrhage.

III. GENERAL INFORMATION:

A. Oxytocic agents may be administered when the physician is not on the premises and may be initiated in the absence of the physician and/or by telephone order as long as the following conditions are met:

1. The patient's present condition must have been evaluated by the attending physician. The interval between actual evaluation and initiation of oxytocics will vary depending on the lability of the patient's condition and stage of labor.

2. The patient's physician must be available within 15 minutes to manage any complications arising from the administration of oxytocic agents including emergency Cesarean delivery as per ACOG standards.

3. The physician or a qualified nurse must examine the patient immediately prior to the initiation of oxytocic therapy.

B. The physician or R.N. starting the oxytocin should be familiar with its effects and complications and be qualified in identifying both maternal and fetal complications.

C. I.V. route is preferable - by infusion pump for more accurate control of flow rate with base I.V. containing NO oxytocin. If another route is used, the physician should be present for the duration of the pharmacological effect.

D. The initial dose of oxytocin in augmentation of labor is determined by physician's orders. The dose should be gradually increased, per physician's order, until normal labor is established.

III. GENERAL INFORMATION: - cont'd

E. Follow procedure for assessing patient in labor. Apply fetal monitor for 15-20 minutes baseline strip before starting oxytocin and then continuously to determine FHR and uterine contraction pattern with oxytocin.

III. EQUIPMENT:

FOR INDUCTION OF LABOR PER TRAVENOL PUMP

1 or 2 - 1000cc I.V. solution of physician's choice
1 or 2 - Travenol pumps (if only 1 pump is available, Pitocin must be on it)
2 - I.V. sets (appropriate use with Travenol pump)
2 - I.V. date labels
1 - "Medication Added" label
1 - 21 gauge needle
1 - 3cc syringe
Fetal monitor
I.V. tray
I & O sheet

Mansfield only
1 - I.V. set (Blood tubing for Base IV)
Oxytocin in amount ordered by physician

Shelby only
1 - 500cc bag 0_5LR
Oxytocin in amount ordered by physician
IV Kardex
1 - Y tubing
1 - Stopcock with tubing

IV. PROCEDURE:

NURSING ACTION	IMPLEMENTATION
FOR INDUCTION OF LABOR PER INFUSION PUMP	
1. Prepare and start base I.V. solution as ordered by physician	a. Explain procedure to patient. b. Follow accepted procedure for starting I.V - using angiocath needle. c. Set I.V. rate as ordered by physician or at 125cc/hr. d. Document on Intrapartum Data and Labor Flow Sheet, and Narrative Nursing Notes and Fetal Monitor Strip.
2. Perform vaginal exam	a. To determine baseline findings.

NURSING ACTION	IMPLEMENTATION
3. Prepare and start I.V. solution with oxytocin per the infusion pump	a. Inject ordered amount of oxytocin in I.V. solution. Shake bag to mix medication. b. Prepare I.V. as per manufacturers instructions. c. Flush all tubing with oxytocin solution. d. Label bottle with medication add on label, note amount added and date the label. e. See Procedure for Use of Infusion Pumps. f. Observe patient for first 15 minutes to determine uterine contractions and fetal heart rate pattern. g. Record on Mecord Record.
4. **Mansfield** -Record FHR uterine contractions q 15 min., BP q 30 min, and TPR q 4 hr. **Shelby** - Record BP, Pulse, Resp q 1 hr, temp q 4 hr. if membranes intact. Temp q 2 hr. if rupture	a. FHR - Report to physician any late decelerations or significant changes in FHR pattern on the monitor tracing. If fetal distress is evident, discontinue oxytocin, turn patient to side, start oxygen per physician order and increase base I.V. rate. Do vaginal exam if indicated. b. BP - report to physician any significant change from first pernatal visit, an increase of 30mm Hg systolic and 15mm Hg diastolic. c. If patient experiences unusual abdominal pain, discontinue pitocin and notify physician. d. U/C's should be palpated frequently for intensity and duration. e. Record changes in rates of flow on Base I.V. in Nurses' Notes and mu/minute rate of oxytocin solution, as ordered by physician, on Labor Flow Record and Fetal Monitor Strip.
5. I & O	a. Maintain I&O during administration of oxytocin. Oxytocin has antidiuretic effects.

MATERNAL CHILD HEALTH MANUAL	SECTION:	PAGE: 4

NURSING ACTION	IMPLEMENTATION
6. Assess vaginal bleeding	a. If any unusual vaginal bleeding, discontinue oxytocin and notify physician.

Approved by OB/GYN Department,
Michael Gunzenhauser, M.D., Chairman

1-1-98
Date

References:

1. ACOG Standards
2. Hospital Formulary
3. Parke-Davis - Pitocin medication insert
4. JOGNN - Jan/Feb 1985
5. Procedure for administration of oxytocin - Akron City Hospital

Approved by Policy and Procedure Committee - August, 1994
Approved by Jo Plaster - October 31, 1996
Approved by