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
	050226	A. BUILDING _____ B. WING _____	02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHMC ANAHEIM REGIONAL MEDICAL CENTER	1111 W La Palma Ave, Anaheim, CA 92801-2804 ORANGE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00431780 - Substantiated Representing the Department of Public Health: Surveyor ID # 21262, 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 1280.3: 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 Section 1279.1 (b): For purposes of this section, "adverse event" includes any of the following: (7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. Health and Safety Code Section 1279.1(c): The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The CDPH verified that the facility had informed the patient or party responsible for the patient of the adverse event by the time the report was made.		The owner of the facility, AHMC Anaheim Regional Medical Center LP, a California Limited Partnership, deems it appropriate and has undertaken to submit this plan of correction as required by California Health and Safety Code Section 1280. In submitting this plan of correction, AHMC Anaheim Regional Medical Center is not admitting to the accuracy or validity of any of the allegations in the statement of deficiencies. AHMC Anaheim Regional Medical Center reserves the right to dispute any allegations made by the California Department of Public Health. T22 DIV5 CH1 ART3-70213(a) & T22 DIV5 CH1 ART3-70215(a)(b) 2015 DEC 24 AM 12:13	

Event ID:GPK911 12/10/2015 1:46:38PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 12/24/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 14

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.

Accepted: 1842
12/24/15

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	DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY: Title 22, Division 5, Chapter 1, Article 3-70213(a): Written Policies Written policies and procedures for patient care shall be developed, maintained, and implemented by the nursing service. Title 22, Division 5, Chapter 1, Article 3-70215(a)(b): Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. The above regulations were NOT MET as evidenced by: Based on interview and medical record review, the hospital failed to ensure RNs (registered nurses) in the ED (Emergency Department) provided Patient 14 with ongoing pain assessments per the hospital's P&Ps (policy and procedure) and failed to implement existing written P&Ps regarding ongoing pain assessments for Patient 14. Patient 14 was nine weeks pregnant and presented to the ED complaining of severe abdominal pain. The hospital failed to ensure advocacy by the RN on behalf of Patient 14 regarding the discharge process when		CORRECTIVE ACTION: 1. The Hospital Chief of Staff appointed a multidisciplinary Intensive Assessment Committee to conduct a root cause analysis of the identified occurrence. The Intensive Assessment Committee is part of the Hospital's Quality Assurance Performance Improvement activities. This Committee first met on 2/16/2015. 2. The RNs involved in the care of the patient were subject to the Hospital's Human Resources policies and procedures, which were implemented by the Director, Emergency Department (ED) Nursing by 2/17/2015. 3. The Hospital's policies and procedures for Pain Management (Program)(Policy # PCS: P-003) and Triage, Medical Screening Examination and Nursing Assessment (Policy # PCS:ED-T5.0) were reviewed during the course of the survey and revised to clarify the responsibilities of the Registered Nurse ("RN") and certain aspects of each policy: a. The Pain Management policy was revised to reinforce the role of the RN as patient advocate for pain control. The policy addresses the need to notify the physician and obtain further orders if the patient's pain-related goal is not met after	2/16/2015 2/17/2015 3/19/2015

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	the RN failed to notify the physician of the patient's abnormal vital signs including unrelieved pain, low blood pressure (BP) and elevated heart rate (HR) at the time of discharge, and failed to refer the patient back to the physician when the discharge plan was contested. These failures resulted in the deterioration of the patient's condition after discharge from the ED requiring resuscitation, readmission to the ED, and emergency surgery due to bleeding from a ruptured ectopic pregnancy (one in which the fallopian tube gets torn or bursts and results in internal bleeding). After the surgery, the patient was comatose with pupils fixed and dilated, and on life support (a machine to keep the body alive by doing the work of bodily functions that are failing) in the intensive care unit (ICU). Findings: Review of the hospital's P&P titled Pain Management originally reviewed 8/03 and last revised 1/15 showed a pain assessment scale would be utilized to determine the method for individualized pain screening, assessment, and management. Recognizing self-report is the most reliable indicator of pain presence and intensity. The P&P also showed to notify the physician if comfort is not achieved, with persistent pain, or changes in pain characteristics, and occurrence of sedation. RNs are responsible for assessment and reassessment of pain. A pain screening would be		CORRECTIVE ACTION (cont.): pain management interventions have been implemented and reassessed at designated intervals (i.e., 30 minutes or less or 60 minutes or less, depending on route of medication administration). ED Nursing Staff was educated on the revised policy at Department Huddles/Meetings via live presentation by the CNO or Director, ED Nursing on 2/26 & 2/27/2015. b. The Triage, Medical Screening Examination and Nursing Assessment policy was revised to clarify that assessment and reassessment of vital signs includes pain assessment, that further ongoing assessment/reassessment by the RN caring for the patient is also determined by the patient's pain persisting unrelieved by treatment and/or medication, and that patients who are being discharged will have vital signs and pain reassessed within 30 minutes of discharge. ED Nursing Staff was educated on the revised policy at Department Huddles/Meetings via live presentation by the CNO or Director, ED Nursing on 2/26 & 2/27/2015. c. The Hospital's policies and procedures for Hand-Off Communication (Policy # PCS: C-004), Communicating a Change in Patient's Condition (Policy # PCS:C-007),	

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	performed as determined by individual patient needs and at a minimum with the vital signs per unit specific standards of practice as indicated by changes in a patient's status and as their condition warranted. Pain assessment components include pain level for the patients able to provide a self-report from the Wong-Baker scale (a pain scale rating from 0-10 with 0 = no pain and 10 = worst pain). The patient's pain would be reassessed to evaluate the effectiveness of pain interventions 30 minutes after receiving the intravenous (IV) medications and 60 minutes after receiving the oral medications. Review of the hospital's P&P titled Triage, Medical Screening Examination and Nursing Assessment originally reviewed 3/98 and last revised 1/15 showed it is the responsibility of the ED nursing staff to assure triage and ongoing assessments are performed on all patients in the ED. Content of the assessment includes pain level. Assessment and reassessment are a continuing process during the patient's length of stay in the ED. Review of the hospital's P&P titled Guideline for Communicating a Change in Patient's Condition effective 1/14/15, showed "Upon assessing a significant change in patient's condition (see Reportable Conditions below), the primary nurse is responsible for notifying the attending physician and any appropriate consulting physicians of the noted changes." "Reportable Conditions include but are not limited		CORRECTIVE ACTION (cont.): Assessment and Reassessment of Patient (Policy # PCS:C-003), After Care Discharge Instructions (ACI) and Follow-up in the Emergency Department (Policy # PCS: ED-A4.0) were also reviewed subsequent to the survey and revised to reflect conforming changes. The revisions to the Hospital's policies and procedures were approved by the Hospital Community Board on 3/19/2015. 4. The ED nursing electronic medical record ("EMR") flowchart was modified on 3/2/2015 by the Director, ED Nursing and Information Services Department staff to facilitate improved compliance with protocols for assessment and reassessment of patient's pain levels. The location of the field for documenting pain assessment was moved in order to be contiguous to the field for documentation of vital signs. This action serves as a visual reminder to complete pain assessments when vital signs are recorded. ED Nursing Staff was informed of the pending flowchart revisions at ED Department Meetings on 2/26 & 2/27/2015 via PowerPoint presentation by the CNO or Director, ED Nursing.	3/2/2015

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	to: ...Change in patient cardiac rhythm or rate (generally rates of less than 50 and over 130 or 20% from baseline)...Change in patient's vital signs, such as hypo or hypertension: Systolic blood pressure less than 90 mmHg or no greater than 160. Diastolic blood pressure over 100 mmHg or 20% of baseline...Increase in pain that is consistently greater than 5 or unacceptable to the patient." Review of the hospital's P&P titled After Care Discharge Instructions and Follow-up in the Emergency Department originally reviewed 7/04 and last revised 1/15 showed the ED physician discusses diagnosis-specific after care instructions with the patient, completing the general aftercare documentation, answering any questions, and assuring understanding with the patient. If the patient has questions or indicates a lack of understanding, the RN refers the patient back to the physician if there continues to be further questions regarding the discharge instructions. The patient or responsible adult signs the After Care Instructions and is given a copy. Patient 14's medical record was reviewed on 2/23/15. Documentation showed the patient was nine weeks pregnant and came to the hospital's ED on 2/14/15 at 0934 hours, complaining of severe abdominal pain rendering her being unable to walk and urinate. The triage nurse's initial assessment showed Patient 14's BP was 99/69 mmHg, HR was 82 bpm (beats per minute) and respiratory rate was 20 breaths per minute (normal vital sign ranges for		CORRECTIVE ACTION (cont.): 5. Education was provided to all ED Nursing Staff on expectations for pain assessment/ reassessment and reporting changes in patient condition, vital sign parameters and documentation. The education was provided to staff in self-learning module developed by the CNO and Director, ED Nursing titled "ED Policy & Process Update". The module included the facility's Pain Management (Program) and Triage, Medical Screening Examination and Nursing Assessment policies and procedures, as noted under "Policies and Procedures" in #3 above. Additionally, the Related Policies and the role of documentation throughout the patient care experience were also included in the module. Nursing staff members were required to sign an acknowledgement that they received, read and understood the content and expectations outlined in the ED Policy & Process Update and to abide by the policies. Education was completed 3/9/2015 with any staff on vacation or leave during the time period of education required to complete the education when they return to work. 6. The ED Policy and Process Update was also distributed to all Emergency Department physicians via e-mail on 2/23/2015 by the Chief Medical Officer.	3/9/2015 2/23/2015

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	the average healthy adult while resting are BP: 90/60-120/80 mmHg, HR: 60-100 bpm, and respirations: 12-18 breaths per minute). The patient rated her lower abdominal pain level as 10. Further medical record showed the following documentation on 2/14/15: - At 1000 hours, RN 1 (the primary ED nurse for Patient 14) took over the care of Patient 14 from the triage nurse. RN 1 noted the patient complained of "labor pains"; however, the RN did not assess the patient's pain level using the Wong-Baker scale as per the hospital's P&P. - At 1245 hours, Patient 14 vomited. The patient stated the pain was worse with rib pain and shortness of breath. The patient was medicated with Zofran (antiemetic medication) 4 mg IV to alleviate vomiting and Tylenol (analgesic) 650 mg orally for pain. Again, RN 1 did not assess the patient's pain levels with a numerical pain scale before and after the administration of pain medication (Tylenol) to evaluate the effectiveness of the administered pain medication as per the hospital's P&P. - At 1300 hours, RN 1 documented the patient's BP was 71/44 mmHg. At 1410 hours, when the patient's BP remained low as 70/51 mmHg, RN 1 notified MD (Medical Doctor) 1 who ordered an IV infusion of 1000 ml of normal saline (a type of IV fluid) and to admit the patient to the hospital for further evaluation by an OB/GYN (obstetrics and gynecology) physician. At 1504 hours, the		CORRECTIVE ACTION (cont.): MONITORING: Audits of at least seventy (70) randomly selected ED medical records per month were initiated on 3/17/2015 by the Director, ED Nursing to evaluate compliance with the revised Pain Management; Triage, Medical Screening Examination and Nursing Assessment policy; Hand-Off Communication; Communicating a Change in Patient's Condition; Assessment and Reassessment of Patient; After Care Discharge Instructions (ACI) and Follow-up in the Emergency Department policies and procedures. Audits will be conducted on a monthly basis until an average of 90% compliance is sustained for 4 consecutive months at which time the frequency, duration and scope of audits will be re-evaluated and modified to ensure an appropriate level of monitoring. Audit results will be aggregated and reported at the Emergency Department Nursing Staff Meetings and to the Hospital's Performance Improvement/Patient Safety Committee and Medical Executive Committee at their regularly scheduled meetings. The Director, ED Nursing; Manager and COO/CNO will be responsible for implementation and monitoring of corrective actions.	3/17/2015

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	patient's BP was 82/56 mmHg and HR was 89 bpm. - At 1430 hours, MD 2 (the OB/GYN Consultant) evaluated Patient 14 in the ED. MD 2 ordered to administer Rocephin (antibiotic medication) 2 gm IV and morphine sulfate (narcotic pain medication) 2 mg IV for pain. The physician's order also showed the nurse could release the patient home after the completion of the medication administration. - At 1501 hours, the Rocephin medication was infused and the morphine sulfate medication was administered to Patient 14 for pain. However, there was no documentation to show the RN assessed the patient's pain levels before and after the pain medication administration as per the hospital's P&P. - At 1620 hours, the patient's BP decreased to 62/33 mmHg. RN 1 notified MD 2 and received a verbal order to infuse one liter of Lactated Ringers (a type of IV fluid) wide open. RN 1 documented per the OB/GYN consult, "may send patient home when systolic BP increased to 70's." - The last set of Patient 14's vital signs documented in the medical record was taken at 1817 hours. The patient's BP was 71/39 mmHg and HR was increased at 120 bpm. The discharge vital signs showed a 28% decrease in systolic BP, 43% decrease in the diastolic BP, and a 46% increase in HR from the patient's vital signs on admission to the ED. In addition, no pain assessment was completed when the vital signs were assessed at			

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	1817 hours as per the hospital's P&P. There was no documented evidence the RN notified MD 2 or the ED physician present at the time of Patient 14's current health status even after the RN had identified the patient's BP and HR had more than 20% changes from the baseline as per the hospital's P&P. - At 1818 hours, RN 1 documented she attempted to discharge Patient 14, but the patient and her family member refused due to "too much pain." With Patient 14 being unable to walk, the family member stated he could not carry the patient to the car. Again, there was no documented evidence Patient 14's pain was assessed and any of the physicians involved was notified of the family member's concerns about the patient continuing to have pain. - At 1830 hours, RN 2, the oncoming night shift charge nurse, documented RN 1 reported to RN 2 that Patient 14 was discharged, but the family was being difficult; the patient just needed her IV needle pulled out and was "okay to go home. Primary assessment was not conducted." The documentation showed RN 2 explained the plan of care to the patient; MD had discharged her with prescriptions for an antibiotic and a narcotic pain medication. Documentation by RN 2 showed the patient was "sitting up in bed, moaning"; was awake, alert, and oriented; and agreed with the treatment plan. The patient was discharged via a wheelchair to the car.			

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	There was no documented evidence found in Patient 14's medical record to show the patient's pain level was assessed at the time of discharge. In addition, the patient was discharged without signing the discharge After-care Instructions form. The form was witnessed by RN 2; however, the patient's signature line was blank. There was no evidence the OB GYN consultant (MD 2) or the ED physician present at that time were notified the patient and family member had further concerns regarding the discharge plan as per the hospital's P&P. - At 1859 hours, 29 minutes after discharging from the hospital's ED, Patient 14's family member called 911 as the patient was found unresponsive when the family member came back to the car after picking up the prescriptions. The patient was resuscitated and brought back to the same ED. Patient 14 was rushed to surgery when the ultrasound revealed bleeding in the abdomen. In the OR (Operating Room), 1300-1600 ml of the patient's blood was removed due to a ruptured ectopic pregnancy. The patient was transferred to the ICU on life support and was comatose with pupils fixed and dilated. During a telephone interview on 2/24/15 at 1200 hours, RN 1 confirmed Patient 14 had complained of an abdominal pain at a level of 10 upon admission to the ED. When asked, RN 1 stated she did not talk to MD 2 when he visited the patient in the ED. The RN stated she only knew MD 2 had seen the patient because the ED physician handed her the physician's orders written by MD 2.			

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	RN 1 stated she did not think MD 2 was aware of the patient's low BP of 70/51 mmHg at 1410 hours when MD 2 ordered the IV antibiotic, morphine sulfate 2 mg IV for pain, and wrote "may release patient home." The RN stated initially the patient was to be admitted to the hospital per the treating ED physician as the patient refused to discharge due to pain. The RN stated MD 2 was called as an OB GYN Consultant to see the patient. MD 2 took over the case and decided to discharge the patient after further treatment. RN 1 stated after the morphine medication administration, the patient's BP had decreased to 62/33 mmHg at 1620 hours. The RN stated she had informed MD 2 who told her it was normal for pregnant women to have a low BP, especially after receiving the morphine medication. The RN stated MD 2 asked the patient's systolic BP for the last 2-3 hours; her response was the BP was mostly in the 70-80's. MD 2 then ordered to infuse a liter of IV Lactated Ringers and told the RN to release the patient once the systolic BP was in the 70's. RN 1 stated after the Lactated Ringers was infused, Patient 14's BP was 71/39 mmHg at 1817 hours. When she went to discharge the patient, she stated the patient looked better and seemed to be in less pain; however, the patient refused to go home as she said she was in too much pain. The RN stated the patient started to yell and was upset. The patient's HR had increased to 120 bpm. RN 1 stated on 2/14/15 at 1830 hours, her shift was			

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	over and she gave report to the on-coming Charge Nurse, RN 2, and explained what was going on with Patient 14 regarding the labs, medications, vital signs, the patient and her family member's refusal of discharge. RN 1 stated she told RN 2 the patient had not yet signed the discharge After-care Instructions form. RN 1 stated RN 2 had physically discharged the patient after RN 1 left. RN 1 stated the After-care Instructions were printed up by the physician; the patient needed to sign the form, and if they did not or refused, the physician should be notified and document why the patient did not sign. When asked about the expected documentation of pain levels for ED patients, RN 1 stated a patient should be reassessed 30 minutes after a pain medication was given. RN 1 stated she "knew she didn't chart her best for how often she checked her. It was every 30 minutes." RN 1 also stated it was difficult to tell how much pain Patient 14 was in as she "presented very flat." RN 1 was asked if she had asked the patient or documented a stated pain level for the patient at the time of discharge and she stated she did not. During a telephone interview on 2/24/15 at 1535 hours, RN 2 stated he was approached by RN 1 and was told Patient 14 was okay for discharge, but the family had concerns that the patient was still in pain. RN 2 stated RN 1 reported to him there were no further orders; therefore, he thought all was needed was the intervention to facilitate the discharge. RN 2 stated on 2/14/15 at 1820 hours, he walked to			

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	Patient 14's bedside and introduced himself. The family member looked upset and expressed concerns that the patient was still in pain. RN 2 stated he told them everything was ready for a discharge and the physician wrote prescriptions for an antibiotic and a pain medication to help relieve the pain at home. The patient was provided with assistance to the car via a wheelchair at 1832 hours. When asked, RN 2 stated he did not perform an assessment of Patient 14 prior to discharge as RN 1 painted a picture where he did not have to do anything but to be a liaison and physically discharge the patient. RN 2 stated he was not aware of the patient's last BP recorded at 1817 hours as 71/39 mmHg. During a telephone interview on 2/23/15 at 1305 hours, MD 2 stated he had examined Patient 14 in the ED at approximately 1430 hours. MD 2 palpated the patient's abdomen and found it benign. The physician stated the patient did not appear to be in pain at that time. MD 2 stated he had explained to Patient 14 that she might have a urinary tract infection (UTI). He felt the cramps might have been from the small subchorionic hemorrhage (bleeding within the layers of placenta) seen on the OB ultrasound, from UTI, or from the intercourse. MD 2 recommended the patient to abstain from the intercourse and follow up with her OB/GYN physician. MD 2 stated he had ordered morphine 2 mg IV for			

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	050226	A. BUILDING _____ B. WING _____	02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	pain per the patient's request and a dose of IV Rocephin for Patient 14 while in the ED, as well as written a prescription for Macrobid (antibiotic medication) and Percocet (pain medication) for the patient to fill on the way home. The physician stated he ordered to release the patient home after the above medication administration was accomplished. The physician stated when he left the ED, Patient 14 seemed to be "fine, happy." When asked if he was aware of the patient's vital signs after admission and prior to his exam in the ED, MD 2 stated he did not recall. MD 2 stated RN 1 did not call him again after speaking with him over the telephone around 1600 hours on 2/14/15. Around 1900 hours on 2/14/15, the ED called him to report Patient 14 was unresponsive after discharge and returned to the ED with paramedics. MD 2 was asked if he would have authorized a discharge for Patient 14 with a low BP of 70/40 mmHg and complaints of severe pain. The MD replied, "no." The hospital's failure to implement existing hospital policy regarding ongoing pain assessments, patient advocacy and the discharge process, as well as the hospital's failure to ensure the RNs in the ED performed ongoing pain assessments for Patient 14, failure to ensure advocacy by the RN on behalf of the patient, failure to ensure the physicians were notified of the patient's abnormal vital signs, including unrelieved pain, low blood pressure and elevated HR at the time of discharge, and failure to refer the patient back to the physician when			

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	discharge was contested, is a deficiency that has 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 1280.3(g)." 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 1280.3(g).			

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