VOL XX, NO 2 **AUGUST 2004**

LEGAL LIABILITY AND THE NEONATAL NURSE: PART I

We are most certainly living in the age of litigation, and in every clinical situation we must be able to prove that appropriate care was provided. There are several high-risk areas of legal liability for us as neonatal nurses. In this issue of *Progeny* and the one to follow, we'll discuss some common allegations and defensive strategies for nurses in these particular areas of risk.

RESUSCITATION SITUATIONS

Common Allegations:

- Delayed, inadequate, or improper resuscitation
- Failure to anticipate and/or recognize asphyxial conditions
- Lack of qualified resuscitation personnel
- Failure to stock and/or check resuscitation equipment and supplies

Anticipation is the key to successful resuscitation, so be prepared for the worst. Know your NRP—this is the national standard for neonatal resuscitation. The AAP and AHA recommend that at least one person skilled in *initiating* NRP be present at every delivery. In cases of high-risk delivery, they recommend that at least two people attend, one with *complete* skills and one to assist. Make sure the resuscitation bed is well stocked with all the necessary emergency equipment, and routinely check these supplies. Resuscitation skills are easily lost if not used very often, so if need be run "mock resuscitations." Practice bag and mask ventilation, suctioning with the meconium aspirator, preparing for umbilical line placement, and drawing up emergency meds. Good documentation is essential in every resuscitation situation. Time frame is important here because the outcome for this infant depends on the amount of time it takes to resuscitate. An easy-to- use resuscitation form or flow sheet can be very helpful as long as the documentation reflects a clear picture of the infant's condition and progression of events. Resuscitation charting should continue until the baby is stabilized or transferred to the special care nursery. Gaps in documentation or lapses of time unaccounted for are very difficult to defend if the record comes under scrutiny in litigation.

RESPIRATORY DISTRESS

Common Allegations:

- Failure to recognize the symptoms of respiratory distress or the progression of these symptoms
- Failure to communicate an accurate picture of the baby's condition to the physician

Be able to recognize the signs and symptoms of respiratory distress—tachypnea, grunting, nasal flaring, retracting, and cyanosis. In the "Guidelines for Perinatal Care," a normal respiratory rate is defined by

the AAP as one "fewer than 60 breaths per minute." Remember…an oxygen saturation level less than 95 in a full term infant indicates an oxygen requirement. I've seen tremendous delays in providing oxygen to desaturated babies because the nurse didn't believe the oximeter was "picking up." When in doubt here, start some free flow oxygen first, then troubleshoot your equipment. Vital signs should be documented at least every 30 minutes for the first two hours of life. This is a critical time for the infant as he transitions to life outside the uterus—watch closely for signs of distress. Again, documentation of your assessments is so important, especially as symptoms progress. Charting should reflect a very clear picture of the baby's condition. As we all know, doctors aren't always at the bedside to witness the decline. So, it is our responsibility to accurately communicate this baby's condition to the physician. We must make him *see* the same baby we are seeing. Avoid generalizations like, "he looks a little worse to me" or "he's just not right." Give the physician very specific clinical facts and an accurate time frame of the progression of symptoms. And, *always* document your communication. If the outcome is bad and it comes down to "he said…she said," this will absolutely be your best defense.

CODE DOCUMENTATION

Common Allegations:

- Failure to anticipate arrest
- Failure to document the condition of the infant and the sequence of events

Arrest situations are frightening, no matter who you are or how many years of experience you have. When cardiac arrest occurs in babies, it is almost always preempted by respiratory arrest. And, respiratory arrest doesn't usually happen without some precluding signs of respiratory distress. One exception here is apnea—secondary apnea after delivery or apnea with a seizure. In any case, assessment of respiratory distress and early intervention are key to preventing an arrest situation. In the event of a code, the nursing documentation is the most important piece of evidence that appropriate care was given. This record should provide a minute-by-minute account of the resuscitation that includes the sequence of events, the time frame in which they occurred, and the name, title, and role of the people providing care. Document vital signs frequently with blood pressure and oxygen saturation. If unable to obtain a blood pressure, document that the attempt was unsuccessful. When intubation occurs, document any and all clinical signs that it has been successful—present/equal lung sounds, chest wall movement, improved color, condensation in the ETT. When medications are given record the what, when, where, and how much is given. Remember to show evidence of a direct response to the intervention; for example, "HR increased to 110's" after Epinephrine was given. Document when chest compressions are started and stopped, and periodically auscultate for heart sounds. Physical assessments should include color, tone, perfusion, pulses, spontaneous movement, and any signs of seizure activity. Code documentation forms are acceptable as long as there is a clear picture of the baby's condition and sequence of events. Although, my personal bias will forever be toward narrative charting in an arrest situation. Nursing notes always tell a better story. And, trust me…if you're called upon to remember the details of this story *years* later in a legal deposition, you'll be glad for a record that is easy to defend. *(References available upon request)*

FOR QUESTIONS OR COMMENTS: Contact Kathy Papke, R.N. or Penny Smith, R.N.C, Statewide Perinatal Care Program, Department of Pediatrics, 200 Hawkins Dr., Iowa City, Iowa 52242-1083 Call (319) 356-2637 or FAX 319-353-8861.