on 'certification', the rationale being that the specialty knowledge required for operating room nursing practice demands high standards of practice and the promotion of a professional image. Certification, she feels, will do much to promote higher standards as well as enhance the professional image necessary.

Secretary

(1) Muriel Shewchuk

Director of Nursing, O.R. & P.A.R.R., Foothills Hospital, Calgary, Alberta, Muriel Shewchuk received her R.N. from the University of Alberta Hospital School of Nursing in Edmonton and her B.Sc.N. from the University of Alberta. Besides having taken a post-graduate course in O.R. Technique and Management, Ms. Shewchuk studied and received her Diploma in Teaching and Supervision from the University of Alberta.

Prior to her current position, she had been an instructor in Operating Room Post-graduate Course Technique and Management, Orthopaedic and Rehabilitative Medicine.

She has held a number of executive positions with the O.R. Nurses Association of Alberta, and has served as a board member of ORNAC where she has chaired a number of committees: Editorial Awards Committee (now ORNAC Awards Committee), Nursing Practice Standards Committee (original member), Technical Standards Committee (current).

Ms. Shewchuk has been a frequent lecturer and speaker at international, national and local conferences and seminars. She has also published a number of papers, including submissions published in the *Canadian Operating Room Nursing Journal, The Canadian Nurses Association Journal and the Alberta O.R. Nurses Association 'Newsletter.'*

Among her stated goals for ORNAC is the maintenance of a high profile of education and communication among operating room nurses across the country. This same high profile she wishes to see established to a degree on an international scale.

She also wishes to see ORNAC continue to support and promote the implementation of O.R. Standards across Canada, as well as support and promote the proposed "specialization and certification" process for operating room nurses.

Treasurer

(1) Carole Starr

Unit Supervisor, Operating Room, Civic Hospital, Peterborough, Ontario, Ms. Starr has close to 20 years operating room nursing experience. Currently, she is president of the Operating Room Nurses Association of Ontario and a board member of ORNAC. She has a certificate in Nursing Unit Administration, Departmental Management Certification, as well as an Operating Room Post-graduate Certificate. Ms. Starr attends the University of Ottawa part time where she is studying for her Bachelor of Science in Nursing.

Her goals and objectives for ORNAC include:

- Promoting and publicizing the work and objectives of ORNAC so that all nursing organizations across Canada will have a greater awareness of ORNAC as a national entity;
- Enhancing the professional image of ORNAC so that all O.R. nurses in Canada are aware of the benefits of membership;
- Greater emphasis on education by the national body.

10th National Operating Room Nurses Conference
Pan Pacific Hotel
Vancouver, British Columbia
May 30 - June 3, 1988

A legal checklist for O.R. supervisors

By L. E. & F. A. Rozovsky

Legal problems can and should be avoided. This is especially true in hospitals and particularly true in the operating room. As the chief administrative officer of the surgical plant, the responsibility for preventive law rests primarily on the shoulders of the operating room supervisor.

To carry out this role, the O.R. supervisor has an essential task. It is to become aware of the legal problems that exist or could exist in the operating room. Many of these problems continue to arise regardless of what the O.R. supervisor does. However, by becoming aware of the problems some of them can be avoided and the risk of others reduced. Often legal problems arise simply because those affected were not aware of their existence.

Why the O.R. supervisor

The O.R. supervisor takes on the preventive law role in a number of capacities. The first is as agent and representative of the hospital which could be held legally responsible for the negligence of its employees. The trend seems to be that the hospital could also be held responsible for the negligence of physicians. Such a responsibility is based on the legal idea that the hospital knows or ought to know that a particular surgeon or an anaesthetist is likely to act in a negligent fashion. There is no one in the O.R. other than the supervisor who can fully carry out the responsibility of the hospital board of trustees in this regard.

The O.R. supervisor should also practise preventive law for self-protection. Even though the hospital as an employer is responsible for the negligence of the employees, this responsibility is shared with the employees in their personal capacity. An O.R. supervisor might be held liable for negligently supervising or failing to take appropriate action which caused reasonably foreseeable injury.

The third reason for the O.R. supervisor's role in preventive law is to protect others in the surgical team. This would include the nurses and technicians who are hospital employees and physicians and surgeons who are self-employed.

Who's protecting whom?

One may question the desirability of protecting physicians and surgeons who are not ordinarily the responsibility of the hospital. The first reason is that the hospital might, in certain circumstances, be held responsible if it knew or ought to have known of a doctor's negligence and did nothing. The second is that when a physician/surgeon is sued, the hospital and its staff are invariably included as defendants. Thus, protecting a doctor protects the institution.

A legal checklist

To translate the O.R. supervisor's awareness of the legal problems into practical action, it may be of

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assistance to create a checklist. This checklist would include a number of questions which should be considered by the O.R. supervisor. Actions taken in response to these questions would help to reduce many of the legal risks.

1. Does the surgeon have the privileges to perform the surgery which has been booked? It may be negligence for a hospital to allow a surgeon to perform surgery for which he does not hold privileges and may not be competent to perform.

Does the surgeon have privileges for the surgery that is actually being performed? The surgery being performed may not have been what has been booked. This creates the problem of having to interrupt the operation which could cause greater harm to the patient than allowing it to proceed.

To avoid this problem there should be an established procedure whereby the O.R. supervisor is notified, so that someone within medical administration can take whatever action is appropriate.

2. Is the documentation of consent to treatment complete? Is there a record signed by the surgeon that the operation has been explained to the patient in accordance with established hospital policy? The fact that the patient acknowledges that it has been explained is not evidence that this in fact has been done. The explanation must include information on the risks and alternatives. The patient is in no position to know whether a full and properly presented explanation has been given.

Is the surgery being performed the procedure to which the patient has in fact consented? If the situation is a medico-legal emergency for which consent is not required, is there a record that the situation was an emergency and that the patient was not able to consent?

3. Following surgery, are the records of the operation accurate? Failure to have accurate records could jeopardize the defence of any lawsuit brought against the hospital, its employees, the surgeon or the anaesthetist. Failure to complete records immediately after the operation is over could also jeopardize, not only the acceptability of the records as evidence, but the credibility of other records as well.

4. Is there a procedure with respect to spectators who are not directly involved in the operation? Has it been followed? Is the patient aware that there were students or other observers who were not involved in the care or performance of the surgery?

5. If observers have been attending, there should be a record as to who they were, why they were present and who authorized their attendance.

6. If foreign objects are found on the patient, such as dentures, rings, jewelry, or are removed from the patient such as bullets, is there a procedure for retaining these objects? Has this procedure been followed and documented? The loss of these objects may result in a claim against the hospital by the patient. It may also be required as evidence in a civil or criminal action.

7. If an incident occurs in the operating room, either before, during or after the surgery has been started, has the procedure for completing the incident report been followed? Is the report accurate? Does everyone in the O.R. know what constitutes an incident and under what circumstances an incident report is to be completed?

8. Is there an established procedure to be followed if an equipment failure takes place? Has that procedure been followed after such a failure? Has it been properly recorded? Has there been a follow-up to ensure that the equipment has been checked and in working order, or that it has been replaced?

9. Is there an established protocol when there is a dispute in the operating room? If a dispute occurs between a surgeon and an anaesthetist, or between a surgeon and a nurse, is there some method of settling such a matter? Can a nurse call for assistance? Are records made of such an incident and is there a method to investigate it so that further incidents will hopefully not occur again?

10. If for some reason a member of the O.R. team must be replaced, or that further assistance is required, is there an established method for doing this? Is there assurance that the replacement or additional staff is competent? Does the nursing office send a nurse who is not trained in O.R. procedures? Was the response appropriate to having such a person on the team? Would it have been better to cancel the surgery or to do without such assistance? Did the operation proceed without sufficient numbers of qualified staff in the first place?

Costly consequences

By establishing a checklist which will raise these questions and other similar issues, immediate action can be taken to reduce the risk of legal problems. Otherwise, the supervisor, the administration and the hospital may never know that some of these problems exist. For that lack of awareness, the legal price may be costly. ■

General Journal Information

The Canadian Operating Room Nursing Journal, copyright, 1983, is published six time a year (February, April, June, September, October and December) for operating room nurses and related surgical nursing personnel across Canada.
The Canadian Operating Room Nursing Journal is indexed in *Index Medicus, the Cumulative Index to Nursing & Allied Health Literature,* and *The International Nursing Index,* U.S. National Library of Medicine, Bethseda, Maryland.
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The Canadian Operating Room Nursing Journal is published by **Health Media Incorporated,** 214 Merton Street, Suite 202, Toronto, Ontario, Canada M4S 1A6 (416) 481-2244.
Also published by **Health Media Inc.**:
- *Canadian Critical Care Nursing Journal*
- *Infection Control Canada*
- *Canadian Journal of Nursing Administration*
- *Ontario Nursing Home Journal*