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Obstetric High Risk Legal Situations: What can nurses do to decrease liability? (Part 3)

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.

VBAC (Vaginal Birth After Cesarean Section):

Common Allegations

- Failure of care provider to fully and properly inform the woman of the risks and benefits of a trial of labor for VBAC.
- Use of excessive doses of oxytocin during labor induction or augmentation that results in uterine rupture.
- Use of prostaglandin agents such as Cytotec for cervical ripening or labor induction of a woman with a history of a prior cesarean birth or uterine scar that results in uterine rupture.
- Failure to recognize and treat uterine rupture in a timely manner.
- Failure to have appropriate personnel and equipment during trial of labor for VBAC.

Simpson, K.R. (2008). *Perinatal Nursing.*

What can nurses do?

- **Ensure on-going, timely, and accurate assessment of fetal and maternal well-being during labor**. The most common sign of uterine rupture is a fetal heart rate tracing with minimal to absent variability, variable decelerations that may evolve into late decelerations, prolonged decelerations, a bradycardia or an undetectable fetal heart rate (AAP & ACOG, 2008). Close attention should be given to any complaints of severe pain in prior incisional area. Epidural anesthesia may be used because it rarely masks the signs and symptoms of uterine rupture. Additional maternal clinical signs of uterine rupture include vaginal bleeding, blood-tinged urine, ascending station of fetal presenting part and hypovolemia (Simpson, 2008). VBAC protocols typically include IV access upon admission, a Type & Screen or Cross, continuous fetal monitoring and notification of surgical team.
- **Ensure informed consent has been obtained by physician/provider and a signed consent is on patient chart.**
- **Cytotec should *NOT* be administered to women with a history of uterine surgery attempting a VBAC (ACOG, 2004b; 2006c).**
- **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). Impending uterine rupture may be preceded by increasing uterine tone or tachysystole.
- **Establish a standard treatment for tachysystole.** Develop a clinical algorithm for the treatment of tachysystole.
- **Administer the LOWEST possible dose of oxytocin to achieve cervical change and labor progress (ACOG, 1999).** Waiting for spontaneous labor and avoiding oxytocin appears to significantly decrease the risk of uterine rupture for woman attempting VBAC (ACOG, 2004c, 2006a).
- **Once labor has begun all necessary personnel (full surgical team: obstetrician/surgeon, surgical assist, anesthesia provider, scrub tech, circulating nurse, and NRP trained staff) needed to respond to emergencies are to be immediately available (ACOG, 2004c).**

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