

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2007
NAME OF PROVIDER OR SUPPLIER LAC/HARBOR-UCLA MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WEST CARSON STREET, TORRANCE, CA 90509 LOS ANGELES COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00132263.</p> <p>Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN.</p> <p>1280.1 (a) 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.</p> <p>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.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>T22 DIV5 CH1 ART3-70215(a)(1)(2)(3)(b)(c)(d) Planning and Implementing Patient Care</p> <p>(a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the</p>			

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5/12/2008

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	<p>Continued From page 1</p> <p>Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.</p> <p>(2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitation of their licensure, certification, level of validated competency, and/or regulation.</p> <p>(3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient.</p> <p>(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.</p> <p>(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient.</p> <p>(d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the</p>			

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	<p>Continued From page 2</p> <p>patient's medical chart.</p> <p>The above Regulations were NOT MET as evidenced by:</p> <p>Based on clinical record review and staff interview, the registered nurses (RNs) failed to provide ongoing and accurate neurological assessment for Patient A after pain medications were administered in the Emergency Room (ER) to the time the patient was transported to the SDU (Step Down Unit). The RNs failed to document their updated findings as required by the regulation, and failed to follow their protocol by not including the summation of patient care provided before transferring Patient A to another patient care area. These failures resulted in a delay of at least three hours in recognizing a significant change in condition and death for Patient A.</p> <p>Findings:</p> <p>On 11/19/07, review of Patient A's clinical record revealed a trauma patient who was involved in a pedestrian versus auto incident.</p> <p>Patient A arrived in the ER (Emergency Room) on 11/1/07 at 2303 hours. The patient was examined and stabilized. Patient A's neurological status was documented as having spontaneous opening of the eyes, obeying commands and was verbally responding, though confused. Patient A's oxygen saturation ranged from 97-100% and his vital signs were stable. Per ER trauma flow sheet, dated 11/2/07 at 0010 hours, Patient A was to transfer to</p>			
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	<p>Continued From page 3</p> <p>the SDU to continue monitoring. The nurse's notes further stated that report was called in to the SDU receiving nurse at 0010 hours.</p> <p>Review of the ER trauma flow sheet revealed that on 11/2/07 at 0045 hours, Patient A received fentanyl 50mcg (micrograms) followed by morphine 5mg (milligrams) at 0205 hours for a pain level of "3" on a scale of 1-10 (10 being the worst pain). Patient A's vital signs were assessed last at 0215 hours, 10 minutes after the medication administration with BP at 116/64, pulse at 112, respirations at 22, with 98% oxygen saturation. Pain score was still "yes" without the documented pain scale of 1-10 and without further evaluation. The last ER nursing notes narrative entry was documented at 0100 hours on 11/2/07 saying that a leg splint was applied by the orthopedic team. Patient A's sensation was intact and he was able to wiggle his toes.</p> <p>On 11/2/07 at 0358 hours, the transferring team composed of another RN and a nursing assistant transferred Patient A from the ER to the SDU. At this point, the transferring nurse assessed and documented that Patient A was not opening his eyes, extremities were flaccid and there was no verbal response. However, the transferring nurse did not communicate and clarify with the ER nurse whether Patient A was ready to transfer to a different unit. There was also no documented updated report noted from the ER nurse to the transferring nurse.</p> <p>The receiving nurse in SDU documented her</p>			
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	<p>Continued From page 4</p> <p>assessment of Patient A upon the patient's arrival. She documented that "no report of any medication given prior to him coming to SDU" and noted that the patient was "unresponsive to pain and verbal stimuli with limbs flaccid." Per record review, the neurological assessment was confirmed by the transferring nurse as; "condition unchanged" from the time the patient was picked up in the ER and transferred to SDU.</p> <p>Further review of the SDU nurse's notes revealed that the level of consciousness of Patient A was changed from what the ER nurse reported to her by phone at 0010 hours on 11/2/07. However, there was no documentation found that the physician was notified regarding Patient A's change in the level of consciousness. There was no documented assessment found to suggest that any of the nursing staff, from ER nurse to transferring nurse to SDU receiving nurse, became aware of Patient A's change in neurological status.</p> <p>At 0530 hours on 11/2/07, approximately an hour and a half after Patient A was admitted in SDU, the patient ' s vital signs decelerated and a Code Blue (cardiopulmonary resuscitation) was called. Resuscitation was attempted but failed. Patient A was pronounced dead at 0632 hours on 11/2/07.</p> <p>In an interview conducted on 11/19/07 at 1030 hours, the Associate Director of Nursing (ADON) and Risk Manager were asked why there was no documented transfer report from the ER nurse to the transferring team. The ADON responded that their Policy and Procedure (P&P) required only</p>			

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	<p>Continued From page 5</p> <p>verbal exchange of information between nurses with no written transfer report. The Risk Manager responded that there was no updated report made to the transferring nurse. When asked why there was no documented vital signs from 0215 to 0347 hours in ER, after the patient received fentanyl and morphine for pain, no further information was received.</p> <p>Review of the facility's P&P on Nursing Communication during change of shift, break times, inter-unit transfer, admission and transport indicated that "the information communicated should be up-to-date and accurate". The nurse and technician role was to report a summation of care provided and activities performed by self/other providers to the accountable nurse.</p> <p>The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).</p>			

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