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Obstetric High Risk Legal Situations: What can nurses do to decrease liability? (Part 2)

As the Perinatal Team travels the state, we often address areas of concern that we see as high risk for medical-legal liability. Dr. Stephen Hunter, Maternal-Fetal Medicine Specialist and Associate Director of the Statewide Perinatal Care Program, has categorized the five areas where the majority of malpractice cases fall in the state. The five areas being: fetal heart rate tracings, Oxytocin and Cytotec, VBAC, shoulder dystocia, and operative vaginal deliveries (forceps and vacuums). In this issue and subsequent issues of Progeny, we are going to address what we as bedside nurses can do to decrease liability in these areas.

Oxytocin/Cytotec:

Common Allegations

- Failure to accurately assess maternal and fetal status during labor.
- Excessive doses of oxytocin or cytotec resulting in uterine tachysystole.
- Failure to appropriately identify and treat uterine tachysystole.
- Failure to accurately communicate the maternal and fetal status to the care provider.
- Failure to implement the chain of command if there is a disagreement on clinical management between nurse and care provider.
- Failure to decrease or discontinue the oxytocin or delay the next cytotec dose during uterine tachysystole.
- Failure to recognize a deteriorating fetal status and act appropriately.
- Use of cytotec in a woman with a history of prior uterine surgery or cesarean section.
- Errors that involve oxytocin administration for labor and augmentation are most commonly dose related.

What can nurses do?

- **Ensure on-going, timely, and accurate assessment of fetal and maternal well-being during labor.**
- **Establish standard order sets and protocols for oxytocin developed by utilizing evidence based practice guidelines (pharmacologic and physiologic evidence).** Example: start at 1-2 mU/min and increase by 1-2 mU/min *no more frequently* than every 30-60 minutes based on maternal and fetal response.
- **Standardize oxytocin concentration prepared by a pharmacy.** Example: 30 Units in 500 mL of Lactated Ringers; 1mL/hr = 1mU/min (1:1 ratio).
- **Use Cytotec that has been prepared by pharmacy. Redosing should be held if three or more contractions occur within 10 minutes (ACOG, 1999; Simpson, 2002).** If oxytocin is needed, it should not be started for at least 4 hours after last dose of Cytotec.
- **Cytotec should not be administered to women with a history of uterine surgery (ACOG, 1999; 2006a).**
- **Establish a standard definition of tachysystole (hyperstimulation) that does *not* include a nonreassuring (abnormal or indeterminate) FHR pattern or the woman's perception of pain.** NICHD definition: more than 5 contractions in a 10 minute period averaged over 30 minutes (2008). A series of single contractions 2 minutes or more and contractions of normal duration occurring within 1 minute of each other (Simpson & Knox, 2009).
- **Establish a standard treatment for tachysystole.** Develop a clinical algorithm for the treatment of tachysystole.
- **Administer the LOWEST possible dose of oxytocin and Cytotec to achieve cervical change and labor progress (ACOG, 1999).** In 2007, the Institute for Safe Medication Practices (ISMP) added IV oxytocin to the list of high-alert medications. High-alert medications are drugs that have a heightened risk for causing significant patient harm if used in error (ISMP, 2007).
- **An important concept of downregulation of oxytocin receptors.** When oxytocin binds with oxytocin receptors there is a decreasing sensitivity to the drug. Desensitization results in less-effective contractions (coupling, tripling, and low-amplitude-high-frequency). Often mistaken for "uterine irritability" and is often attempted to correct with increases in oxytocin ("pit through the pattern"). Recommendations are to discontinue the oxytocin for 30 minutes to 1 hour and bolus with Lactated Ringers. When oxytocin is resumed, normal uterine activity may be successfully established (Mahlmeister, 2008).

IMPORTANT REMINDER:

Standardization and simplification are the hallmarks of safe patient care processes.

(Kohn, Corrigan, & Donaldson, 1999)

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