PROGENY

VOL XXVI, NO 1 March 2010

Obstetric High Risk Legal Situations: What can nurses do to decrease liability? (Part 4)

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.

Shoulder Dystocia:

Defined: A delivery that requires additional maneuvers following failure of gentle downward traction on the fetal head to effect delivery of the shoulders. Shoulder dystocia occurs when after delivery of the fetal head, impaction of the shoulders within the maternal pelvis prevents further expulsion of the infant (ACOG, 2002).

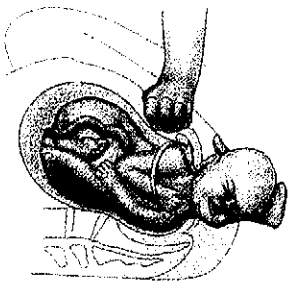
Common Allegations

- Failure to accurately predict risk of shoulder dystocia.
- Failure to diagnose labor abnormalities
- Failure to initiate appropriate maneuvers to alleviate shoulder dystocia.
- Allegations that fundal pressure was performed after diagnosis of shoulder dystocia and this delayed the birth resulting in maternal or fetal injuries.

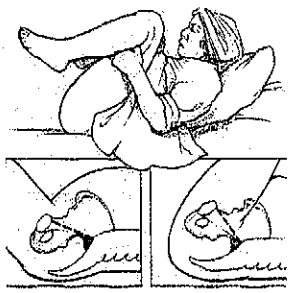
Simpson, K.R. (2008). *Perinatal Nursing 3rd Ed.*

What can nurses do?

- **Be prepared for shoulder dystocia at every vaginal delivery.** No single risk factor or a combination of risk factors is predictive for which infants will experience shoulder dystocia. Some identified potential risk factors include: fetal macrosomia (>4000 g), maternal obesity, diabetes, previous history of shoulder dystocia, postdates, and labor induction (ACOG, 2002).
- **When a shoulder dystocia is identified:** note time, call for additional assistance (nurses, anesthesia, and neonatal resuscitation team), perform McRoberts maneuver, perform suprapubic pressure upon request of provider (instruct the mother to stop pushing *until* suprapubic pressure has been applied, apply direct downward pressure above the maternal symphysis to dislodge the anterior shoulder). ***Do not use fundal pressure.*** If possible designate someone to call out the time since delivery of the head at fixed intervals i.e. every 30 seconds.
- **Document, Document, Document:** Provide a narrative note that summarizes the series of interventions and clinical events that have taken place. Document minute by minute when it is absolutely certain that the times included are accurate. Attempt to closely approximate the time interval between delivery of fetal head and body. Review the EFM tracing and talk with other providers in attendance to ensure the most accurate details of the clinical events are recorded. Include fetal assessment data and/or attempts to obtain data about fetal status during the maneuvers. List all providers at the delivery and resuscitation. Document maternal and fetal condition following delivery (Simpson, 2008).



Suprapubic Pressure



McRoberts Maneuver

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