



Ministry of
the Solicitor
General
Ontario

Office of
the Chief
Coroner

Verdict of Coroner's Jury / Verdict du jury du coroner

Ministère du
Solliciteur
général

Bureau
du coroner
en chef

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We / Nous soussignés, Gail Allegri of / de Toronto
Diane Cassman of / de Toronto
Angelina Santa Ana of / de Toronto
Lawrence Dillon of / de Toronto
Brian Bamford of / de Toronto

the jury serving on the inquest into the death of: / dûment assermentés, formant le jury dans l'enquête sur le décès de:

Surname / Nom de famille Shore Given names / Prénom Lisa

aged / âgé(e) de 10 held at / qui a été menée à 15 Grosvenor Street, Toronto
 on the / le Nov. 8, 9, 12 1999 Jan. 17, 18, 19, 20, 21, 26, 27, 28, 31 2000
Feb. 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24 2000

by / par Dr. James Cairns Coroner for Ontario, / coroner pour l'Ontario.

having been duly sworn, have inquired into and determined the following: / avons enquêté et avons déterminé ce qui suit:

- 1. Name of deceased / Nom du (de la) défunt(e) Lisa Shore
- 2. Date and time of death / Date et heure du décès October 22, 1998 @ 0620-0700
- 3. Place of death / Lieu du décès Hospital for Sick Children- Toronto
- 4. Cause of death / Cause du décès Caused by probable complex drug interaction leading to cardiac and respiratory arrest
- 5. By what means / Circonstances entourant le décès Homicide

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(Continue on reverse side if necessary / Continuer au verso si nécessaire)

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 Foreman / Président du jury

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JURY RECOMMENDATIONS CONCERNING THE DEATH OF

LISA SHORE

The following recommendations are not presented in any particular order of priority:

MANUFACTURER and HOSPITAL (HSC)- RE: RESEARCH

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.

HOSPITAL (HSC) – RE: KIDCOM

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 the Kidcom orders are activated.

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.”

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.

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.

6. **RECOMMEND** that Kidcom Print Request Tapes be stored for eighteen (18) months and be made available for Coroner’s investigation.

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.”

8. **RECOMMEND** that all Shift Change – Nursing Notes be inputted on Kidcom

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HOSPITAL (HSC)- RE: EDUCATION

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 at initiation of opioid therapy and restart again from the moment of admission to the ward. The Kidcom orders should be changed to reflect this.

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.

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

HOSPITAL (HSC)- RE: MONITORING/PROTOCOL

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.

13. **RECOMMEND** that all nurses be made aware that doctors monitoring orders or other mandatory monitoring 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 change,
- b) Authorization is obtained from the doctor, or
- c) The level of monitoring is to be greater than that ordered by the doctor.

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

HOSPITAL (HSC)- RE: CHARTING

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.

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: “Corimetric Monitor” – “High/Low Heart Rate” setting 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.

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

HOSPITAL (HSC)– RE: MONITORS

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

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.

HOSPITAL (HSC)– RE: PAGING/COMMUNICATION

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

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

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

HOSPITAL (HSC)– RE: "CLINICAL JUDGEMENT"

23. **RECOMMEND** that a committee be formed and made responsible for defining the term "Clinical Judgement". 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.

HOSPITAL (HSC) – RE: STAFFING

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

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

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.

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HOSPITAL (HSC)– RE: CORONER’S CASE

27. **RECOMMEND** that the hospital appoint a team of doctors and nurses to act as Coroner Co-ordinators 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.

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.

29. **RECOMMEND** in cases of unexplained or unexpected death 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.

HOSPITAL (HSC)/CORONER’S OFFICE – RE: CORONER’S CASE

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.

CORONER’S OFFICE – RE: PAEDIATRIC/PEER REVIEW COMMITTEE

31. **RECOMMEND** that where nursing issues are relevant in a Coroner’s Case, that a Nursing Representative from the Regulatory Body of the nursing profession be added to the Paediatric/Peer Review Committee.

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CORONER'S OFFICE – RE: CORONER'S CASE

32. **RECOMMEND** that when an unexplained or unexpected death occurs in a hospital, the Coroner's Office should designate one Coroner – who is not affiliated with the hospital – to be the liaison between the hospital and the family. This responsibility should continue at least until the conclusion of any Coroner's investigation or inquest.

33. **RECOMMEND** that a standard form be used as a "Coroner's Checklist" to be completed during the Coroner's initial visit. The Coroner's Checklist to include the following items:

- i) The full and complete Patient Chart including:
 - Kidcom Doctor's Orders
 - Progress Notes
 - Flow Sheet
 - Patient Care Plan
 - Any Nurses' handwritten notes
 - Any Doctors' handwritten notes
 - Medicinal orders
 - Lab results
 - Nursing Written Notes re shift change
 - Names and responsibilities of all involved personnel
 - Summary Notes of Events of all involved personnel
 - Comments re Coroner interviews with all involved personnel
- ii) PCA devices
- iii) Corimetric Monitor – leads, patches
- iv) Oximetry Monitor – leads
- v) Any other devices used in patient care
- vi) Recycle bin contents

No monitoring equipment or notes to be changed or altered without Coroner's consent

OFFICE OF THE CHIEF CORONER

34. **RECOMMEND** that a report be issued within eight (8) months, regarding the implementation of the Lisa Shore Inquest – Jury Recommendations.

35. **RECOMMEND** that a copy of the Jury Recommendations be sent to:

- i) Ministry of Health
- ii) College of Nurses of Ontario
- iii) College of Physician & Surgeons of Ontario

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