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INTERVENTION REPORT (EXCERPTS)

Intervention at McGill University Health Centre

Québec City, March 17, 2022

THE INTERVENTION

The Québec Ombudsman decided to intervene on its own initiative further to information it received about the quality of day surgery perioperative care (before, during and after surgery) at Montreal Children's Hospital (MCH).

THE FINDINGS

First, it is important to point out that some of the information brought to the Québec Ombudsman's attention had to do with administering medication. The investigation did not confirm that these shortcomings existed, so this aspect will not be dealt with any further in this report.

However, study of users' records confirmed that care was deficient. These shortcomings are detailed in the analysis that follows.

MONITORING FLUID BALANCE

According to the clinical literature, liquid intake (ingesta) and waste from elimination (excreta) must be monitored and documented to ensure post anesthesia fluid balance. MCH's documentation tool contains a grid for that purpose. In three of the records analyzed by the Québec Ombudsman, no monitoring of ingesta and excreta was indicated, even though the nursing notes mention miction or ingesta that should have figured in the grid. Already aware of these shortcomings, MCH says that audits are underway to determine, in an action plan, the measures that must be put in place to improve the situation.

The Québec Ombudsman received the preliminary results of the audits. However, MCH had not analyzed them yet. The Québec Ombudsman has noted that the raw data obtained confirm what was seen in the users' records. Two recommendations about audit analysis, and production and implementation of an action plan, have been made (R-1 and R-2).

MONITORING OF VITAL AND NEUROLOGICAL SIGNS

In more than half the files analyzed, monitoring of vital and neurological signs did not correspond with what MCH expects as laid out in its guidelines titled *Post Anesthesia Care Unit Guidelines for Standards of Care*. Generally, there is compliance with the measurement of vital signs every 15 minutes during Postoperative Phase 1. However, for several patients, vital signs were not taken often enough during Phase II (every 30 minutes). Moreover, only a few users' records document vital signs at discharge. A few make no mention of vital signs whatsoever.

Furthermore, the Aldrete score, a scale that includes consciousness, activity, respiration and circulation, is only indicated at admission to the post anesthesia care unit (PACU) and sometimes only at discharge. MCH's nursing documentation sheet and guidelines prescribe that this score must be indicated 15 minutes after admission and anesthesia, as well as when

the patient leaves the postsurgical recovery room. The Québec Ombudsman was informed that audits are underway concerning these elements and that an improvement action plan would follow. The Québec Ombudsman is satisfied with MCH's proactivity. To ensure that these steps lead to concrete improvements, recommendations have been made (R-3 and R-4).

For two patients more specifically, vital signs were abnormal and the subsequent monitoring by nurses was insufficient. One user, age 16, was discharged even though his blood pressure was 90/36, a much lower level than the baseline, which ranges between 125 and 137 over 78 to 87 for the patient's sex and age. The team concerned must be reminded of normal blood pressure readings and of the importance of ensuring patients' stability at discharge. The Québec Ombudsman is therefore asking the institution to provide it with confirmation that this reminder was issued and to indicate how this was done (S-1).

Regarding the second patient, a four-month-old baby, the Québec Ombudsman's analysis showed that the nurse assigned to monitor the baby did not take his vital and neurological signs often enough. If this had been done, the nurse would have seen that the baby's condition was deteriorating. According to the information in the record, vital and neurological signs were taken five times between the baby's admission to PACU at 9:40 and 11 a.m. They were then taken every half hour until noon and every hour until 5 p.m. Partial readings were carried out at 6:30 and 7:30 p.m. At 7:45 p.m., when the nurse on the next shift took charge of the baby, she did a full reading of the vital signs, leading her to call for the medical staff immediately. The child was then transferred to the intensive care unit with septic shock.

The Québec Ombudsman has noted that leaving too much time between the nursing assessments was not adequate. The fact is that the baby's vital signs were abnormal as of morning. More frequent monitoring was called for, as provided for in post anesthesia Phases 1 and II. Given the preceding, the Québec Ombudsman considers that the nurse did not adequately report the changes in the child's condition to the medical team.

MCH says that it analyzed this event. The nurse concerned was called in by her manager and the educator to go over the situation with her and brief her on expectations in such cases. Feedback is exchanged frequently. According to the information obtained, the nurse displays great openness and continues to improve. The event was also reviewed with the medical staff and the nursing staff there during the event. Certain people said they felt uncomfortable about expressing concern about a patient under the care of a colleague. The members of the staff were therefore given means enabling them to do so in strictest confidence.

The Québec Ombudsman feels that MCH took charge of the situation adequately and is establishing measures so that there is no recurrence. Considering the requested follow-up and the comments about the monitoring of this patient found in the following section, the Québec Ombudsman will not intervene any further concerning this situation.

MONITORING THE ADMINISTRATION OF OPIATES

In the 16 audited users' records, nearly half the patients had received opiates, and only one patient had been monitored correctly. For the others, the quality of monitoring varied. In almost all cases, pain assessment was repeated. However, for the vast majority of patients,

including the above four-month-old, the following parameters were not measured often enough:

For intravenous administration:

- Sedation, oxygen saturation (if respiratory depression factors are present) and respiratory rate:
  - Before administration
  - 30 minutes after administration
- Full vital signs according to the postoperative phase underway.

For oral administration:

- Sedation and respiratory rate:
  - Before administration
  - 30-60 minutes after administration
- Full vital signs according to the postoperative phase underway.

The investigation showed that during the two-day general orientation and PACU orientation, new nursing employees were given initial training. The manager concerned noted the Québec Ombudsman's findings about the supervision of opiate administration and said she was open to improving existing practices. However, at the time of the investigation, the measures that would be put in place had not yet been chosen. Given the preceding, a recommendation has been made (R-5).

COMPLIANCE WITH DISCHARGE REQUIREMENTS

The grid laying out discharge requirements enables nursing staff to ensure that patients are given a safe hospital discharge. In the sample of files analyzed by the Québec Ombudsman, there were times when the requirements were not all met at discharge. For example, patients were discharged without having urinated. The reference literature regarding children states that parents must be informed that miction must occur within six hours after surgery. There is no indication that the parents receive this information even though the grid contains a box for that purpose.

The Québec Ombudsman was told by MCH that this is basic information given when parents are briefed and that the issue was one of documentation rather than of knowledge by the nursing staff. Since the information about miction is indicated in the grid, that the staff are familiar with the grid, and that the files in which shortcomings were observed concerned patients who recovered quickly and who do not need very much nursing care, the Québec Ombudsman feels that MCH's explanations are plausible.

As part of the investigation, the head nurse committed to issuing a reminder to nursing staff to ensure that the grid is completed properly and that the parent signs in the space provided for that purpose. The Québec Ombudsman feels that this measure is satisfactory and is requesting confirmation that it was carried out (S-2).

THE RECOMMENDATIONS

With a view to continuously improving the quality of care and services provided, the Québec Ombudsman has made the following recommendations to McGill University Health Centre:

R-1 **Analyze** the results of the audits concerning monitoring of ingesta and excreta on the PACU of Montreal Children's Hospital;

By June 30, 2022, send the Québec Ombudsman a copy of the results of this analysis.

R-2 **Produce** an action plan stemming from the analysis of the audits carried out on the PACU of Montreal Children's Hospital concerning monitoring of ingesta and excreta;

By September 30, 2022, send the Québec Ombudsman a copy of the action plan stemming from the analysis of the audits.

R-3 **Analyze** the results of the audits concerning the assessment of vital signs, neurological signs and the Aldrete score during post anesthesia Phases I and II on the PACU of Montreal Children's Hospital;

By June 30, 2022, send the Québec Ombudsman a copy of the results of this analysis.

R-4 **Produce** an action plan stemming from the analysis of the audits carried out on the PACU of Montreal Children's Hospital concerning assessment and monitoring during post anesthesia Phases I and II, as well as at discharge;

By September 30, 2022, send the Québec Ombudsman a copy of the action plan stemming from the analysis of the audits.

R-5 **Train** the PACU nursing staff at Montreal Children's Hospital in MUHC Pediatric Opioid Therapy Guidelines;

By September 30, 2022, provide the Québec Ombudsman with confirmation that this training was given.

EXPECTED FOLLOW-UP

In accordance with the provisions of the *Act respecting the Health and Social Services Ombudsman* (CQLR, c. P-31.1) within 30 days of receiving this report, McGill University Health Centre must inform the Québec Ombudsman of whether it intends to implement the recommendations made to it, or of its reasons if it has decided not to act on them.

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Québec City Office
800, place D'Youville, 19e étage
Québec (Québec) G1R 3P4
Phone: 418 643-2688

Montréal Office
1080, côte du Beaver Hall
10e étage, bureau 1000
Montréal (Québec) H2Z 1S8
Phone: 514 873-2032

protecteurducitoyen.qc.ca
Toll-free: 1 800 463-5070
Fax: 1 866 902-7130
protecteur@protecteurducitoyen.qc.ca