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LEGAL LIABILITY AND THE NEONATAL NURSE: PART II

In this issue of *Progeny*, we will discuss three more high-risk areas of legal liability for neonatal nurses. Even in the routine aspects of care we are at risk. As in the previous issue, I've included some common allegations seen in malpractice cases and several defensive strategies to minimize our risk in caring for newborn patients.

INTRAVENOUS THERAPY

Common Allegations:

- Extravasation injuries
- IV fluids delivered at an inappropriate rate
- Injuries resulting from arterial cannulation

I know several NICU nurses who were personally named in a lawsuit over an IV that went bad. The worst-case scenarios include necrosis, skin grafting, and lost digits. What seems like the most basic therapy in newborn care can become a very big deal. Constant vigilance and good documentation are the keys to avoiding this pitfall. IV sites should be inspected at least once every hour while fluids/medications are infusing. You are looking for any signs of tissue infiltration: redness, blanching, edema, coolness, or fluid leaking from the site. Hourly documentation of the site condition is essential. IV flow sheets can be very helpful, and there are several nice staging codes out there. But, remember…"unchecked" boxes imply that care was not given. Documenting an hourly IV intake number implies that you actually looked at the pump and verified that the amount did infuse. It's always a good idea to document what the site looks like when the IV is started. I have inadvertently put in a few art lines, and it's easier than you think. How do you know if you're in an artery? Rapid blood return and blanching are often your best clues. The site will blanch initially when the catheter is flushed, then it quickly refills without any evidence of edema. If you suspect you're in an artery, don't infuse anything. Take the catheter out immediately, and hold pressure on the site for several minutes.

MEDICATION ERRORS

Common Allegations:

- Injury resulting from an error in medication administration
- Failure to follow institutional procedure and policies

There is such a small margin for error with newborns. What would be considered a minor error in adults and older children can be devastating for babies. We must judiciously follow the "Rule of 5 R's": right patient, medication, dose, route, and time. We try to avoid errors at our institution by double-checking every medication with another nurse. As professionals, we are expected to *know* what we are giving our patients. This means understanding the pharmaceutical action of the medication and knowing what the appropriate dose is. If you don't have a copy of the Neofax in your nursery or access to it on-line, consider getting one. Finally, don't be afraid to question the prescribing physician if the order seems wrong. We are a team, and most physicians will thank you for preventing a mistake that could be harmful.

HYPOGLYCEMIA

Common Allegations:

- Failure to monitor for hypoglycemia in the high-risk neonate
- Failure to recognize the symptoms of hypoglycemia in the low or high-risk neonate

This is often an area of newborn care that we glaze over as not being so important. What's at stake here is *long-term neurological sequelae*. These four words strike fear in the heart of every neonatal nurse, as well they should. Remember, serum glucose is only an *approximation* of cerebral glucose. This level can be altered by any condition that affects cerebral blood flow or glucose utilization. So, a blood glucose level of 40 in a full term infant who is eating and transitioning well may be acceptable. But, the same level would be considered low in the symptomatic high-risk infant with multi-system organ failure who has an increased glucose requirement. Every hospital caring for newborns should have a hypoglycemia protocol for identifying and screening infants at risk for hypoglycemia. Follow-up screening after treatment should be included. When to treat has been an issue of some debate in recent years. We don't know exactly how low the blood glucose level needs to be for cerebral damage to occur. Adverse neurodevelopmental outcome has been reported in preterm infants experiencing only *moderate* hypoglycemia. At our institution, we have adopted a more conservative approach with a treatment level of 50 or less for infants at risk for neonatal hypoglycemia. When we look at the current research, it is reasonable to assume that the longer hypoglycemia goes on undetected, even at moderately low levels, the higher the risk of cerebral damage.

FINAL NOTE

Sometimes bad things happen, despite our efforts to provide good care. Most neonatal nurses are conscientious advocates for their newborn patients. Taking care of babies is not only what we *do*, it becomes a big part of who we *are*. So, when this care comes under scrutiny in litigation we are more than a little threatened. I speak from experience, having "survived" a malpractice case. My best advice to avoid legal liability is to *always* practice within the standard of care for your nursery. And… be able to prove that you've done so in your documentation. This is without a doubt your best defense. *(References available upon request)*