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
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00457925 - Substantiated Representing the Department of Public Health: Surveyor ID # 1864, 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(g): 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. Title 22 Regulations § 70213. Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy § 70214. Nursing Staff Development. (a) There shall be a written, organized in-service education program for all patient care personnel,		This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 70213: To ensure no other patients were affected we implemented immediate system changes as stated below in the Plan of Correction.	

RECEIVED
MAR 24 2017
LICENSING AND CERTIFICATION
SAN DIEGO DISTRICT OFFICE SOUTH

Event ID:V2I611 3/16/2017 2:54:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Valerie Olsen TITLE Director Regulatory Affairs (X6) DATE 3/22/17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	including temporary staff as described in subsection 70217(m). The program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213(c). (2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions: (A) Assignments shall include only those duties and responsibilities for which competency has been validated. The above regulations were NOT MET as evidenced by: Based on observation, interview and record/document review the hospital failed to develop and implement nursing policies and procedures that met the cardiac (heart) monitoring and safety needs of a patient (Patient 1) who was monitored with telemetry (an electronic system, which provides centralized, constant real time visual and audible observation of patient heart rate and rhythm). The hospital failed to approve policies and procedures that included interventions to address unplanned and unexplained interruptions with telemetry monitoring. Furthermore, the informally developed "Telemetry Technician Monitoring Guidelines", were not followed by staff and the assigned telemetry staff did not have verification of telemetry competencies. Patient 1		**Plan of correction:** 1. Immediately an addendum to the cardiac monitoring guidelines was created to define the order of call for telemetry technicians (TTs) 1) if a life threatening arrhythmia is detected 2) if the patient is unexpectedly disconnected or 3) if a non-life threatening arrhythmia is detected from telemetry. • Life Threatening arrhythmias (Vtach, vfib, sustained SVT or asystole: Immediately notify RN by calling the designated phone line used by telemetry monitoring person for urgent telemetry notifications with the RNs ("Hotline"). If unable to immediately reach nursing staff, activate a Code Blue • Unexpected telemetry disconnect (TT did not receive a call informing of planned disconnection): Notify RN by calling the "Hotline".	Compl-eted 9/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	was discovered unresponsive with no pulse or respirations. At the time the patient was discovered, it was determined he had been inadvertently disconnected from the bedside telemetry monitor. It was determined the patient's disconnection from the telemetry monitoring system went unrecognized for more than 30 minutes. Patient 1 did not respond to resuscitation interventions and was pronounced dead after a "code blue" (a coordinated team response to an identified cardiac/respiratory emergency). Findings: Patient 1 was admitted to the hospital on 9/7/15 with diagnoses which included chest pain, which is often a symptom of a heart attack known as a STEMI. An Inferior STEMI is an abnormal variation/elevation in a segment of an electrocardiogram tracing of a heartbeat, known as PQRST (a lettering identification assigned to the heartbeat segment tracing, shown on the electrocardiogram). Specific changes in height/width, of the PQRST segment tracings could indicate an MI [myocardial infarction] or heart attack. This diagnosis was included in the admission Attending History and Physical Attestation document, dated 9/7/15. Patient 1 underwent a PTCA (percutaneous transluminal coronary angioplasty) on 9/7/15. This is an invasive procedure performed on the heart to restore blood circulation. The post procedure physician orders, dated 9/7/15, included "Cardiac Monitoring...ONGOING, Until specified...Routine". During an interview on 9/17/15 at 10:30 A.M., the Director of Regulatory Affairs (DRA) stated that Patient 1 had been provided post procedure nursing		If unable to reach nursing staff or if telemetry leads have not been put back on within five minutes of RN notification via hotline, activate a Rapid Response. After activating a Rapid Response notify patient's assigned RN via hospital cell phone and document. If unable to reach patient's RN, notify the charge RN via hospital cell phone and document. Repeat the process if necessary. • Non-life threatening arrhythmias: the TT will notify the patient's assigned RN via hospital cell phone and document. If no answer, the TT will notify the Charge RN via hospital cell and document.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	care since 9/8/15. The DRA stated the patient was on a nursing care unit which provided telemetry cardiac monitoring. The DRA stated that Patient 1 was found unresponsive, pulseless and "off the monitor at approximately 6:30 that morning" (9/8/16). The DRA stated the central telemetry monitor indicated that Patient 1's heart rhythm had not been captured on the telemetry monitor since 5:43 A.M., on 9/8/15, and that it was "unknown" why or how the telemetry equipment became disconnected from the patient. The DRA acknowledged that an excessive amount of time (greater than 30 minutes) had occurred between the time the patient was disconnected from the telemetry monitor and the time the patient was discovered unresponsive and pulseless. The DRA stated that a code blue was performed, however, the patient was pronounced dead at 7:15 A.M. During an observation and interview on 9/17/15 at 12:20 P.M., Telemetry Technician (TT) 1 was observed seated at the monitor screens in the central telemetry monitoring area. TT 1 stated that a telemetry monitor screen rhythm would appear as a straight line on a blue background, in the event of a patient disconnection or in the event that the patient's heart stopped beating. TT1 stated that no audible sound would be generated when telemetry equipment was disconnected, "only arrhythmias (abnormal heart rhythms) would make a sound". TT1 stated nursing staff were expected to inform central monitoring if a patient was intentionally taken off telemetry equipment and then the TT would document the information on a patient's individual log form. Central monitoring is a specific area designated to observe telemetry screens by		The TT will then notify the nurse on the unit by calling the "Hotline". In addition, the expected communication from nurses to TTs regarding planned removal from cardiac monitoring was defined and includes calling the TT to give advance notice of the patient information and reason for time off-monitor and anticipated duration. The RN must obtain a physician order to cover any planned time off monitor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	specially trained staff. TT 1 stated that the nursing staff was not consistently compliant with this expectation. TT 1 stated the usual practice had been that, if a patient's heart rhythm was "lost" or not visible on the monitor screen, the patient's primary nurse would be alerted by a phone call from the assigned TT. The inability to see a heart rhythm on the telemetry monitor could indicate a disconnection or a patient having a cardiac emergency. If a patient was found to have a cardiac emergency a special team would be called to perform lifesaving interventions. TT1 stated that if the primary nurse was not accessed, a second phone call would be placed to a charge nurse by the assigned TT. TT 1 stated if neither of the nurses responded, "we would wait a few minutes and try again." TT 1 described "a few minutes" as up to 15 minutes. During an interview and joint document review on 9/17/15 at 2:30 P.M., the Critical Care Unit Manager (CCUM) stated her role and responsibilities included oversight of the telemetry policies, procedures, and staff performance. An un-authored and un-dated document entitled "Telemetry Technician Monitoring Guidelines" was reviewed. The document included expectations of staff during the following scenarios: "Start of Shift Duties...Admission or Request for Telemetry...Bed Transfers...Discharges...Non-Life Threatening Arrhythmias...Life Threatening Arrhythmias...Off Unit Procedures." The CCUM acknowledged, that prior to this event, she was unaware that these guidelines did not include approved interventions or timelines for the unplanned or unexplained loss of a patient's monitored heart rhythm. In addition, the		All nurses and TT for units with centralized cardiac monitoring were educated to the addendum with 1:1 sign offs. Based on an analysis of the unexpected telemetry disconnects, the addendum that was immediately implemented was further revised by adjusting time frames for Rapid Responses from a five minute response to a 15 minute respone; TT and nursing staff were re-educated on the revisions **Responsible person(s):** Director, ICU Hillcrest; Director, ICU La Jolla **Plan of Correction:** 2. On 9/19/15 additional TT resources, either a telemetry nurse or a TT, were added on the 12 hour night shift for both the Hillcrest and La Jolla facilities while an	Began 9/12/15 Completed 9/30/15 Revision Completed 10/4/16 Re-education began 10/4/16 completed 11/30/16 Completed 9/19/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	CCUM could not state who created the document or when it was implemented into the system. Furthermore, the CCUM stated the TT's informal development of the nurse call sequence and timeline practice, that was identified during TT1's interview, was "unacceptable". The CCUM was unable to demonstrate a formal policy and procedure for this expectation. During an interview on 9/18/15 at 3:00 P.M., the Assistant Nurse Director (AND) stated the AND's role and responsibilities included telemetry technician supervision, staff break/relief and verification of the telemetry technicians individual competencies. The AND acknowledged that the telemetry technician interventions for the unexplained and unexpected loss of a monitored heart rhythm had become a practice without a formal policy or procedure. The AND also recalled personal observations of unplanned or unexpected loss of patients' monitored heart rhythms and stated the primary nurse or charge nurse would be "called until the tech got an answer". The AND stated the timeline for accessing a nurse could "sometimes take 5 to 15 minutes". During an interview and joint document review on 9/18/15 at 3:45 P.M., TT 2 stated that he "typically monitored 38-48" patients' heart rhythms at a time while on duty. There was no hospital policy which determined the ratio of monitored patient to TT ratio. TT 2 stated the "Telemetry Technician Monitoring Guidelines" were given to him at the time of his initial orientation and were accessible, for reference, at the telemetry central station. TT 2 stated he "would assume" that an unplanned or unexpected loss of a monitored heart rhythm		assessment was conducted to determine the standard number of patients for maximum monitoring. A team of Clinical Nurse Specialists (CNSs) staff and ICU management evaluated and implemented standard monitoring expectation at both the Hillcrest and La Jolla facilities for the maximum volume permitted. The evaluation included a community query and a search of the literature. Upon completion of the evaluation, the team put forward the standard of a defined maximum number of patients not to exceed 60 which are to be monitored per tech. **Responsible person(s):** Director, ICU Hillcrest; Director, ICU La Jolla	Completed 10/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	occurred because the patient had been intentionally taken off the monitor by a nurse or other healthcare provider. TT 2 stated it was "usual practice" for the nursing staff not to communicate intentional patient monitor disconnections to the telemetry technicians. TT 2 acknowledged that he had not discussed this practice with nursing management. TT 2 stated the usual practice was to wait 15 minutes and then phone the primary nurse assigned to the patient. TT 2 stated that if he was unable to access the primary nurse he would try to phone the charge nurse, the nurses' station or call a "rapid response" (a code used to summon a special team response to an emergency situation). TT 2 acknowledged the referenced guidelines did not include his usual practice and stated those directions had been verbally communicated to him "by management, in staff meetings". TT 2 stated he was on duty and assigned to monitor Patient 1's telemetry on the night shift (7:00 P.M. - 7:00 A.M.), 9/8/15 to 9/9/15. TT 2 stated the usual practice for documenting patient telemetry rhythms was at the beginning of the shift and as needed for observed changes. Patient 1's "Arrhythmia Flowsheet" indicated that 4 entries had been documented on TT 2's shift for Patient 1. TT 2 confirmed the documentation. The same flow sheet indicated the patient's heart rate was 60 beats per minute at 8:32 P.M. and the heart rate was 54 beats per minute at 12:18 A.M. At 6:40 A.M., no heart rate was documented on the flow sheet, however, a handwritten note included "leads (telemetry equipment) placed since 0544 (5:44 A.M.) - Asystole (no heart activity)". At 6:46 A.M., no heart rate was documented on the flow sheet;		**Plan of Correction:** 3. An educational email was sent out to all hospital Staff for review of the "Patient Safety Alert on Chain of Command and Culture of Safety." **Responsible person(s):** Chief Administrative Officer, Performance Improvement Department **Monitoring:** Beginning 9/10/15, daily until 9/22/15 five logs at the Hillcrest (HC) and five logs at the La Jolla (LJ) facility were audited for completion and accurate documentation of notification by nursing for planned removals from cardiac monitoring and documentation of TT actions taken for unexpected removals from cardiac monitoring. On 9/23/15 through 11/18/15, daily audits of three logs as stated above were conducted at the HC and LJ facilities. Further actions will be taken as necessary.	9/22/15 Auditing began daily 9/10/15 to 11/18/15 Ongoing if compliance not met

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	**200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	however a handwritten note included "code called - CPR/compressions" (cardio-pulmonary resuscitation. An emergency intervention used for the absence of heart and respiratory function). Patient 1's telemetry monitor recording indicated a monitored rhythm at 5:43 A.M. There was no documentation of an abnormal rhythm prior to the loss of the monitored rhythm, which occurred several heart beats later. The "Arrhythmia Flowsheet" and corresponding telemetry monitor rhythm strip documented the loss of a monitored heart rate from 5:44 A.M. until Patient 1 was observed, by a nurse, without a heart rate at 6:40 A.M. TT 2 stated that he did not notice that the monitor rhythm recording had stopped at 5:44 A.M. TT 2 acknowledged that he did not notice until over 30 minutes later and stated "that the monitor was off to the side. I just didn't scan over that far". TT 2 stated that he did not hear an audible alarm. TT 2 stated when he realized that the monitor had been disconnected, he phoned the patient's primary nurse. TT 2 stated that he was unable to access the patient's primary nurse and did not attempt to call the charge nurse. TT 2 stated he decided to wait and call again 15 minutes later, however in the meantime, the patient's monitor was reconnected at 6:46 A.M. and indicated that CPR compressions were in progress. During an interview on 9/18/15 at 5:00 P.M., Registered Nurse (RN) 1 stated that he was assigned as Patient 1's primary nurse on the night shift (7:00 P.M. - 7:00 A.M.), 9/8/15 to 9/9/15. RN 1 stated Patient 1 was on telemetry monitoring and was assessed as stable at the beginning of the shift. RN 1 stated that he spoke to the patient at		**Responsible person(s):** Manager, ICU Hillcrest; Manager ICU La Jolla Audit results were reported out to the Significant Events Committee meeting. Further actions will be taken as necessary. **Responsible person(s):** Manager, ICU Hillcrest; Manager ICU La Jolla **<u>70214:</u>** **Plan of Correction:** Immediately, nurse managers validated competency of all Telemetry Technicians (TT) by ensuring that each TT passed a telemetry competence validation exam prior to working their next shift as a TT.	9/16/16 9/23/15 11/18/15 ongoing if compli-ance not met Began 9/12/15 Comple-ted 9/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	5:38 A.M. while performing the patient's routine IV (intravenous) care. RN 1 stated that Patient 1's telemetry equipment was connected and that the bedside monitor and alarms were on. RN 1 stated nursing staff relied on telemetry technicians to monitor for alarms, equipment malfunction, and heart rate or rhythm changes. RN 1 stated that the bedside monitor alarms were audible, outside of the patient's room, "for only about 10-15 feet". RN 1 stated that he re-entered Patient 1's room "about 6:35 A.M." to perform care on the patient's roommate. RN 1 stated that as he re-entered the room he observed Patient 1 "gray and unresponsive" on the bed. RN 1 stated he called for assistance and began CPR. RN 1 stated that the patient's telemetry equipment was connected to the patient's body; however, the cable from the patient's telemetry equipment had been disconnected from the mounted bedside monitor and was "curled" behind the patient's back. RN 1 stated that he did not receive a phone alert from the telemetry technician. On 9/18/15 at 2:00 P.M., a joint review of TT 2's personnel file and concurrent interview was conducted with the DRA. The personnel file included an "Employee Evaluation", dated 5/1/2015. The employee evaluation listed job standards specific to TT 2's position and described performance expectations related to the listed job standards. TT 2 was rated as meeting standards and consistently above standard on the performance of the various identified job standards. The performance expectations included "Observes the patient's cardiac rhythm for assigned shift reporting all variances to the nursing staff...Assures		Validation was also conducted to ensure that there was documented evidence that all TTs at both Hillcrest and La Jolla were oriented to their role as TT and their physical environment using the "Telemetry Tech Orientation Checklist." For TTs that did not have documented evidence of the orientation, a "Telemetry Tech Orientation Checklist" was completed prior to the TTs next working shift. A Competency Based Orientation (CBO) for all TTs and Registered Nurses, who will monitor the telemetry desk, was developed and implemented to include the following content: Telemetry Monitoring roles, successful completion of a newly implemented online Telemetry Exam, Alarm Parameters, Documentation, Communication of Patient Events, and Patient Admission,	Began 9/12/15 Completed 9/30/15 Completed 5/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	that the patient's monitor is intact and notifies the nursing staff if receiving a poor signal...Works independently applying sound judgement and routine problem solving...Sets priorities, maintains composure and function effectively under high volume, multiple work demands and urgent situations..." In addition, the DRA stated that the hospital telemetry technicians were required to complete an annual competency test for cardiac rhythm recognition and monitoring. A review of TT 2's "Telemetry Technician Annual ECG (electronic cardiogram) Competency Evaluation" was undated and without a verification of test answers accuracy. The DRA acknowledged that TT 2 had not performed expected job standards in a manner that met patient care needs or safety. Furthermore the DRA acknowledged TT 2's required annual test for cardiac monitoring competency had not been validated for accuracy. A review of the hospital policy and procedure titled "Management of Clinical Alarms in Patient Care Setting", dated 10/17/13 included "Attachment B...Acute Care with Cardiac Monitoring...Reliance on physiological monitors to continuously "watch" patients and to alert the clinician when a change occurs is standard practice on monitored units. Alarms are intended to alert clinicians to deviations from set limits and require prompt attention." The policy had not identified specific alarm response timeframes or interventions related to alarm response. During a joint interview on 9/22/15 at 1:00 P.M., the DRA, Chief Nursing Officer (CCO) and Chief Medical Officer (CMO) acknowledged that staff response to the unexpected and unintentional		Transfer, and Discharge. The CBO was implemented on 5/21/16 for new hires as well as for annual competencies for the existing TTs. **Responsible person(s):** ICU Manager, Hillcrest; ICU Manager, La Jolla **Monitoring:** In order to ensure that all TTs have proper evidence or orientation and telemetry monitoring competence, a review of all TT employee files at both Hillcrest and La Jolla was conducted to ensure there is evidence of successful completion of the telemetry competence validation exam and "Telemetry Tech Orientation Checklist." In the event a TT did not have evidence in their employee file, they would need to complete them prior to their next working shift. **Responsible person (s):** ICU Manager, Hillcrest; ICU Manager, La Jolla	Began 9/10/15 Completed 9/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050025	A. BUILDING _____ B. WING _____	01/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UC San Diego Health Hillcrest - Hillcrest Medical Center	**200 W Arbor Dr, San Diego, CA 92103-1911 SAN DIEGO COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	disruption of Patient 1's telemetry monitored cardiac rhythm had not been detected by the telemetry technician for more than 30 minutes. In addition, the DRA, CCO and CMO acknowledged that staff interventions, at the time the telemetry disruption was initially discovered, were informal, inconsistent and failed to ensure patient safety and wellbeing. The DRA, CCO and CMO acknowledged that assigned telemetry staff competency was not verified and that formal interventions for the unexpected and unexplained disruption of a telemetry monitored cardiac rhythm had not been developed by the hospital. Patient 1 was found disconnected from the telemetry monitor, unresponsive and in a cardiac arrest (loss of heart activity). Attempts to resuscitate Patient 1 were unsuccessful and the patient died. 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).		Exams were reviewed with all TTs to ensure a successful passing score of 100% Results and progress were reported out to the Significant Events Committee. **Responsible person (s):** ICU Manager, Hillcrest; ICU Manager, La Jolla	Comple-ted 9/30/15 9/16/15 9/23/15 11/18/15