FORM H

INQUISITION

CANADA)
)
Yukon Territory)
)
TO WIT:)

AN INQUISITION taken for Her Majesty the Queen at the Andrew A Philipsen Law Centre, City of Whitehorse, Yukon, on June 2 to 7, 2014, before Coroner Norman Leibel, one of Her Majesty's Coroners for the Yukon Territory, who did act under Section 12(1) of the *Coroners Act.*

The undersigned Coroner and:

1. DEBORAH WALSH (Foreperson)
2. Loretta Boorse
3. Donna Sippel
4. Judith Miller
5. Donna Luschyk
6. Jacqueline Hynes

being duly sworn and charged to inquire for Her Majesty when, where, how and by what means the said Teresa Ann Scheunert came to her death, do upon their oath say that the said Teresa Ann Scheunert died at Watson Lake in the Yukon Territory, on the 21st of June 2012 at approximately 11:34am o'clock in the ~~afternoon~~ morning, as a result of mixed drug toxicity We the Jury classify this death accident.

IN WITNESS WHEREOF, the Coroner has hereunto set his hand (and, the jurymen have hereunto set their hands) this 7th day of June ,2014

(Foreperson) D Walsh

Boorse

Donna Sippel

Judith Miller

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Norman Leibel

Coroner Norman Leibel

RECOMMENDATIONS

Each recommendation must be directed to an agency or person

1. Directed to: Yukon Hospital Corporation
Implement all recommendations of the Institute for Safe Medication Practices Canada report dated May 16, 2014.

2. Directed to: Yukon Hospital Corporation
Develop a formal process for providing a consistent level of care for medical peers in Yukon community hospitals and possible transfer to Whitehorse hospital.

3. Directed to: Yukon Hospital Corporation
~~Review and simplify existing forms to make~~ an
Review and simplify monitoring and reporting forms and records to make them more user-friendly to create a complete and organized patient's file.

4. Directed to: Yukon Hospital Corporation
Provide mandatory in-service training annually and as needed on all hospital policies and procedures.

5. Directed to: Yukon Hospital Corporation and Workers Compensation Board
Improve coordination between Yukon Hospital Corporation and Workers Compensation Board to ensure no delays in receiving necessary medical diagnosis and treatment.

6. Directed to: ISMP Canada and Office of the Chief Coroner, Yukon
Work collaboratively to share the learning from this case in a national safety bulletin.

(Foreperson)

Coroner Norman Leibel

June 7, 2014
Date

Recommendations:

TASKS:

Task 1: Pain management:

1. Develop or adopt predefined order sets and protocols for pain management. Ensure that order sets include guidance on opioid selection, recommended initial doses with consideration of patient risk factors, specific monitoring requirements and triggers for intervention. Examples of pain management tools currently available include the Opioid Manager and associated resources developed as part of the Canadian Guideline for Safe and Effective Use of Opioids for Chronic NonCancer Pain (Appendix 5).

2. Ensure that all medication orders are reviewed by a pharmacist in a timely way.

Task 2: Patient Monitoring

3. Establish clear expectations for assessment documentation of vital signs in the health record, in particular, related to opioid administration. When developing protocols for assessment and monitoring, consider the requirements for the initial period of opioid therapy, the period after a dose increase, and when concomitant medications that may depress respiration are added.

4. Establish clear processes for assessment and documentation of pain level and response to analgesics administered.

5. Require medical staff to document a care plan in the hospital health record and provide regular written progress notes.

6 Review hospital policies related to criteria for leave of absence to ensure that appropriate consideration is given to the need for patient monitoring. Consider a standard timeframe for leave of absence (e.g., 4 hours) when granted.

7. Ensure that patients are provided with education about the signs and symptoms of opioid toxicity and when to seek medical attention. An example of a patient handout developed by ISMP Canada is provided in Appendix 6 and a video is available from: http://youtu.be/SDMz4IqnpPk (EN) andhttp://youtu.be/FNfUrZLUZU8 (FR).

Task 3: Medication Administration

8. Ensure that processes for high-alert medications are in compliance with Accreditation Canada Medication Management Standards and Required Organizational Practices, e.g., independent double check, (Note that this was also a recommendation from the 2013 Judgement of Inquiry and the hospital has reported this as addressed.)

9. Develop audit and feedback processes to improve consistency of documentation of medication administration.

10. Establish clear expectations that medications are not to be left at the patient's bedside for self-administration and that documentation of medication administration is to occur at the time the medications are actually observed to be ingested by the patient.

11. Develop clear policies and procedures for management of medications required during leave of absence from the facility.

Task 4: Resuscitation Effort

12. Provide education to all staff about signs and symptoms of opioid overdose.

13. Develop naloxone protocols as part of the overall pain management approach to ensure appropriate management of opioid overdose when a need for intervention is identified.

Work Environment

14. Provide education for staff and physicians on the system-based causes of errors and the need for structured, consistent processes to support high quality patient care. Consider education and skills development in critical incident analysis and prospective risk assessment (e.g., using Failure Mode and Effects Analysis.)

Care Team

15. Review the timing of telepharmacy services to optimize pharmacist support at the time medication orders are written and prescribers are available for consultation and clarification.

Organization

16. Develop formal consultative relationships between the small hospital sites and the regional referral centre to facilitate timely assistance for challenging cases if these do not already exist.

17. Convene an interdisciplinary team at each site in the hospital corporation and complete the ISMP Canada HYDROmorphone Safety Self Assessment (information available from: https://mssa.ismp-canada.org/hydromorphone-ssa). This assessment is specific to HYDROmorphone but includes safety strategies applicable to all opioids. Use the results of the assessment to identify and address vulnerabilities in opioid management in all the hospitals in the corporation.

Incidental

18. Review the process for provision of emergency supplies of medication from the local community pharmacy to the hospital to ensure it is clear when medications are being dispensed for hospital use vs. for individual patient use in the community. Quantities dispensed should reflect immediate needs; medications for routine hospital use should be primarily provided through the regional referral centre in standardized packaging.

19. Provide narcotics for hospital use in a format that supports accountability at all transfers (e.g., pharmacy to hospital, shift counts) such as blister packs.