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A LEGAL INFORMATION SHEET FOR NURSES

Operating Room Nursing

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Canadian Nurses Protective Society

Professional Liability Protection for Nurses by Nurses

Each year, nurses working in the operating room are the second or third largest group of nurses reporting their involvement in lawsuits or occurrences[1] to the Canadian Nurses Protective Society. Reported case law is an indicator of some of the potential risk areas facing operating room nurses. The most common lawsuits involve issues related to:

Medication Errors

During a cataract extraction the surgeon asked for irrigation solution and noticed foam or bubbles on the surface of the solution in the medicine glass. He asked to see the container the irrigation solution came in. He was shown the container and then proceeded to use the solution. Pharmacy had substituted Eye Stream for the usual balanced salt solution. Unfortunately, a preservative in the Eye Stream solution caused damage to the patient's eye. The patient initiated a lawsuit and successfully sued the hospital and the surgeon. Liability was apportioned 60% to the hospital (because of the negligence of the pharmacy and the circulating nurse) and 40% to the surgeon.[2]

Foreign Bodies / Retained Sponge

A patient developed a severe post-operative infection after a presacral neurectomy. A laparotomy was performed and a non-radiopaque roll, six feet long and six inches wide, was discovered. Two months passed before the surgeon informed the patient about the retained roll. The patient successfully sued the hospital, the operating room nursing staff and the surgeon. The hospital was found vicariously liable[3] for the negligence of its nursing staff because of their failure to include the roll in the presacral neurectomy's operative count. The surgeon was liable for his failure to carry out an exploration of the abdomen before closing the incision and for his attempt to conceal the truth from the patient. The judge apportioned the liability for the retained sponge equally between the nurses and the surgeon and awarded aggravated and punitive damages against the surgeon because of his attempted cover-up.[4]

Incorrect Site

A patient had a three centimetre lump at the five o'clock position in her left breast. Before the surgical procedure, the surgeon came into the theatre and palpated the patient's left breast. The surgery was commenced and the surgeon removed tissue from the ten o'clock position. At her post-operative visit, the patient informed the surgeon that he had removed tissue from the wrong location. The patient went to a second surgeon and had the lesion removed. It was benign. The patient initiated a lawsuit and successfully sued the first surgeon. The trial judge stated that marking the location before surgery with a marker ought to be the practice of all breast surgeons. And, he found the surgeon's conduct fell below the standard of care because of his lack of consultation with the patient to confirm the correct location of the lesion before starting the surgery and the consequent removal of the wrong tissue.[5]

Burns

A patient sustained second degree burns on her buttock during a procedure to remove rectal tags. The cautery ignited Hibitane vapours from solution which had pooled between the patient's buttock and the operating room table in an area screened by the lithotomy drape. At trial, the physician was found liable. There was no finding of liability against the hospital or its nurses. The judge stated that the warnings on

the Hibitane bottle and the information in the electrosurgery device manual "charged the surgeon with knowledge or a need to know of the dangers of using them in close proximity."[6] These warnings also cast a duty of inspection upon the surgeon that was not met.[7] Because the action was commenced after the one year limitation period found in the *Health Disciplines Act,*[8] the physician was able to successfully appeal the trial decision.[9]

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Infection

A patient, who was a known staphylococcus aureus carrier, died from septicaemia following a splenectomy. The cause of death was staphylococcal sepsis. The patient was very hirsute and was given clippers to clip his own hair pre-operatively. While clipping the hair, the patient scratched himself on the abdomen several times, but no notation was made of the scratches by the nursing staff on the surgical unit. The deceased patient's wife initiated a lawsuit against the nurses and the physician. The judge found the sepsis was caused by the improper skin preparation and held the surgical unit nursing staff liable because of their failure to follow the skin-prep protocol. As for the surgeon, the judge found no liability and stated that the surgeon was entitled to rely on the nurses to perform their duties as required. The judge also commented on the role of the operating room nurses and said that, if the operating room nurses had seen the scratches and failed to bring them to the surgeon's attention, they too would be liable.[10]

Risk Management

Risk management strategies can decrease the incidence of patient injury and the risk of potential liability for nurses and employers. The strategies should include:

- ensuring that nurses have appropriate education, skills and experience;
- providing adequate staffing;
- following professional guidelines, standards and institutional policies;
- keeping current by attending inservices and specialty conferences (e.g. Operating Room Nurses Association of Canada), reading professional journals and materials, and obtaining speciality certification;
- ongoing review and evaluation of policies and procedures for relevancy and accuracy;
- conducting and documenting routine equipment inspections and servicing;
- auditing of documentation;
- reporting and investigating adverse events; and
- consulting risk management resources such as the employer's risk management department and the Canadian Nurses Protective Society.

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1. Occurrences are adverse events which could result in future litigation.
2. *Misericordia v. Bustillo et al.*, [1983] A.J. No. 270 (C.A.) (QL).
3. *infoLAW*®, Vicarious Liability (Vol. 7, No. 1, April 1998).
4. *Shobridge v. Thomas,* [1999] B.C.J. No. 1747 (S.C.) (QL).
5. *Ainsworth v. Ottawa General Hospital,* [1999] O.J. No. 2157 (Sup. Ct.) (QL).
6. *McSween v. Louis*, [1997] O.J. No. 3702 at para. 26 (Ct. J. (Gen. Div.)) (QL).
7. *Ibid*. at para. 40.
8. *Health Disciplines Act*, R.S.O. 1990, c. H.4, s. 17. As of January 1, 2004, the *Limitations Act, 2002,* S.O. 2002, c. 24. Sch. B. sets a limitation period of two years for Ontario health professionals.
9. *McSween v. Louis* (2000), 187 D.L.R. (4th) 446 (Ont. C.A.).
10. *Crandell-Stroud v. Adams*, [1993] N.J. No. 224 (S.C. (T.D.)) (QL).

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