

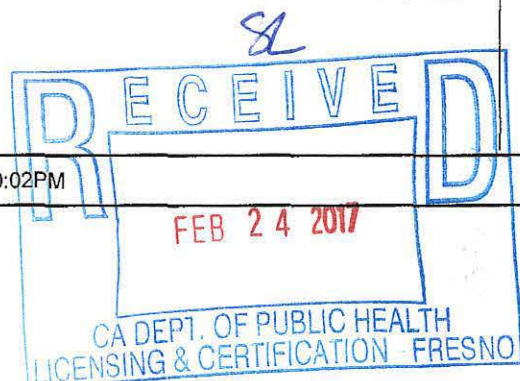
CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 053300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2016
NAME OF PROVIDER OR SUPPLIER Valley Children's Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Valley Childrens Place, Madera, CA 93636-8761 FRESNO COUNTY		
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	<p>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.</p> <p>This rule was not met as evidenced by:</p> <p>Based on staff interview, clinical and administrative document review, the hospital (Hospital 1) failed to ensure Medical Doctors (MD's) in Radiology, Surgery and the Emergency Department (ED) adhered to Medical Staff Rules and Regulations when critical radiological results obtained for Patient 1 (Pt 1) were not communicated in a timely and effective manner. Pt 1's chest x-ray and CT scan (an imaging method that uses x-rays to create pictures of cross sections of the body) obtained on 10/3/15 in the ED indicated a possible aneurysm (an abnormal bulging of a blood vessel wall) near the heart. Physicians in the ED and Radiology delayed communicating this critical value (aneurysm) to the surgeon (MD 2) causing medical and/or surgical management of the aneurysm to be delayed. On 11/6/15 Pt 1 presented again to Hospital 1's ED with chest pain resulting from hemorrhaging due to the aneurysm and died the same day.</p> <p>This failure resulted in a delay in communicating a critical radiological value; a delay in initiating medical and surgical treatment which resulted in Patient 1's potentially avoidable death.</p> <p>FINDINGS:</p>		<p>(2) The Department of Medical Imaging created a new policy DP-7630.079 Imaging Critical Findings that identifies significant findings and/or situations the radiologist deems may need immediate patient treatment and physician interventions. The critical findings must be communicated within 30 minutes of the completion of the procedure or transmission to vRad. The communication process includes the documentation of the critical finding and the method of communication to the patient's healthcare provider by the radiologist in "Rad Comm" PeerVue within PACS. The policy and procedure was approved by the Department of Medical Imaging, the Medical Executive Committee, and the Board of Trustees.</p> <p>(3) The Department of Medical Imaging communicated the new policies and procedures expectation (DP-7630.080 Imaging Critical Test Results and DP-7630.079 Imaging Critical Findings) to all applicable staff and physicians.</p> <p>(4) The Hospital policy PC-0025, Communication Critical Patient Information has been revised to include references to DP-7630.080 Imaging Critical Test Results and DP-7630.079 Imaging Critical Findings. Organizational approval by Nursing Practice Council, Patient Safety Committee, the Medical Executive Committee and The Board of Trustees is currently in process.</p>	<p>4/30/2016</p> <p>6/7/2016</p> <p>6/30/2016</p>

Event ID:331711

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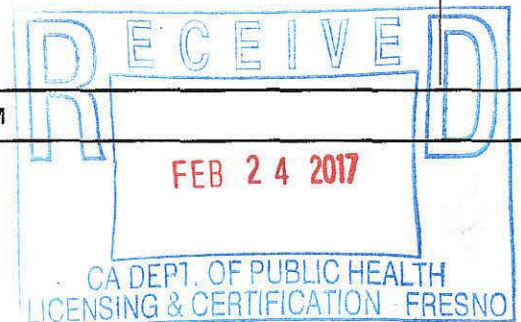
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	<p>contracted radiology company per hospital policy. The company reads the films and faxes the results to the ordering MD's. Rad MD 1 stated he returned to work the next morning, 10/4/15, and began reviewing radiology films completed during the night. Rad MD 1 stated he reviewed the results for Pt 1 and saw the chest CT scan was completed without IV contrast. Rad MD 1 stated he reviewed the chest CT scan and agreed with the faxed after-hours report which indicated, "Heart: There is a deformity of the left heart border with a mass like density that appears continuous with the left ventricle...MRI or contrast enhanced CT may be helpful in further evaluation. Impression: Suspicion of a mass or aneurysm (bulging in the blood vessel) in the upper left ventricle causing contour abnormality in the left heart border." Rad MD 1 dictated his results on 10/4/15 at 10:03 a.m., which read, "Findings: Exam was unfortunately obtained without intravenous contrast significantly limiting exam motility...finding is concerning for a large aneurysm of either the ventricle, possibly the coronary artery, or could still represent a benign duplication cyst. Contrast evaluation is required..." Rad MD 1 stated he was disappointed the CT scan was done without IV contrast, because the contrast would have shown the density of the "bump" and made diagnosis easier. Rad MD 1 stated for critical findings on an x-ray or CT scan, the doctor who orders the test is usually called to discuss the findings. In this case, Pt 1 was admitted therefore the call would go to the admitting doctor. Rad MD 1 stated, "I was going to call Pt 1's admitting doctor, Surgeon (Surg) MD 2 on the phone, but was distracted by another call and didn't call a report."</p>		<p>C. The Director of Medical Imaging Services or designee will monitor 100% of radiology critical test results for process compliance. Compliance includes critical test results being processed and communicated to the next provider within 30 minutes of the completion of the procedure or transmission to vRad. Monitoring will continue on a monthly basis until 4 consecutive months of 100% compliance is achieved. The compliance data will be reported to Department of Medical Imaging on a quarterly basis. In order to sustain compliance, on-going monitoring occurs through our patient safety alert reporting process. Any critical test result not meeting the 30 minute requirement will be submitted as a patient safety alert. All patient safety alerts will be investigated by the Director of Medical Imaging or designee and resolution will be submitted to the Manager of Patient Safety for tracking and trending. Trended results of all Patient Safety Alerts are reported to the Patient Safety Committee, Medical Executive Committee and the Board of Trustees.</p>	On-going

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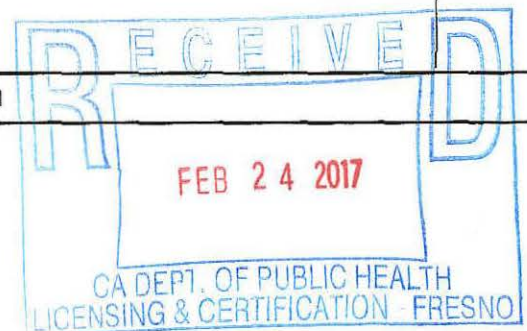
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	<p>A copy of the report was sent via electronic medical record (EMR) to Surg MD 2. Rad MD 1 stated he did not follow up on Pt 1 to see if a chest CT scan was ordered with IV contrast.</p> <p>On 11/19/15 at 3:59 p.m., during an interview, Surg MD 2 stated on 10/3/15, he was called by ED MD 4, to consult on Pt 1 sometime in the evening. Surg MD 2 stated he reviewed Pt 1's history and read about Pt 1's traumatic motor vehicle accident including the brain injury, trauma to his chest with a laceration and surgery to remove his spleen. Surg MD 2 stated when he evaluated Pt 1 he was having significant abdominal pain. He stated Pt 1 was also complaining of left shoulder pain, but thought it was referred pain from the abdomen or possibly chronic pain from the accident. Due to Pt 1's complaints of abdomen pain, and the results of the abdominal fluid in the CT scan, Surg MD 2 decided to admit Pt 1 and order the placement of a drain in his abdomen to remove the fluid. Surg MD 2 stated he was not aware Pt 1 had a chest CT scan, did not see the faxed report or discuss the results with ED MD 4. He stated when getting report from ED MD 4 about all the tests, results and treatment that had been done for Pt 1 prior to admission, he did not remember discussing a CT scan of the chest. Surg MD 2 stated Pt 1 was admitted about 11 p.m. on 10/3/15. Surg MD 2 stated there was no discussion about the results of Pt 1's chest CT scan with Rad MD 1. Surg MD 2 stated radiology reports are, "Sent to me in Medi-tech (part of the Electronic Medical Record) and I did not read the chest CT report, and I just signed it off as reviewed." Surg MD 2 stated, "I was just focused</p>			

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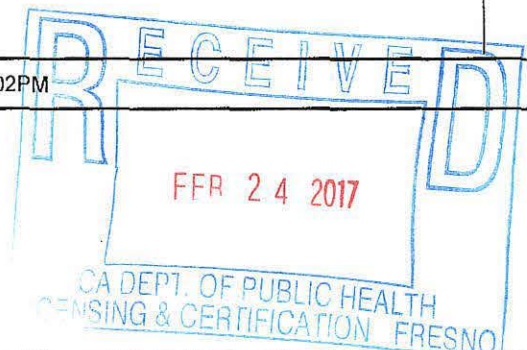
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	<p>on his complaint of abdominal pain." Surg MD 2 stated he was very distressed to hear Pt 1 came back to the hospital on 11/6/15 and died in the ED as a result of an aneurysm on his heart. He stated, "Several areas of missed opportunities occurred; not doing a CT scan with contrast as recommended by the radiologist; not following up on the CT scan in the ED on the next day; and assuming a discussion about the abdomen CT with Interventional Radiology (IR) covered all the information I needed to treat Pt 1."</p> <p>On 11/23/15 at 9:10 a.m., during an interview, ED MD 4 stated on 10/3/15 Pt 1 presented to the ED with complaints of vomiting and abdominal pain, so her focus was on his abdomen. ED MD 4 stated she ordered a chest x-ray because Pt 1 also had complaints of difficulty breathing and a CT scan with contrast of his abdomen because of his abdomen pain. She stated she received a call from Rad MD 1 and they discussed the results of the abdomen CT and chest x-ray. He told her Pt 1 had fluid in his abdomen, with a possible abscess, a possible pneumonia and empyema in his chest, and recommended a chest CT with contrast. She stated they had a long conversation but she didn't remember details. ED MD 4 stated she put the order in the system for the chest CT with IV contrast. ED MD 4 stated she left her shift before the after-hours CT report was faxed and she never saw it. She stated she remembered sitting with Surg MD 2 looking at films, but does not remember discussing the chest CT. ED MD 4 stated she didn't remember the exact conversation she had with Surg MD 2 as she gave report to sign over care</p>			

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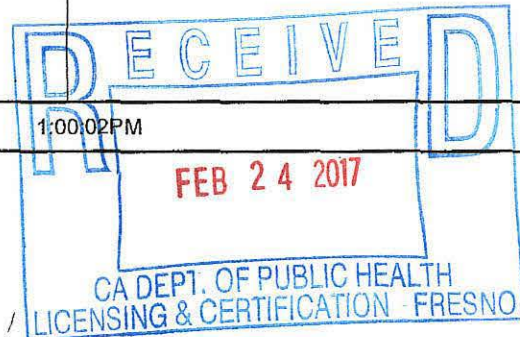
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	<p>for admission.</p> <p>On 11/24/15 at 2:36 p.m. during an interview, ED MD 7 stated she was on duty 11/6/15 when Pt 1 came to the ED, for the second time with complaints of chest pain. She stated Pt 1 said he woke up with gradual pain, which got worse when he breathed in and several other vague complaints including sore throat, urinary urgency and left arm pain. ED MD 7 stated she ordered lab tests, an electrocardiogram (checks electrical activity in the heart) and chest x-ray. She stated his vital signs were stable and his heart sounds were normal when she listened with a stethoscope. ED MD 7 stated she began to go back through his previous admission record from 10/3/15 and saw the chest CT report, with documented abnormality around the heart. She stated she contacted Rad MD 5 in radiology about the previous CT scan. After review, a CT scan with contrast was ordered on 11/6/15 and completed at 8:27 a.m. ED MD 7 stated Rad MD 5 called her and said there was a large, very concerning problem in the left side of Pt 1's heart. ED MD 7 stated she had ordered an echocardiogram (ultrasound test of the heart) for Pt 1, and had consulted with a cardiologist (heart doctor) and cardiothoracic surgery regarding the results of the CT scan. ED MD 7 stated about 9:45 a.m., she was discussing the findings of Pt 1's tests with the family including the aneurysm Pt 1 had in his heart and that he would possibly need surgery. ED MD 7 stated Pt 1 began having seizure like activity, became unresponsive and went into cardiac arrest. ED MD 7 stated all attempts were made to revive Pt 1 including</p>			

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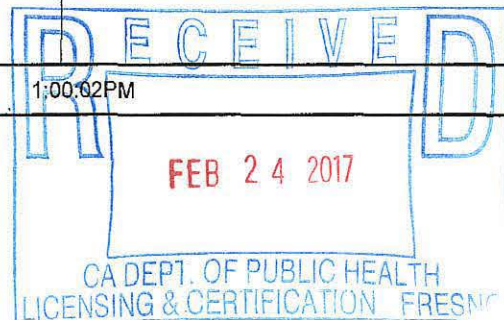
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	<p>opening his chest cavity in the ED to stop the bleeding from his heart. The team was not successful and on 11/6/15 at 11 a.m. Pt 1 was pronounced dead.</p> <p>Review of the Operative Report written on 11/6/15 at 2:16 p.m. by the cardiothoracic surgeon after the sternotomy (opening the chest cavity) was performed read, "...An exploratory median sternotomy was then performed...The sternum was retracted...there was a large amount of a fresh blood and blood clots in the pericardium (area or sac enclosing the heart)...Manual open chest cardiac massage was performed...the heart was inspected and was palpated and felt to be nearly completely empty, given that the patient appeared to have exsanguinated (bled out) nearly completely. The heart was asystolic (not beating)...It appeared that there was a large very thin walled pseudoaneurysm (a collection of blood forming between the two outer layers) involving...the left ventricle (one of four chambers of the heart; responsible for pumping oxygen rich blood to the body)... pseudoaneurysm had ruptured leaving a large opening that communicated with the left ventricle...At this point, the patient had been in cardiorespiratory arrest for a prolonged period of time, had nearly exsanguinated with an empty and flaccid heart with asystole. The physicians involved in his care agreed that any further attempts at treatment were futile and the patient was pronounced dead. Estimated blood loss was several liters."</p> <p>A review of the hospital policy and procedure titled,</p>			

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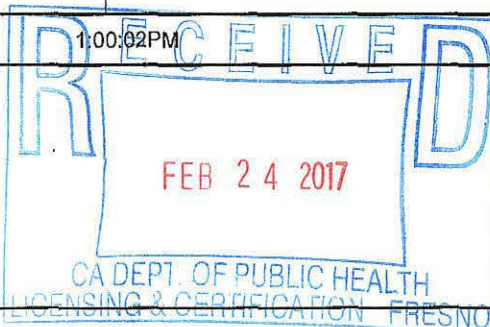
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	<p>"Communication, Critical Patient Info", dated 9/15 read, "Purpose Statement: To promote accuracy and clarity of communication regarding critical patient care... Policy ...Qualified/Applicable Personnel 1. For patients residing in inpatient units and the emergency department, critical test results will be called by laboratory CLS, the radiologist or designee, or the cardiologist to a Registered Nurse, LVN, or Respiratory Care Practitioner (RCP) assigned to care of the patient... Procedure ...3. Critical test results are important medical information which must be communicated to the appropriate licensed care giver in a timely manner and include laboratory, radiology and cardiology testing results. A review of the hospital policy and procedure titled, "Hand off Communication" dated 8/15 read, "1. The purpose of this policy is to ensure that transmission of clinical/patient care information is timely, accurate and understandable to those assuming patient care responsibilities...3. Ensure that hand-off communication includes up-to-date information regarding the patient's/client's care, treatment and services, condition and any recent or anticipated changes...1. Continuity and coordination of care are essential elements that support high quality, safe and patient centered care. Hospital patient care providers will use a standardized communication process when communicating information during transfer of care and when communicating critical patient care information...3. B. Physicians transferring complete responsibility, or on call responsibility for the care of a patient...G. After hour transfer of care in radiology department. Important radiological findings are communicated to</p>			

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	<p>the referring/treating physician...5. Hand off communication of current patient information includes the following: B. Results of diagnostic studies relevant to patient's condition and care...."</p> <p>A review of the MEDICAL STAFF BYLAWS dated 2011 read, "ARTICLE I NAME AND PURPOSE 1.2 Purpose: The purposes of the medical staff include: 1.2-3 To provide oversight of care, treatment and services provided by practitioners with privileges; provide for a uniform quality of safe patient care, treatment and services...1.3 RESPONSIBILITIES: THE RESPONSIBILITIES OF THE MEDICAL STAFF INCLUDE: 1.3-1 To account for the quality and appropriateness of patient care rendered by all..."</p> <p>A review of the MEDICAL STAFF RULES & REGULATIONS dated 9/24/15 read, "II. CONDUCT OF PATIENT CARE: A. All Practitioners' Responsibilities It is the responsibility of all medical staff members involved in a patient's care, treatment and services to communicate with one another and with any ancillary staff member in direct patient care in a timely and effective manner."</p> <p>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).</p>			

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