

Ruth Doerksen's notes (transcription)

October 23, 1998; Recall Note of LN October 21, 1998.

I was the NP on shift, with 4 patients, 2 RN's, Anagail S. with 4 patients and Maureen F. with 4 patients. After midnight, I received a call from the ER regarding a patient that needed to be admitted. I questioned the admission to our floor as the child was being admitted with chronic pain by the Pain Service. This was cleared up by the admitting doctor being Dr. Wright (Orthopaedics) and Pain Service writing the orders. Anagail took report at approximately 1:30 a.m. from the ER nurse and the ER nurse called transport to bring the patient upstairs. This is unusual in that the receiving ward usually calls when they're ready for the patient.

I was to be Lisa's nurse. The report (as written by Anagail) was that this was a 10 year old girl with chronic hip pain. She had originally fractured her R tibia in January, and since had suffered this pain. There was some question as to whether she needed to be MRSA screened as she had been hospitalized in Boston. The ER was going to start her PCA and send her up. She had been given a couple of boluses of morphine.

I received Lisa via stretcher at 0145. Transport person and Mrs. Shore were present. Lisa was asleep on the stretcher. She moved herself from the stretcher to the bed without any complaint of pain, there was no facial indication of pain. I did her vital signs which were normal. Her PIV was insitu with a PCA hooked up and a normal saline line running at 20 cc/hr. I checked the PCA orders against the pump for accuracy and noted that the syringe was almost full and readings correct. At this time Lisa had received a total of 10 mls of morphine. Mrs. Shore and I changed Lisa's top and removed her shorts for sleeping. At this point I asked Lisa if she needed to go to the bathroom, she declined. Mrs. Shore and I arranged her pillows from home for her to sleep, she wanted the hospital pillow as well, but mom sort of smiled and said that one was for her. I went to place the blankets over Lisa, mom quickly stopped me saying she could not tolerate anything touching her leg - it was very sensitive. I noted that both her legs were warm and pink. I left the room to get linen for Mrs. Shore, when I returned I went over her list of medications she was on at home and wrote them down on the same sheet of paper as her vital signs. I left the room again and returned with the corometric monitor which I placed on Lisa and turned on. Mrs. Shore was at the door and was about to settle to sleep, I asked her if there was anything I needed to know about Lisa's medical history that was new or different and whether she had any allergies. She stated that there was nothing to add. I pulled the door almost shut and left. I did a little bit of paper work, at the desk and Lisa's monitor went off, it was reading Apnea, I went in and cleared the monitor - it beeped again before I left. I cleared it and went to the desk to find a pair of scissors - I returned and reset the Apnea - At this time I took all my paperwork into Room 12 as I was covering for Maureen who was going on her break. I popped out of Room 12 for something and Lisa's monitor was going off again and this time I reset it again. I turned off the Apnea dial as I thought that both Lisa and mom needed to

get some sleep and would not if the monitor kept beeping.

I did not go into Lisa's room again until 0500 hrs. to do her vital signs. I went on my break after I finished relieving in room 17 at approximately 0230 hrs. I returned from my break at approximately 4:15 a.m., took report from Anagail - she told me she had called the Pain Service as Lisa's RR went down to 8 - 10 and that they said to remove her PCA button from her - we had a discussion about whether Lisa was using the button a lot and Anagail said she had not pushed it at all, but she removed it from the bed anyway and raised Lisa's bed as (per pain service). At this time I asked her if her RR had picked up and she said they had been okay - I did my charting audits and then rounds on all the patients. At 5 a.m. I took Lisa's vital signs. I asked her to open her mouth so that I could take her temperature, she did but she appeared to fall asleep while I was still taking her temperature and was snoring a bit while I did it. She was settled back to sleep before I left the room. Her RR were 16. I checked them against the corometric as I left the room.

At 6 a.m. her RR were 14 and I read and wrote her HR down as from the monitor.

At 0700 I checked my patients down the one hall, but in the confusion of a sick call, the new staff coming on and MD's rounding, I missed Lisa - I decided to go in and clear her pump when I went in with the other residents. As we entered the room, mom woke up, turned on the light, we all looked at Lisa - one of the doctors yelled at me to call a code - I ran to the desk, called the code and called to Anagail to get into the room to administer O2, and that the setup was all there. I went for the crash cart and when I returned to the room, Dr. Yee had started compressions and there was many other people present then ran to desk to get Narcan which someone else was already getting. I looked at the monitor to see if there was any vital signs - but it was turned off.

Once the Resus team arrived and everything was started I became immobilized and removed myself from the room and watched.

October 24 - spoke with Anagail today - Stated she paged anaesthesia X 2, first time did not respond - Did not ask about O2 sat. She did not turn off the monitor.