
NAME OF INTERVIEWEE: Pat McDonell, Nurse Analyst
PLACE OF WORK: The Hospital for Sick Children
DATE INTERVIEWED: October 12, 2000
INTERVIEWED BY: C. Flear, CNO Investigator
PRESENT: Susan Anderson, Applications Director

INTERVIEW SUMMARY: In person

Background Information:

Pat McDonell has worked at The Hospital for Sick Children (HSC) for 19 years; she has worked in the Nurse Analyst role for 9 years.

The Kidcom System:

Pat McDonell demonstrated how the Kidcom system operates from a user's perspective. She explained that

- Each authorized user receives a unique sign-on code to Kidcom after attending a formal training session. This sign-on code becomes the person's legal electronic signature. It consists of two parts. The first part is the user ID which Information Services issues to the user. It has the person's name associated with it and it gives access to certain functionality based on their position in the hospital. The second part is a password which the person chooses.
- Doctors select orders from a menu of items. Each department (e.g., Orthopaedics, General Surgery) has a separate menu for orders that are specific to their department. These are the standard orders for each department. Doctors click on the orders that they want (either a mouse or a light pen is used). If they wish to add additional instructions to an order, they can use the "type" option at the bottom of the screen. If doctors wish to enter orders that are not available from their department menu, they can select them from the general ordering pathways for the different areas (e.g., Pharmacy, Lab, Nursing)
- Doctors can enter admission orders for patients while they are still registered in the Emergency Department and before they are admitted to an inpatient unit. They locate the patient name on Kidcom from the Emergency patient list and enter their orders in suspended mode.

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- Suspended admission orders are not to be used by the nurses in the Emergency Department; they are for admission only. Nurses in the Emergency Department and on inpatient units can view these suspended orders while the patient is still registered in Emergency.
- When a patient is admitted to the unit from the Emergency Department, the nurse caring for this patient receives a verbal report from an Emergency nurse.
- Inpatient nurses are trained to activate any suspended admission orders entered while the patient was registered in Emergency. There is a manual on all of the units which outlines the steps to be taken to activate these orders. The expectation is that the nurse would look for suspended admission orders when a patient arrives on the unit from Emergency and activate these orders.
- The nurse on the admitting unit needs admission orders to act upon. The nurse signs onto the system, picks the patient, selects "Ordering Functions", and then selects "Activate Suspended Admission Orders". The nurse must click on a box for each order to activate it; this forces the nurses to focus on each order. After the orders are activated, they become current medical orders and are no longer suspended.
- A Daily Orders Summary report automatically prints on the inpatient units at midnight. This summary shows all orders including active, suspended, activated and held, that have been entered during the previous 24 hours. As long as a patient is admitted to a nursing unit before midnight, the Daily Orders Summary will show any suspended admission orders entered while registered in Emergency. With respect to the Lisa Shore case, the patient was admitted after midnight so no Daily Orders Summary report printed.
- As of January 2000, when a patient is admitted a "Suspended Orders from Emergency" report automatically prints on the admitting unit. This is a permanent document which is filed in the patient chart. A quicker, easier pathway is also available for inpatient nurses to view suspended admission orders while the patient is still registered in Emergency.
- At any time nurses can request a copy of the Patient Care Summary that prints at the beginning of each nursing shift. They can also view this report on-line at any time. Both paper and on-line versions show all current and suspended orders.
- The nurse must go into the Assessment Form pathway on Kidcom where she enters information about the patient being admitted to the unit, such as weight, vital signs, history of present illness, and assessment of general appearance. The nurse is also asked to fill in a list of current medications (dosages and times of administration) and when the last dose was given to the patient at home.
- The nursing Progress Notes are not entered into the system, but are hand-written on the chart.

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- A group of discharge reports automatically print when a patient is discharged or expired from the Kidcom system. These reports include a Daily Orders Summary, a Patient Record (which includes medications given, height, and weight), an Assessment Form and a Discharge Order / Summary.
- An electronic trail is left of who activated the orders at which date and time.
- A taped record is kept of the name, time, date, and which terminal was used each time the system is accessed. However, these tapes are kept for only 6 months, and then are overwritten.
- It is possible to enter Assessment Form data on a new patient, and look at the Doctor's orders, but have no record that the orders were viewed. The audit trail records do not capture when a user views patient information on-line.

Audit Trail of the Kidcom System as it Relates to Lisa Shore:

The audit trail shows that

- Ruth Doerksen, RN, entered information regarding Lisa on the Assessment Form at 02:05 hours. Under the History of Present Illness section she noted that Lisa had chronic right hip pain and listed the medications she was currently taking at home. Ms Doerksen did not complete the section which pertains to the time that the last dose of these medications was given at home.
- Ms Doerksen completed the physical findings and the physical examination; in this latter section she entered Lisa's vital signs.
- At 5:44 hours on October 22, 1998 an RN on 5A used the expire pathway on Kidcom to remove Lisa Shore from the 5A inpatient list.

Ms Doerksen printed off a copy of the Patient Care Summary a few days after Lisa's death and took it home with her. Since she did not make any changes to the record, no audit trail of this interaction is available.

Patricia McDonell

Signature (Pat McDonell)

October 24, 2000

Date