

5A Incident

I arrived at work around 7:35 AM and just as I got to my office I heard an overhead call to 5A stat. I went to the unit where a full code was already in progress. I spoke briefly to the manager then proceeded to where the crash cart was just outside of the patient room to see if I could support the staff in any way. They said they were doing OK and were beginning to sort through some used wrappings etc that they could remove from the cart. As I stood there, Ruth Doerkson, the nurse who had cared for the patient on nights came right out of the room and firmly grabbed my arm pulling me into the 5AB classroom. She began to cry right away saying "what did I miss" "I don't get this, she was fine an hour ago, I checked her and she was fine" "why didn't the monitor go off" "I left her on the monitor, why didn't it work" "why didn't I check her at 7, I always check all my kids at 7, I checked my other 4 but not her" "What did I miss"

I let her get it out for a few minutes when 3 or 4 other nurses came in the room, also crying. Lvnnette Avery, Anagaile, Lisa... maybe one other. I ask if they had pronounced the child and they nodded yes and continued to cry saying they had never seen a child pronounced before. The CHS Manager, Bill Kreuzweiser came in the room to offer his words of support as well.

As people began to leave I stayed with Ruth. She talked more about the monitor saying "I know I checked it, I set the heart rate limits to 50 and 160 [she may have said 180 - I can't remember now] and turned the apnea alarm off. I don't know why I turned the apnea off, I never do that, maybe I shouldn't have done that, I don't know, but why didn't it alarm. It was turned off when we went in the room." When I asked her further about this she said she entered the room with the 2 doctors and they went in ahead of her, they turned on the light, and as mom woke up they began to talk to her. Each of them turned to the child and realized "she was gone" as Ruth described it. She said she ran for the desk to call a code blue while the resident started CPR and she grabbed the crash cart. She said when she went back in the room with the crash cart, she noticed the monitor "was turned off". She didn't know who had done it but she said "I know I left it on because I checked her at 6 and it was on then". I went to the room where the body still remained waiting for the coroner to arrive, where 3 or 4 staff were with the body, stroking her head and holding her hand. The nursing supervisor was also present. Two of the nurses were checking the PCA pump to see how much was left in the syringe.

I picked up the apnea monitor and confirmed that, indeed the limits were set just as Ruth had stated. Heart rate 50 to 160 [or 180 - I can't recall now] and the apnea reading was off. The leads were lying attached to the monitor at their end, but not clipped on to the child. I don't know when these were removed. I sat with Ruth while she charted the incident. As well, the CNS, Daria Romaniuk had also joined us while she was charting.

Mary Douglas November 12, 1998