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
	051318	A. BUILDING ______ B. WING ______	11/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REDWOOD MEMORIAL HOSPITAL	3300 RENNER DRIVE, FORTUNA, CA 95540 HUMBOLDT COUNTY

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	The following reflects the findings of the California Department of Public Health during an Entity Reported Incident/Adverse Event visit. Entity Reported Incident/Adverse Event: CA00163279 - Substantiated The inspection was limited to the specific entity reported incident/adverse event investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: [redacted] Health Facilities Evaluator Nurse. 70203(a) (2) Medical Services General Requirements (a) A committee of the medical staff shall be assigned responsibility for: (2) Developing, maintaining and implementing written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Based on staff interview, physician interview, medical record review, and document review, the facility failed to ensure that the medical staff developed and implemented the central venous catheter (CVC) policy for pre and post central venous catheter insertion, incorporating the CVC manufacturer's safety guidelines. The medical staff		Corrective Actions: 1. Development of Hospital Wide Policy "Insertion & Assessment of Central Intravascular Catheters" and Central Line Insertion Note (Attachment A) 2. To ensure patient safety immediately after initial insertion (AII). a. Assess patient condition; auscultate breath sounds, mentation, and vital signs. b. Clear area (accounting for all IV kit equipment and guide wire) ensuring proper disposal of all sharps. Nurse and Physician confirm removal of guide wire and document on central line placement note. c. Initial Chest X-ray is ordered/performed to assure catheter placement location, removal of guide wire, or potential complication (i.e. pneumothorax), prior to infusion of IV fluids. d. Proceduralist completes Central Line Placement Note or if PICC line placement, PICC Insertion/Repair record. Proceduralist or nursing staff document confirmation of X-ray catheter placement in medical record.	8/31/09 8/31/09

Event ID:SDQ311 8/13/2009 3:19:45PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE [redacted] (X6) DATE 9/11/09

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9/14/09 at 8:25 Am accepted & notified [redacted], Chief

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	Continued From page 1 failed to ensure the procedure included steps to take to ensure that the CVC is in the correct position and the guide wire, which is used during the catheter insertion procedure, is removed after the catheter insertion in order to prevent complications from occurring. A guide wire was left in Patient 1 following the insertion of the CVC. This resulted in the guide wire migrating up to Patient 1's neck and required the emergent transfer of Patient 1 to another acute care hospital's cath lab for a second procedure to immediately remove the guide wire. These failures placed Patient 1 at potential risk for complications, internal injuries, and/or death from the migrated guide wire. THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.1 IN THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT THE CENTRAL VENOUS CATHETER GUIDE WIRE HAD NOT BEEN REMOVED FROM THE PATIENT AFTER THE CVC INSERTION PROCEDURE. THIS VIOLATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED GUIDE WIRE. Findings: Patient 1 was admitted to the Emergency Department (ED) on 9/8/08 at 1:30 p.m., with diagnoses including grand mal seizure, acute		Responsible Party: Chief Nursing Officer 3. Education of medical and clinical staff to new policy and note. Responsible Party: Director of Quality Management Chief Nursing Officer 4. Monitoring of compliance to new policy. Review of all Emergency Department patients who have central lines placed within the unit. Will monitor monthly until 100% compliance is achieved for three consecutive months.	9/30/09 10/30/09

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	Continued From page 2 gastrointestinal (GI) bleed, hypovolemia (low blood volume), nasal fracture, and complaints of neck pain. Patient 1 had a temperature of 96øFahrenheit (F), pulse 106, respirations 20, and blood pressure of 75/21 (normal range 120/80). The physician's ED record dated 9/8/08, indicated that at 2:08 p.m., an intravenous (IV) was started and 1000 cc of normal saline was given. Patient 1 had no change in his pulse rate. Another 1000 cc of normal saline was given at 2:30 p.m., with no change in Patient 1's blood pressure or pulse. An interosseous (IO-infusing IV fluids in the bone marrow cavity) was inserted in the left tibia and 500 cc of normal saline was infused, and Patient 1's leg began to swell. A left femoral vein central venous catheter was then inserted using ultrasound guidance. During an interview on 9/23/08 at 9:00 a.m., Physician A stated that it was a very busy shift. Patient 1 had cervical spine precautions and his neck had not been cleared, so he avoided inserting a central venous catheter in the jugular or subclavian area (neck area). Physician A said Patient 1 had a GI bleed and was hypovolemic. Physician A inserted the central venous catheter in the left femoral vein, threaded the triple lumen catheter over the spring-wire guide wire, but did not take the caps off the triple lumen ports, leaving the guide wire in Patient 1. Physician A said, "I spaced out and it was a regrettable incident." During an interview on 9/18/08 at 10:10 a.m., Licensed Nurse B stated that on 9/8/08, she was			

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helping out in the ED and had assisted Physician A with the central venous catheter insertion. Licensed Nurse B stated that they started infusing IV solutions and blood products. Licensed Nurse B said they had cleaned up all the equipment and supplies after the central venous catheter insertion and did not think about or look for the guide wire.

Physician A stated that on 9/9/08, the next evening he was thinking back on the events of the previous day, when he could not remember if he had taken the guide wire out of Patient 1. Physician A called the ED physician on duty and asked to have an x-ray taken of Patient 1's femoral area.

The x-ray report dated 9/9/08 indicated, "There is a wire like device noted overlying the inferior portion of the inferior vena cava. This apparently is a wire that was placed or lost during placement of the iliac catheter."

During an interview on 9/23/08 at 9:00 a.m., Physician A said in the morning on 9/10/08, he went to look at Patient 1's x-ray. Then, Physician A went to look at the position of the electrocardiogram (EKG) wires and confirmed with nursing staff that the EKG wires had not been over the femoral area. An abdominal x-ray on 9/10/08 revealed that the guide wire had migrated to Patient 1's neck.

The manufacturer's instructions and recommendations for the use of the multiple lumen central venous catheter, dated 3/02, indicated the following;

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	Continued From page 4 "Warnings and Precautions (all written in red): 2. Warning: Do not place the catheter into or allow it to remain in the right atrium or right ventricle (heart chamber)... For femoral vein approach , the catheter should be advanced into the vessel so that the catheter tip lies parallel to the vessel and does not enter the right atrium... 6. Warning: Passage of the guide wire into the right heart can cause dysrhythmias (irregular heart beat), right bundle branch block, and a perforation of the vessel wall, atrial or ventricular... 13. Precaution: Only x-ray examination of the catheter placement can ensure that the catheter tip has not entered the heart or no longer lies parallel to the vessel wall. If catheter position has changed , immediately perform chest x-ray examination to confirm catheter tip position..." "A Suggested Procedure: Use sterile technique. 1. Precaution (in red): ...If femoral approach is used, place patient in supine position (lying flat on back)... 9. Hold spring-wire guide in place and remove introducer needle... Precaution (in red) : Maintain firm grip on spring-wire guide at all times... 11. Thread tip of multiple-lumen catheter over spring-wire guide. Sufficient guide wire length must remain exposed at hub end of catheter to maintain a firm grip on guide wire. Grasping near skin, advance catheter into vein with slight twisting motion... 12. Using centimeter marks on catheter as positioning reference points, advance catheter to final indwelling position... 13. Hold catheter at desired depth and remove spring-wire guide. The Arrow (brand name) catheter included in this			

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product has been designed to freely pass over the spring-wire guide... 14 Verify that the entire spring-wire guide is intact upon removal... 17. Verify catheter tip position by chest x-ray immediately after placement... If catheter tip is malpositioned, re-position and re-verify... 18. Secure catheter to patient using staple anchoring device, sutures, or 'Statlock' anchoring device... Dress insertion site according to hospital protocol."

The ED record & nurses notes dated 9/8/08 and the dictated ED physician's record dated for 9/8/08 and electronically signed on 9/10/08, did not document the positioning of the patient for the procedure, did not include that an x-ray was immediately taken after the procedure to determine correct catheter placement and/or the presence of the guide wire, did not include the length of the central venous catheter from the insertion site using the catheter's centimeter marks as a point of reference, and did not include that the entire spring-wire guide wire was verified and inspected upon removal.

The facility's central venous catheter policy and procedure revised on 5/2006, was listed as a hospital wide nursing policy and addressed care provided by registered nurses for the various types of central catheters after insertion and during use for intravenous therapy. The policy did not reflect any of the warnings, precautions, and/or guidelines as indicated by the manufacturer for the triple lumen central venous catheter for the insertion of the catheter, verification and inspection of the guide wire, and determining correct catheter placement by immediate x-ray in order to prevent

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	Continued From page 6 complications. The facility ' s failure to develop and implement the central venous catheter policies and procedures to ensure patient safety 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 1280.1			

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