**(2) Carol Lenox-McDougall**

Nurse Clinician, the Operating Room, P.A.R., Day Surgery and Endoscopy, Mississauga Hospital, Ms. Lenox-McDougall is President of the Operating Room Nurses Association of Ontario, a past-president of the Operating Room Nurses Association of Hamilton and District, and has served on the ORNAC executive and board for the past four years, the last two as Vice-president.

She received her R.N. from the Miami Valley Hospital School of Nursing in Dayton, Ohio and attended Wright State University there as well as McMaster University in Hamilton, where she received her B.Sc.N. She is a member of the Rules and Regulations, Standards, and Editorial Advisory Committees of ORNAC.

Ms. Lenox-McDougall wants to see ORNAC develop a strategy plan with both short and long term objectives. She also wants to see ORNAC become more actively involved in continuing education programs for operating room nurses in Canada.

She envisions the exploring of various mechanisms for financial assistance to operating room nurses who wish to expand their educational horizons. As well, she advocates lobbying the appropriate government and health care agencies in order to allow ORNAC the opportunity to provide input into educational programs for O.R. nurses.

## Vice-president

**(Two nominated)**

**(1) Jackie Waisman**

Presently, she is a general duty nurse, operating room, Red Deer Regional Hospital Centre in Red Deer, Alberta. Her experience includes specialty nursing in general and thoracic surgery, and gynecology and obstetrics.

Ms. Waisman, an ORNAC board member for the past two years, has been an active participant in O.R. nursing at all levels. Currently, her involvement includes: provincial president, O.R. Nurses of Alberta; ORNAC board member representing Alberta; member of the ORNAC Finance Committee; Protocol chairman for the 1991 National Conference Committee (Banff, Alberta); and vice-president of the Central Operating Room Nurses of Alberta.

Ms. Waisman sees four areas within ORNAC where she would like to see greater emphasis:

1. The promotion of continuous communication between the ORNAC executive and board members;
2. Effort expended that will see ORNAC continue to be recognized as dynamic and professional;
3. The support and promotion of the established goals and plans of ORNAC, i.e., standards, certification, strategic planning, encouraging new ideas and goals for the association, and emphasis on continued growth and the promotion and maintenance of professionalism within the association.
4. Encourage the involvement and support at the regional, provincial and national levels.

**(2) Anne Hughes** (See profile previous page)

## Secretary

**Muriel Shewchuk**

Director of Nursing, OR, PAR, Foothills Hospital, Calgary, AB, she received her R.N. and B.Sc.N. from the University of Alberta in Edmonton. Besides post-graduate studies in O.R. Technique and Management, she studied and received her Diploma in Teaching and Supervision from the University of Alberta, and prior to her present position, was an instructor in Post-Graduate O.R. Technique and Management.

She has held a number of executive positions with the O.R. Nurses of Alberta, and has served as an ORNAC board member, executive member and has chaired several committees for ORNAC.

## Treasurer

**Carole Starr**

Unit Supervisor, O.R., Civic Hospital, Peterborough, Ontario, Ms. Starr is currently on the executive of ORNAC and is Past-president of the Operating Room Nurses Association of Ontario.

She has a certificate in Nursing Unit Administration, Departmental Management Certification, as well as an O.R. Post-graduate Certificate. She currently attends the University of Ottawa part time where she is completing her B.Sc.N.

Her goals and objectives for ORNAC include:

- Promoting its work and objectives so that all nurses in Canada have a greater awareness of ORNAC;
- Enhancing ORNAC's professional image so that nurses are aware of membership benefits.





# Legal woes of incomplete intraoperative charting

**By L.E. and F.A. Rozovsky**

Legal defense to litigation based on a surgical or anaesthetic accident can be made or lost on the basis of intraoperative charting. Plaintiffs' lawyers thrive on weaknesses or glaring contraindications in the surgical and anaesthetic record. They cringe, however, when faced with well documented records that demonstrate clear, concise charting that provides plausible or reasonable explanations for intraoperative problems.

For operating room supervisors and staff nurses it is important to understand the legal pitfalls of incomplete charting. In doing so, steps can then be taken to avoid some of the more common, yet serious legal problems.

### The issue in context

The fact that a patient emerges from the operating room in a vegetative state is not by itself a sufficient basis for establishing a claim of negligence. By the same token, the fact that the patient leaves the operating room suite with a "retained" surgical needle is not automatically considered a cause for a negligence suit.

The plaintiff must demonstrate that it was more likely than not that the "injury" occurred as the result of the failure to abide by reasonable, prudent standards, resulting in reasonably foreseeable harm or injury; and, in the circumstances, there was no reasonable excuse for failing to live up to the recognized standard of care.

In particularly grey areas, the record might supply the "reasonable excuse" for failing to meet the recognized norm.

In other instances, the record may demonstrate that the injury experienced by the patient was not attributable to negligence, but a recognized and accepted risk of the procedure. In other instances, the record may show glaring deficiencies in treatment to warrant making a prompt offer of settlement to the plaintiff.

Whatever the decision, the record plays a pivotal role in how the defence and the plaintiff handle potential litigation.

### How plaintiffs use poor records

Plaintiffs' lawyers can use the poor intraoperative record in a number of ways, including:

1. Demonstrating departures from the standard

Plaintiffs' lawyers can introduce into evidence policies and procedures governing intraoperative charting to establish the average, reasonable, prudent practice. They can then compare the record against the standard practice to show deficiencies in charting required information.

If the deficiencies focus on the injury, the record can be used to show a departure from recognized practices resulting in reasonably foreseeable harm.

2. Attacking credibility of the record

Lawyers can also use poor intraoperative documentation to destroy the credibility of key aspects of the record. Once the court is aware of how the record is supposed to appear and what it actually contains, plaintiffs' lawyers can use record keeping deficiencies to question the reliability or credibility of the entire record. This could be terribly damaging, particularly if great reliance is placed on the record by the defense.

3. Attacking credibility of witnesses

Poor intraoperative recordkeeping can also be used to destroy the credibility or weight of evidence given by defendants. An operating room nurse, anaesthetist, or surgeon may "claim" that they followed procedure, but a heavy shadow may be cast on their testimony by intraoperative records that do not support or even contradict their evidence.

## Other spin-offs of poor charting

Aside from litigation, poor recordkeeping in the operating room may be the basis for professional disciplinary or staff privileges proceedings. The failure of anaesthetists to record concurrent observations in the operating room may be sufficient grounds for taking privileges action. Similarly, the failure of nurses to properly complete and record instrument counts in the operating room suite may be the basis for professional disciplinary proceedings.

## Preventing legal problems

Several steps can be taken to avoid the legal pitfalls in intraoperative charting. These are largely quality assurance and risk management measures designed to establish and maintain a reasonable level of patient care and liability exposure. The steps which should be considered include:

1. Documentation analysis

Is there too much charting taking place on inconsequential matters? Are more important considerations being overlooked? Can the charting requirements be streamlined? In many instances, a rationalization of intraoperative charting may reduce problems with doctors and nurses failing to comply with recording requirements.

2. Education

Is it assumed that anaesthetists, surgeons, and nurses are well trained in handling documentation? It may be that charting difficulties stem from little time and energy being devoted to practical, hands-on training in managing intraoperative recording requirements.

3. Monitoring

Is the system geared to accurately monitor intraoperative charting? If the answer is "no," there is little incentive for recalcitrant individuals to become more compliant. Furthermore, hospitals need effective lines of communication to facilitate reporting and investigation of non-compliant intraoperative charting.

4. Discipline

Are offenders let off with a slap on the wrist? Are they let off without any discipline at all? Documented reports of substandard charting, warnings, and education may not be enough to turn around the most stubborn professionals. If so, consideration should be given to disciplinary action. This is a last resort, but an important tool employed to assure compliance with accepted practice. ■

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### About the authors

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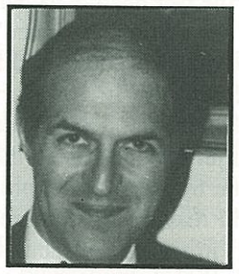

Lorne Rozovsky

Fay Rozovsky



# ORNAC

## Executive and Board of Directors (1988 - 1990)



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## ORNAC Board/Provincial Representatives

Each province is permitted two "Provincial Representatives" to sit on the ORNAC Board of Directors.