

THE HOSPITAL FOR SICK CHILDREN'S RESPONSE TO THE LISA SHORE INQUEST RECOMMENDATIONS

The hospital claims that it has diligently attempted to implement many of the recommendations. However, in many cases, it has interpreted the recommendations in a manner that totally misses the jury's objectives.

1	In-process	11	Not implemented	21	Implemented
2	Not implemented	12	Implemented	22	Implemented but not followed
3	Not implemented	13	Not implemented	23	In-process
4	Implemented	14	Not implemented	24	Not implemented
5	Not implemented	15	Not implemented	25	Not implemented
6	Implemented	16	Implemented but not followed	26	Implemented
7	Unable to determine	17	Implemented?	27	Implemented
8	Not implemented	18	Not implemented	28	Implemented
9	Action worsened the problem	19	Not implemented	29	Implemented
10	Implemented	20	Implemented?	30	Implemented
31-35: These recommendations are not applicable to the Hospital for Sick Children					

SUMMARY:

IMPLEMENTED	10
NOT IMPLEMENTED	12
IN-PROCESS	2
POSSIBLY IMPLEMENTED	2
UNABLE TO DETERMINE	1
IMPLEMENTED BUT NOT FOLLOWED	2
ACTION WORSENERD THE PROBLEM	1

Following is the Hospital for Sick Children's response to the Lisa Shore inquest recommendations. The document is reproduced verbatim, with the Shore family's comments inserted in red.

Review of Progress on the Recommendations of the Coroner's Jury which Investigated the Death of Lisa Shore - April 25, 2001

On July 28, 2000, the Hospital for Sick Children (HSC) submitted its initial response to the Coroner's Office regarding the recommendations of the coroner's jury, which investigated the death of Lisa Shore. More recently, follow up reports were prepared for internal review by the Medical Advisory Committee (February 28, 2001) and the Hospital Quality and Resource Management Committee (March 6th, 2001).

HSC continues to work towards completing implementation of the recommendations with the expectation that they will result in continued improvement of health care for children, both here and elsewhere.

1. Recommend a study be undertaken to examine interactions between morphine/Gabapentin/other therapeutic drugs. The results of these studies should be widely disseminated to the medical and hospital communities.

An animal study to examine drug interactions between morphine, Gabapentin, carbamazepine and amitriptyline has been given approval by HSC's Research Ethics Board. When the manufacturers declined to fund the study, the hospital made the decision to finance the research itself. Experiments will be completed in the fall of 2001. Analysis and dissemination of findings will be shared by the end of the year. A manuscript describing the study will be submitted to a peer-review journal for publication. Systematic reviews of literature are being undertaken but no new data has been published. We are monitoring a study regarding the interaction of morphine and Gabapentin that is being conducted at the Father Sean O'Sullivan Research Centre, Hamilton, Ontario. This study is in progress.

STATUS: In-process

2. Recommend for computerized information systems such as KIDCOM, automated warning technology should be explored and implemented. For example, when “suspended” KIDCOM orders are entered in Emergency for an incoming admission, a page or other audible warning should sound regularly, such as every five minutes, on the destination ward, and stop only when KIDCOM orders are activated.

While some software companies are developing automated warning systems, no such system is currently available. HSC's Information Services department will review available software and will make recommendations if a suitable solution becomes available. A new Hospital Information System will be implemented in 2002 that will have improved capabilities, which may include such a warning system. As we await such a warning system, other changes have been implemented. As of March 7, 2000, suspended orders automatically print on the unit where the child will be admitted. In other words, the need for a warning is eliminated as the automatic printing of the orders alerts unit staff to the existence of suspended orders. Furthermore, Information Services implemented new screen pathways to facilitate access to suspended orders on patients who have not yet been admitted to inpatient areas. Consequently, all staff have timely access to medical orders.

STATUS: Not implemented

SHORE FAMILY COMMENTS: The reason for this recommendation was to ensure that nurses could not forget to check for doctor's orders, as they claimed to have done in Lisa's case. The hospital says that as of March 7, 2000, suspended orders automatically print on the unit, alerting staff to the existence of suspended orders <doctors orders input from Emergency stay in suspended mode in the computer until the nurse reads them>.

On January 19, 2000, an employee of the hospital told the Lisa Shore inquest jury that this change had been implemented on January 11, 2000 (Inquest Exhibit 25A). The jury made the above recommendation thinking that this change was already in effect. It obviously felt that the recommendation was required *in addition* to this change.

Either the hospital lied to the inquest jury about the implementation date, or it is lying now in an effort to show that it did take some action following the recommendation. Either way, the jury felt that this response was insufficient to address the problem.

3. Recommend the standard order set within the KIDCOM system for patients on parenteral opioids, whether by PCA pumps or any other method of delivery, should include a line which the physician can delete if not applicable. This automatic entry should state “Warning: patient is on other concurrent medications that may potentiate adverse side effects. Increased vigilance is advised.”

The Anaesthesia Pain Service has reviewed this recommendation and has incorporated additional wording into relevant KIDCOM order sets. The PCA KIDCOM order sets include: “This patient is using a Patient Controlled Analgesia device. No narcotics or Central Nervous System depressants are to be administered unless approved by the Anaesthesia Pain Service.” The Opioid Infusions KIDCOM order set includes: “D/C (Discontinue) all other sedatives/analgesics if ordering from these sets.” Pre-printed orders in Emergency also reflect this wording. (Screen prints are attached) Warnings were in place on the PCA order sets when they were first implemented on June 22, 1994. These order sets were revised on October 31, 2000 and again on March 6, 2001.

STATUS: Not implemented

SHORE FAMILY COMMENTS:

STANDARD WORDING IN PLACE FOR PCA ORDERS DURING THE LISA SHORE INQUEST:

"Patient is on PCA Device. No CNS depressants or narcotics to be given unless approved by the Anaesthesia Pain Service."

NEW STANDARD WORDING FOR PCA ORDERS AS IMPLEMENTED BY HOSPITAL:

"This patient is using a Patient Controlled Analgesia device. No narcotics or Central Nervous System depressants are to be administered unless approved by the Anaesthesia Pain Service."

This recommendation was made because Lisa was on several medications besides morphine. One of Lisa's nurses testified that she didn't know that, and the other one said that she was aware that Lisa was on other medications but never gave it a second thought.

The hospital has implied that the wording of the Kidcom orders has changed significantly. The changes made by the hospital are minor and do nothing to

address the problem of nurses who ignore important medical information about their patients.

4. Recommend when a patient is discharged or expired, any suspended orders in the KIDCOM system should print automatically and form part of the patient's permanent record.

This recommendation was implemented as of March 7, 2000. In addition, suspended orders are printed on admission. A report showing "All suspended orders entered in emergency" now prints on admission and is labeled a "permanent document". The Health Records Department carefully reviews all KIDCOM documents and audits all charts of children who die in hospital to ensure all permanent documents are printed and placed in the health record.

STATUS: Implemented

5. Recommend that KIDCOM be programmed so that when a new patient is admitted to a ward through Emergency Department that the ward computer lock-out access to patient care update until KIDCOM Patient Doctor's Order is activated, i.e. Progress Notes, History, etc. cannot be accessed until KIDCOM Doctor's Order is activated.

After careful consideration, we believe that blocking access to the chart may have a negative impact on patient safety by preventing key members of the team from accessing current information. However, we believe that we have achieved the intent of this recommendation through the automatic printing of all suspended orders, the new screen pathways to facilitate access to suspended orders, and the inclusion of all suspended orders as part of the permanent health care record.

STATUS: Not implemented.

SHORE FAMILY COMMENTS:

The hospital states that "blocking access to the chart may have a negative impact on patient safety by preventing key members of the team from accessing current information". The jury's recommendation does NOT suggest restricting access to the chart, only to patient care UPDATE, a fact the hospital has chosen to ignore. Lisa's nurse entered comments about Lisa into

the computer system without ever having looked at the doctor's orders. The purpose of this recommendation was to ensure that this could never happen again. It does not suggest that computer access be denied, only that new information cannot first be entered where there is vital information that has not yet been seen.

Locking out the computer system to UPDATES would force nurses or other health care professionals to think about why the system was not allowing them to update information. Instead of just keypunching data, the employees would play a direct role in eliminating a serious threat to patient safety.

6. Recommend that KIDCOM Print Request Tapes be stored for eighteen (18) months and be made available for Coroner's investigation.

This recommendation was implemented as of December 10, 1999. Health Records now alerts the KIDCOM Clinical Systems Manager when notified of a Coroner's investigation. The KIDCOM tapes containing the printed audit trail are then preserved until the investigation is completed.

STATUS: Implemented

7. Recommend as per Paediatric Review Committee Final Report, that "the KIDCOM orders were not read/opened on admission to the ward, or during the night: the committee recommends that HSC investigate the frequency with which orders are not accessed from the KIDCOM system and the average delay between children being admitted and the orders being accessed."

Information Services undertook an analysis of delays in activating suspended orders. This analysis commenced January 31, 2000. The Health Records Committee will review the data at their April 24, 2001 meeting. Following this meeting a report that sets out any relevant findings will be presented to the Patient Care Committee meeting in May 2001.

STATUS: Unable to determine.

SHORE FAMILY COMMENTS:

Michael Strofolino, CEO of Sick Kids, told us privately in answer to our

direct question that to his knowledge, no nurse at the hospital had ever before failed to access doctor's computer orders.

The recommendation was that an investigation be conducted. The hospital has advised that it did do an investigation, but has declined to report the results. The Health Records Committee reviewed the data on April 24, 2001. The findings were reported to its Patient Care Committee in May. The status report on the inquest recommendations was presented to the Sanchia Bulgin inquest jury on July 4, 2001, over two months later.

Why has the hospital not reported the results of its investigation? Could this be because Lisa's nurses were indeed the only nurses who failed to read doctor's orders applicable to patients under their care, and that admitting this would force the hospital to acknowledge that Lisa's nurses were negligent?

8. Recommend that all Shift Change – Nursing Notes be inputted on KIDCOM.

KIDCOM software does not have the capability to input narrative information such as nursing notes. The Shift Change Report consists of transmitting information verbally that is already contained in the patient record. Information contained in the patient record is permanent. The new Hospital Information System, due for implementation in 2002, may have the ability to enter detailed narrative information.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

The use of the word "may" <The new ...System **MAY** have the ability to enter detailed ... information> suggests that the hospital has no intention of implementing this recommendation. If the system is due for implementation next year, the hospital already knows what the system will and will not do.

9. Recommend all nurses and doctors should be educated or re-educated to ensure they know that KIDCOM monitoring orders and PCA monitoring protocols begin on initiation of opioid therapy and restart again from the moment of admission to the ward. The KIDCOM orders should be changed to reflect this.

This recommendation has been implemented. The Pharmacy and Therapeutics Committee endorsed this recommendation in June 2000 and directed the Pharmacy department to facilitate the changes required in the Pharmacy and Drug Information Manual for Nurses, in all opioid protocols and in KIDCOM order sets. The order sets states: "On admission/transfer to a nursing unit: RR (Respiratory Rate), HR (Heart Rate), Pain score, sedation score q1h x4 hours (every hour for four hours)...These changes are also reflected in the Drug Formulary and in the orientation for new residents and fellows. Each year, the Pharmacy Drug Information Bulletin, which is circulated throughout HSC, will highlight changes to opioid policies and protocols.

STATUS: ACTION WORSENE THE PROBLEM

SHORE FAMILY COMMENTS:

The orders in existence at the time of Lisa's death said "sedation scale, pain scale, HR <heart rate>, BP <blood pressure>, RR <respiratory rate> Q1H x 4 hours on admission." The new orders make no mention of blood pressure.

Lisa's blood pressure was taken once only on arrival to the ward and never again, in spite of respiratory depression and tachycardia (fast heart rate). Sanchia Bulgin's blood pressure was taken once only on arrival to the ward and never again, in spite of the fact that it was a dangerously low 80/40.

Why did blood pressure get dropped from the revision? This change is **WORSE** than doing nothing!

10. Recommend the KIDCOM Orientation Program for both nurses and doctors be revised to accommodate changes. The revised Orientation Program to be presented to all doctors and nurses in hospital.

Information Services continually revises its education programs to ensure that they are current and provided in collaboration with clinicians and the Clinical Systems Training Team. This team, responsible for KIDCOM education programs, has added an additional clinical trainer to carry out in-service training in order to enhance KIDCOM expertise. A total of three trainers are now in place; the third trainer was hired in January 2001.

The Clinical Systems Training Team revises written resources. When major changes or new initiatives are introduced, the team or a special implementation project team provides initial training to all affected staff. New

employees who require access to clinical computer systems are enrolled in a mandatory Clinical Systems Orientation program. Clinicians also have access to a 24-hour help line.

The dates outlined below indicate when revisions to KIDCOM training materials were made since January 2000:

- NICU RN's training manual – May 29th 2000, April 4th 2001
- PACU RN's training manual – July 7th 2000, February 15th 2001
- EMERG RN's training manual – July 7th 2000
- CNS/NP training manual – October 12th 2000
- CCU RN's training manual – August 15th 2000
- Inpatient RN training manual – March 7th 2000
- Inpatient RN Quick Reference Guide – February 9th 2001

In July 2000 all RNs were given a copy of the second version of the Nursing Quick Reference Guide printed May 18th 2000. The MD Quick Reference Guide was updated March 2001. Fellows and Residents are also given information related to Patient Observation, Vital Sign Monitoring and Continuous Electronic Monitoring – this began in June 2000.

STATUS: IMPLEMENTED

11. Recommend annual education sessions for all nurses, doctors and nurse educators who care for patients on parenteral opioids should be mandatory. These sessions should cover: a) the mechanism and actions of morphine and other opioids; b) the interactions with other classes of medications; c) review of normal and abnormal parameters for vital sign assessment; and d) review of new research and case studies on drugs that may be used in combination with opioids.

The key issue highlighted in this recommendation is the need for health professionals to be appropriately educated in the use of parenteral opioids. The hospital has addressed this need in several different ways that are intended to make information readily available at the time it is needed in the care of each patient.

In June 1999 two nursing procedures were developed. Set up and Monitoring for Patients Receiving Patient Controlled Analgesia (PCA) and Continuous Infusion of Opioids. These were available in the Nursing Policy and

Procedure section on the Public Server and in paper form in each unit's Nursing Procedure Manual. As of January 17, 2001, they were migrated to the HSC Policy and Procedure Intranet site.

KIDCOM order screens were revised to include monitoring requirements for patients receiving opioid medications on October 31, 2000 and March 6, 2001. The screens will be further modified as the recommendations from the monitoring project are rolled out across the organization.

The IV administration guidelines for opiates in the Policies and Drug Information for Nurses Manual were extensively revised in December 1999, another set of revisions were approved at the April 2001 meeting of the Pharmacy and Therapeutics Committee. These guidelines include important clinical information about the onset of action as requirements for monitoring the patient's physiological response to these drugs.

Opioid medications have been added to the Potentially Highly Toxic Drug policy in June 1999, which means that drug administration is subject to extensive checks before a dose is given.

Dosing information for parenteral opioids has been prepared in the form of a wall chart that will soon be posted in medication room to help nurses check that doses are appropriate for the patient's weight.

As new policies are introduced from time to time, there are several mechanisms for communicating changes. Nurse educators communicate directly with nursing staff. The Nursing Post, a new electronic bulletin board for all nursing staff, and the Drug Information Bulletin, produced by the pharmacy department are two publications that provide a means of communication to a wide audience. The Pain Service team also provided a significant amount of education directly to health professionals.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

Lisa's nurses failed to follow the PCA and opioid protocols already in existence. The purpose of this recommendation was to ensure that vital information reached nurses <the original recommendation was for educational sessions *for nurses* only. The hospital insisted that we add doctors to the list> who did not follow the protocols, by teaching them directly instead of asking them to read more manuals and guidelines.

The following areas were specifically highlighted because of what the jury felt to be serious deficiencies in the nursing care provided to Lisa: interactions with other classes of medications and review of normal and abnormal parameters for vital sign assessment.

Sanchia Bulgin's nurses failed to understand normal and abnormal parameters for vital sign assessment.

12. Recommend that when doctors prescribe PCA pump use in the Emergency Department, that they document on handwritten Emergency Room Doctor's Orders, any variation in monitoring aside from Protocol.

This recommendation has been implemented. The Anaesthesia Pain Service implemented this recommendation by ensuring that the pre-printed PCA doctor's order sheets used in the Emergency Department mirror the KIDCOM order set. This ensures that appropriate vital sign and electronic monitoring are completed as per the protocol. The pre-printed PCA order sheet has been in place since December 1992, two revisions have been made since that time. The latest revision occurred in March 2001, this included the warning message outlined in recommendation #3.

STATUS: IMPLEMENTED

13. Recommend that all nurses be made aware that doctor's monitoring orders or other mandatory protocols are never discretionary and must be followed at all times unless: a) the orders are clearly erroneous, and authorization is obtained from the doctor to make changes; b) authorization is obtained from the doctor; or c) the level of monitoring is to be greater than ordered by the doctor.

Commencing in January 2000, HSC undertook a comprehensive review of all of its monitoring protocols and policies. At the inquest, HSC presented draft Electronic Monitoring Guidelines; these were implemented in February 2000. The Patient Monitoring Practices Project, as noted above, was established in January 2000 to examine and address issues relating to monitoring practices at HSC. These monitoring practices include: (i) the continuous electronic monitoring of vital physiological parameters, which includes electrocardiography (ECG), heart rate, respiratory rate/apnea and oxygen

saturation monitoring; (ii) levels of observation required; and (iii) frequency of vital sign monitoring.

A comprehensive review was undertaken that included: (i) a thorough examination of monitoring practices in all patient care areas; (ii) a detailed literature review to ensure that future recommended practices and monitoring systems were evidence-based; and (iii) benchmarking with other comparable paediatric hospitals across Canada, the US and England and use of National Association of Children's Hospitals and Related Institutions (NACHRI) practice opportunities.

Results of the literature review and benchmarking activities revealed little to assist HSC in developing new monitoring practices. In fact, paediatric centres that did respond to our benchmarking surveys indicated they would appreciate receiving a copy of our final product.

The monitoring project's report was issued May 10, 2000. It included 24 recommendations, including implementation of monitoring criteria, policies, and guidelines, extensive re-design of the nursing flow sheet and the purchase of new monitoring systems. This report received approval in principle from the Patient Care Committee in May 2000 and from the Medical Advisory Committee in June 2000. The new protocols were then piloted in three areas, 5C, 7C and 8C between July 2000 and September 2000. Following the pilot, some revisions were made to the criteria, policies, and guidelines. Both the Patient Care and Medical Advisory Committees approved the report with the changes from the pilot in March 2001.

The review of paediatric monitoring systems was extremely comprehensive. We have surpassed existing standards and the leading edge practices we have developed will be implemented at other paediatric institutions. Of particular interest to other institutions is the process we have undertaken to thoroughly integrate the development of monitoring policies and guidelines with existing hospital policies, purchasing monitoring systems that reflect these policies, and our new monitoring philosophy.

Hospital-wide implementation will take place as the final step in replacing all patient monitors, a \$2.5-million project agreed upon by the Capital Equipment Committee. A combination of comprehensive protocols and state-of-the-art equipment places HSC as a leader in paediatric monitoring policy.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

1) The hospital has undertaken an admirable project which can only lead to improved patient care. Notwithstanding, nothing has been done to implement the recommendation itself. This recommendation was made to address the fact that nurses told the Lisa Shore inquest jury that they believed they were justified in ignoring doctor's orders because they used their own "clinical judgment" instead. The former Chief of Nursing, Dr. Jean Reeder, defended her nurses and agreed that they were properly exercising their clinical judgment.

The jury wished to express its disapproval of the nurses' conduct and its outrage at the misuse of the term clinical judgment by making this very strong and very specific recommendation.

2) The hospital discusses the replacement of all patient monitors, although it has not yet begun to implement this. Dr. Jean Reeder, the former Chief of Nursing, told us in September 1999 - two years ago - that the hospital was planning to replace its monitors.

14. Recommend that a laminated Sedation Scale be posted on the wall in each of the patient's room.

Rather than post the sedation and pain scales in a patient's room, HSC is adopting an alternative which, we believe, will increase the scales' usefulness and ensure they are readily available. The following scales will become a permanent part of the patient's flow sheet: Sedation Scale, five Pain Scales (the FLACC Scale, CHEOPS, Oucher, 0-10 Scale, Wong/Baker Faces Scale), Chest Assessment, HSC Mobility Scale, Epidural Block Scale and Glasgow Coma Scale.

The flow sheet revisions commenced in the summer of 2000. Initially it was thought that the changes required could be accomplished in a relatively short period of time, but due to the extensive nature of the revisions, the work has taken longer than expected. The scope of the project was expanded to address specific nursing documentation practice issues which needed to be completed before the flow sheet was revised to reflect these changes. The flow sheet underwent four draft revisions, gaining extensive input each time from inpatient units and the Nursing Practice Committee. The final draft was approved for piloting by Nursing Practice Committee on March 20, 2001; and by the Forms Committee on April 10, 2001. The form is now in the Graphic

Centre for formatting and will be piloted on 5A/5B, 7C and 8B in the near future. The Forms Committee has approved a pilot of the revised flow sheet beginning at the end of April.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

Lisa died almost three years ago. Her nurses did not follow the hospital's protocols for pain and sedation scales nor did they use the accepted hospital terms to properly indicate the degree of sedation. Posting the information in the room until alternatives are adopted would have been an acceptable short-term solution to some of the deficiencies in Lisa's nursing care identified by the jury. Posting the information in the room and also adding it in the new form would make the information available to parents as well as to nurses.

15. Recommend that for patients admitted to wards from Emergency, nurses must review the Emergency nursing notes, doctors' orders, flow charts, and vital sign assessments, and should initial all documents as evidence that they have been reviewed.

As part of the admission procedure from Emergency, the admitting nurse on the ward is required to review the documents accompanying the patient and record this review as part of the Admission Note. This process was reviewed by the Nursing Practice Committee in February 2001 and it was felt that the scope needed to be broadened to address communication and exchange of information that is required to ensure the safe transfer of patients from any area of the hospital to another. As a result, a sub-committee of the Nursing Practice Committee has developed an Intra Hospital Transfer Policy/Procedure and a transfer checklist. The Nursing Practice Committee is overseeing implementation, starting with patient transfers from the Emergency Department and from the Post Anaesthetic Unit. This pilot will be completed by May 15, 2001. If any changes to the policy, procedure or checklist are required based on data/information gathered during the pilot, they will be made prior to full HSC implementation, planned for July 15, 2001.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

The purpose of this recommendation was to ensure that information relating to

the patient's condition just prior to being admitted to the ward was reviewed by the nurses responsible for that patient. In Lisa's case, the nurses did not read the information from the Emergency Department. In Sanchia's case, no one read her pre-operative flowchart to see her baseline vital signs; had they done so, they would have immediately known that she was in crisis.

Dr. Alan Goldbloom, Chief Operating Officer of the Hospital, testified at the Bulgin inquest on July 5, 2001, that this recommendation was not implemented because forcing nurses to initial documents would require too much time. He said that the expectation was already in place that nurses would review the transfer documents.

This expectation was in place when Lisa died, too, but the nurses did not meet it. Initialing a document when it has been read is something done routinely by many people in various walks of life, and is not particularly time-consuming or onerous.

The hospital's proposed alternative - a transfer checklist and an Intra Hospital Transfer Policy/Procedure - sounds much more time-consuming. Moreover, as evidence has shown, introduction of a policy is no guarantee that the policy will be followed.

Initialing documents would bring accountability to the process.

16. Recommend that the hospital should formally adopt the Electronic Monitoring Guidelines – see Exhibit # 68, attached. Further that the Nursing Flow Chart be redesigned to include appropriate columns marked: “Corometric Monitor” – “High/Low Heart Rate” and “Apnea” setting; “pulse Oximeter Monitor”, “Other Monitor”. Also that the chart have columns marked: “Sedation Scale”, and “Pain Scale”, and, that there be a space allocated for the registering of monitor serial numbers. “See PCA Protocols for Sedation Scale and Pain Scale Guidelines” is to be clearly marked on the chart. This chart to be used with all patients on PCA Pumps, and opioids. See attached.

As noted in the response to Recommendation 13, an extensive process has been undertaken including the adoption of the draft Electronic Monitoring Guidelines throughout the hospital. The flow sheet is also being revised as noted in the response to Recommendation 14. Nurses are already noting HSC control numbers and alarm limits on flow sheets and will continue to do so on

the new sheet. Other components of this recommendation have been implemented.

STATUS: IMPLEMENTED BUT NOT FOLLOWED

SHORE FAMILY COMMENTS:

According to Dr. Goldbloom's testimony at the Sanchia Bulgin inquest, those guidelines were given to everyone shortly after Lisa's inquest concluded in February 2000. Sanchia's nurses received those guidelines, but they didn't follow them - they kept checking Sanchia's monitors but forgot to check Sanchia.

17. Recommend that periodic spot checks to audit Nursing Flow Charts be conducted throughout the hospital to assess the thoroughness of Nurse charting to Doctor's orders, with particular attention being paid to monitoring. The audits to be conducted by a Nursing Review Committee.

In January 2000, HSC's Health Records Committee initiated a monthly chart audit process that monitors adherence to documentation standards for all disciplines. The audit tool used is based on standards for documentation outlined by the College of Nurses, the College of Physicians and Surgeons and the Public Hospitals Act. The tool includes elements of the nursing flow sheet as well as the completeness of Progress Notes. Each clinical area is consulted in advance in order to have an opportunity to customize the tool and include additional documentation elements for review. Audit results are analyzed and presented to the Health Records Committee as well as to the clinical area reviewed. It is an expectation that clinical areas will follow-up on specific issues, while the Health Records Committee will identify and act upon hospital trends and issues.

For example, it was noted that across all areas entries made in the Progress Notes were not being consistently dated and timed. As a result, the Health Records Committee advised all Professional Service leaders that this should be a documentation standard regardless of discipline. Documentation guidelines have been updated to address <and?> more clearly outline documentation expectations.

The 5A/B area has also developed a unit-focussed patient care audit process including aspects of nursing documentation. These audits were initiated in August 1999 and were done four days a week (two patients each day,

alternating 5A and 5B). The Clinical Nurse Specialist prepared monthly summaries of issues to be addressed and things that were done well. Unfortunately, due to an unexpected shortage of nursing support staff these audits were put on hold for a period of time but were reactivated in January 2001.

In addition, the evaluation component of the patient monitoring project includes a comprehensive audit process. Adherence to the new policies, criteria and guidelines will be monitored by chart review, direct observation of the patient, their environment and the monitoring equipment being used.

STATUS: IMPLEMENTED?

SHORE FAMILY COMMENTS:

It is hard to understand how multiple nurses could record information on Sanchia Bulgin's nursing flowsheet yet not one actually looked at what they or their colleagues had written. How could such a practice not have been discovered in the course of comprehensive chart reviews?

18. Recommend that a committee be struck to recommend age and weight appropriate settings of Corometric monitors; including high and low heart rate; and pulse oximeter monitor. Recommend that these settings then be posted on all monitors.

As noted in our response to Recommendation 13, a comprehensive process has been undertaken to determine appropriate settings for patient monitors. Age and weight settings are not useful. Rather, as shown in our response in July, we have established a table of alarm limits that sets upper and lower limits from the patient's baseline. Alarm limits have been set for oxygen saturation, heart rate, respiratory rate and apnea. Monitoring instruction sheets will be available to all clinical staff.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

Sanchia Bulgin's nurse thought that baseline vital signs meant those she recorded when she first came on duty. Sanchia was already going into shock at the time, and the signs the nurse used as her baseline were already highly abnormal. As a result, the nurse set the monitor to inappropriate levels.

The recommendation may not have been useful on its own, but the intent was to make sure that nurses understand what appropriate monitor settings are. The table of alarm limits used by the hospital did not address this lack of understanding and did nothing to improve Sanchia Bulgin's nursing care.

19. Recommend that the attending nurse on the ward of admission be responsible for handing out preprinted “Facts On” brochures to parent(s), regarding monitors, and for holding verbal discussion with parent(s) to ensure the parent(s) feel included in the care.

The hospital has more than 500 information sheets for families, including several on monitors. Each unit in the hospital maintains a resource centre that both parents and nurses access so that families get the information that is relevant to them. The hospital is devoted to family-centred care and holds ongoing verbal discussions with families about the care their children receive. Parents are also encouraged to take part in all aspects of their children’s care and in all decision-making.

In addition, the hospital has a Centre for Health Information and Promotion on the main corridor that provides families with additional information on their specific diagnosis and treatment.

To ensure that new nurses are oriented well, a new nursing general orientation session focuses on the services of the Centre for Health Information and Promotion including written resources that are available for families (such as Facts On sheets). The need for verbal discussions with families is incorporated into most sessions of the orientation program.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

Dr. Jean Reeder, the hospital's former Chief of Nursing, presented these brochures to the Lisa Shore inquest jury and said that they were already being given to patients and their families. Had the jury known that this was untrue, it may have made different recommendations.

20. Recommend that when nurse paging doctor for urgent need consultation, that the nurse is not to allow a lapse of more than five (5)

minutes to pass before repaging. If a second attempt to page is not successful within five (5) minutes, nurse must then consult alternative source.

Following the inquest, the Patient Care Committee asked each Division to develop a hierarchical response to pages for urgent consultation, as well as guidelines for nursing staff to use in defining urgent need. All relevant divisions (the Emergency Department, Operating Rooms and Intensive Care Units have special policies) have submitted guidelines that comply with this recommendation. Because the Divisional guidelines have proven to be very similar, a common hospital-wide policy has been developed.

STATUS: IMPLEMENTED? (refers to policy which has not been provided)

21. Recommend that all failed attempts to communicate through pages be documented on Nurses Flow Chart and in KIDCOM Progress Notes.

The guidelines noted in the Recommendation 20 include information for nurses regarding the documentation of failed attempts to page physicians. As KIDCOM cannot be used to record Progress Notes, this documentation will take place in the “Progress Notes” section of the patient’s chart.

STATUS: IMPLEMENTED

22. Recommend that a doctor must ask for all specific vital signs and scales in any telephone consultation with nursing staff.

The Chiefs of Surgery and Paediatrics sent out directives in March 2000 to all Division Heads indicating that all staff physicians, fellows and residents should request specific vital signs and scales whenever they are contacted by nursing staff concerning patients receiving parenteral opiates. All Divisions supported this recommendation.

STATUS: IMPLEMENTED BUT NOT FOLLOWED

SHORE FAMILY COMMENTS:

When Sanchia Bulgin's nurse spoke to doctors in September 2000, no one

asked what Sanchia's vital signs were. Sanchia was receiving parenteral opiates - and her vital signs were highly abnormal.

23. Recommend that a committee be formed and made responsible for defining the term “Clinical Judgment”. The committee to be responsible for defining the terms, parameters and limitations of application. The committee to be comprised of both nurses and doctors. The committee being held responsible for the dissemination of information to all hospital staff.

A Clinical Judgment Task Force led by the Centre for Nursing was set up in January 2001 to define Clinical Judgment. It began the process with a literature review, a concept analysis and completed a definition of Clinical Judgment. The development of an explanatory model is under way that identifies relevant factors that will aid or restrict clinical judgment. The anticipated outcome of this project is a paper that will be used to review clinical assessment, orient staff, and facilitate communications with other professionals. Interdisciplinary input has been received and the final paper will be completed by early May.

STATUS: IN PROCESS

SHORE FAMILY COMMENTS:

The reason for this recommendation was that the Lisa Shore inquest jury was angry at how her nurses used the term clinical judgment over and over again in their testimony to justify not following doctors orders, hospital protocols, or good nursing practice.

Dr. Goldbloom testified in the Sanchia Bulgin inquest he believed this recommendation was made because the nurses used the term several times in explaining how they came to make decisions. Sorry, Dr. Goldbloom, it was because they used the term to excuse their negligence, and showed no clinical judgment whatsoever.

24. Recommend that a) when new graduate nurses are hired by HSC they have comprehensive training through Pain Service Department in care and monitoring of patients on opiate drug treatment, and that b) they are on the Preceptor Program for a minimum six (6) month term.

Self-directed learning packages have been developed on medication administration that includes a focus on opioids. This is included in all orientation programs for new nurses. The expectation is that new nursing staff demonstrate competence in monitoring the effects of opioids.

All new staff have a preceptor during their orientation period. Several units, including 5A/B, have now implemented a new clinical support role, this role was implemented on 5A/B in October 2000. The clinical support role increases the number of experienced nurses available to front-line staff on a 24-hour basis.

Performance reviews continue to be undertaken at three months for new staff. Orientation periods are set based on the achievement of objectives and may be extended based on competency levels.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

The expectation that new nursing staff demonstrate competence in monitoring the effects of opioids was not met by Sanchia Bulgin's novice nurses.

The Lisa Shore inquest jury did not feel that the existing preceptorship period (20 nursing shifts) was sufficient orientation and training for novice nurses. It believed that one of Lisa's nurses, a novice of four months experience, was unprepared to have sole responsibility for patients. This same nurse - who, by the time of Lisa's inquest had been working at the hospital for more than a year - told the jury that she had applied to become a preceptor herself.

25. Recommend that a Relief Staff Nurse be added to all LN (Long Night) and LD (Long Day) shifts at HSC.

In an effort to provide an environment that allows front-line nurses to deliver the best possible care, several new roles and initiatives have been established. A Clinical Response Team of experienced paediatric nurses has been created. This team is available 24 hours a day, seven days a week to provide flexibility for relief on patient units, including coverage for breaks. The team is also available to assist in managing urgent patient care situations.

The Administrative Associate role (the senior officer on duty in the hospital)

has been enhanced to provide leadership in all patient care areas and to identify areas that require additional supports or resources. The Associates are available 24 hours a day, seven days a week, and work closely with clinical leaders on each unit to ensure that safe nurse to patient ratios are maintained.

62% of inpatient units have also implemented the Clinical Leader and/or Clinical Support role. These roles will be phased into all areas over the next four months.

STATUS: NOT IMPLEMENTED

26. Recommend that nursing breaks on any twelve (12) hour shift be regulated so that nurses take breaks at appropriate times throughout shift, and that a Relief Staff Nurse be responsible for covering off for nurses on break, only. No Relief Staff Nurse (or any other nurse on shift) is to be responsible for more than five (5) patients at one time.

As part of the operating planning process, nursing resource plans are in place to deliver care at a ratio from 1:1 to 1:4, depending on patient need. During breaks, nurse patient ratios may be higher than the planned range. The Clinical Response Team (referred to in Recommendation 25) will assist with break coverage based on patient acuity and needs. Nurse to patient ratios are regularly monitored.

STATUS: NOT IMPLEMENTED

SHORE FAMILY COMMENTS:

The night of Lisa's death, the three nurses on duty alternated their breaks from approximately 2:00am until after 6:00am. The nurse patient ratios were higher than the planned range for over four hours.

27. Recommend that the hospital appoint a team of doctors and nurses to act as Coroner Coordinators of all events in the situation of a Coroner's Case. That team to be responsible for securing the room of the deceased to include: all items on recommended "Coroner's Check List"; arranging for all personnel involved in the deceased's care to write a summary of events; and for those persons to remain on the Ward, available for a discussion with the Coroner.

The hospital has a critical occurrence review process based on the premise that the primary responsibility for investigation of an incident falls to the line managers. This process is described in a step-by-step flow diagram and is available on the HSC Intranet and in paper format. The process covers all key steps and responsibilities. When the Coroner's Check List is complete, it will be incorporated into the process.

It is our expectation and belief that by using this clear process and working closely with the Coroner's Office, line managers in all areas of the hospital will be able to carry out their responsibilities in cases of critical occurrences. The process has been closely followed in all critical occurrences since the inquest and has been documented carefully.

When developed, the process was reviewed and approved by the appropriate committees and managers, including the Quality Council of the Board of Trustees, Hospital Quality and Resource Management Committee, Operations Team, Patient Care Committee and Operational Forum.

The Hospital Quality and Resource Management Committee reviews all critical occurrences at each month's meeting, and this information is then reviewed at the Quality Council of the Board of Trustees.

STATUS: IMPLEMENTED

28. Recommend that when an unexplained or unexpected death occurs, all persons who had any responsibility for the patient's care, including relieving nurse, in the previous twelve hours must be available, at the hospital, for an interview with the Coroner when he attends at the hospital, on his initial visit, to investigate the death.

Senior officials of the hospital have met and continue to meet with the Deputy Chief Coroner to ensure that there is full and timely cooperation between the hospital and the Coroner's Office in the case of any reportable death. This would include ensuring that individuals involved in the patient's care be available at the Coroner's request and that all relevant equipment and data (paper and electronic) are preserved.

STATUS: IMPLEMENTED

29. Recommend in cases of unexplained or unexpected deaths occurring in a hospital, the Coroner should direct that the contents of all recycling and shredding bins at the nursing station be preserved, as well as all documents, audio and videotapes, audit trail records, incident reports, nursing notes, and any other information relating to the patient who died. This direction should be quickly and clearly conveyed to the hospital employees by the Investigating Coroner, and by the above recommended hospital appointed coroner's team.

In all reportable deaths since the inquest, this recommendation has been followed. As noted above, the hospital and the Coroner's Office have met to look at ways to ensure timely and complete cooperation in case of reportable deaths. We have also identified a single, senior staff member, the Executive Vice-President and Chief Operating Officer of HSC, who is in regular contact with the Deputy Chief Coroner when unexpected or unexplained deaths occur. This has substantially improved communications between the two organizations.

STATUS: IMPLEMENTED

30. Recommend that when the family of a deceased patient – whether on its own or through a lawyer – requests detailed information about the circumstances of the child's death, every effort should be undertaken to respond quickly, accurately and openly. In cases of unexplained or unexpected deaths, a member of the hospital's Medical Ethics committee must be included in any discussion of, meeting with, or written response to the family or to a Coroner looking into the child's death.

HSC is committed to responding to families' requests for information as quickly, accurately, and openly as possible. For Coroner's cases, a representative of the medical staff, usually the responsible physician, acts as the primary contact with the family.

The hospital does not have a Medical Ethics committee – we have a Research Ethics Board and a Bioethics department. However, in order to deal sensitively with families, we ask the family whether they would like a non-medical staff member to participate in meetings.

At HSC, three full-time Patient Representatives help families and advocate for them when they have questions, concerns or complaints about their children's care. Bereaved families often request that one of the Patient Representatives attend meetings to advocate on their behalf. In other cases, families prefer to have other professionals involved such as social workers, chaplains or bioethicists. The hospital believes the family should have the choice of whom to involve.

Because we are committed to working collaboratively with families, HSC has also set up a task force to develop and communicate a policy and guidelines regarding the disclosure of all adverse events at the hospital, not just unexplained or unexpected deaths.

STATUS: IMPLEMENTED

NOTE: THERE WERE 5 ADDITIONAL RECOMMENDATIONS WHICH DID NOT APPLY TO THE HOSPITAL FOR SICK CHILDREN.