CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050036	A. BUILDING _____ B. WING _____	04/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAKERSFIELD MEMORIAL HOSPITAL	420 34th St, Bakersfield, CA 93301-2237 KERN COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00221802 - Substantiated Representing the Department of Public Health: Surveyor ID # 28467, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Health and Safety Code 1280(a) (a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1280.3, if a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation. Health and Safety Code 1280.1(c)			

2013 OCT -8 PM 12:16

Event ID:FDOJ11 9/5/2013 3:35:53PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

VP/CNO 10-8-13

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 6

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

10/08/13

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	(c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY: Title 22: 70213 (a)(d) (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff. These requirements are not met as evidenced by the following: Based on interview and record review, the facility failed to ensure that all cardiac rhythm alarms were answered promptly when the facility staff failed to respond to a visual continual low battery alarm for up to 8 hours. These failures may have contributed to the death of Patient 1. On 4/1/10 at 3:45 PM an Immediate Jeopardy was called with the Director of Risk Management. After an		70213(a)(d) Corrective Action: Telemetry Monitors – internal battery setting reset with audible alarm ON with high volume All Telemetry monitor specifications for initial setup reviewed with Manufacturer (on-site). Created Physiological Alarm Settings policy & procedure to address changes in physiological monitoring (internal) settings. Responsible Person(s): Director, Biomedical Engineering Policy & Procedures reviewed and revised: 1. Cardiac Monitoring 2. Use of Clinical Alarms on Medical Equipment to include: • Process for notification for non-response to alarm condition or change in rhythm • Alarm settings • Process for changes in settings Staff education for Monitor Tech Role (complete at the beginning of the next scheduled shift for each person working in the capacity of monitor tech). Staff education regarding communication between Monitor Tech and Primary Care RNs related to: • Confirm High/Low settings for heart rate • Reporting of Alarm activation or rhythm changes • Documentation on Monitor Tech Log • Patient location/ activities • Escalation process for alarm resolution	[redacted]10 4/1/10 5/1/10 3/18/10 4/30/10 3/18/10

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	acceptable plan of correction was accepted, the Immediate Jeopardy situation was abated on 4/6/10 at 10:10 AM. Findings: Patient 1 was a sixty-three year old female with a history of hypertension, cerebral bleed (brain bleed) and a newly diagnosed cardiac rhythm of rapid atrial fibrillation (a cardiac rhythm that can require medication and cardiac monitoring). Patient 1 was to be on a continual telemetry cardiac monitoring system (a system with a small box connected by leads to the patient that is powered by a 9 volt battery). A cardiac monitoring alarm at 10:46 indicated Patient 1's telemetry battery was dying and could no longer record Patient 1's cardiac rhythm. Patient 1 suffered an unmonitored cardiac arrest and was pronounced dead at 12:30 AM. During an interview with the Director of Risk Management on 3/30/10 at 9:20 AM, she stated, "this incident happened on [redacted]10, it was found that all the audible alarms for battery life were turned off and only the visual ones were on. Our policy and procedure states to change the battery when the yellow alarm comes on. The monitor tech (a person trained to watch cardiac monitors and		Employee involved in this incident was counseled and role changed until prioritization skills are demonstrated. . Responsible Person(s): Director & Manager(s), Telemetry Director, Nursing Standards . Monitoring: . Director of Telemetry conducted an audit on all telemetry units to ensure that all policies & procedures related to cardiac monitoring reached 100% compliance, then periodic checks were done. The results of this audit reported to Quality Council and shared with staff. . Person(s) Responsible: . Responsible Person(s): Director, Telemetry	3/25/10 4/9/10 - 5/27/10

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	report to the nurse any irregular rhythms) does nothing else but watches the monitors. We have a monitor tech for each shift and if they are not available we use a registered nurse as monitor tech. Patient 1 was found at 12:08 AM, unresponsive and a code was called. The leads and telemetry box were attached to the patient but they were not reading the cardiac rhythm because the battery was dead." During an interview with Monitor Technician 1 on 3/30/13 at 9:55 AM she stated, "We watch the monitors the whole shift, we don't get another assignment. If a battery is dying we know at least 2-4 hours before, because there is a yellow alarm that then turns to red indicating the end of the batteries life. I change the battery before it gets to a red alarm." During an interview with Registered Nurse 1 on 4/5/10 at 10:05 AM, he stated, "I was working as a monitor tech and unit secretary, I had to do the paperwork for 6 admits that night as well as be the charge nurse from 7 till 8 PM. The floor was very busy and people kept coming to me asking questions. I don't remember seeing the battery alarm. I don't know what happened. At 12:10 AM, the nurse in charge told me to call a code and I said why nobody's			

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	coding on my screen. The screen for Patient 1 was blank (indicates no cardiac rhythm transmission), and I saw no red alarm (indicating a critical cardiac rhythms). The screen was blank, like no patient was there." During an interview with the Chief Nursing Officer on 3/30/10 at 14:05 PM, she stated, "we want you to know that this not only involves our monitors, but it is an employee error as well." During a review of the clinical record on 3/30/10, the [redacted]10 cardiac rhythm strip recorded at 10:46 PM indicated the telemetry battery had died and the telemetry box transmitted no further rhythm. The rhythm strip obtained at 12:09 AM, using the emergency cardiac monitor obtained during a code blue (cardio-pulmonary resuscitation needed) indicated Patient 1 was in asystole (flat lined). The physician orders dated [redacted]/10 indicated Patient 1 was to be Maximal Care Status, indicating that all appropriate resuscitation measures were to be provided. Patient 1's Autopsy Report dated [redacted]10 indicated, "CHIEF CLINICAL CAUSE OF DEATH: cardio-pulmonary failure." The hospital policy and procedure titled, Remote Telemetry dated 10/26/09 indicated, "The Monitor tech will respond to ALL alarms/issues related to the			

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	cardiac monitoring, including routine alarms...." This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).			