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
	050009	A. BUILDING _____ B. WING _____	02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen of the Valley Medical Center	1000 Trancas St, Napa, CA 94558-2906 NAPA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00372887, CA00372443 - Substantiated Representing the Department of Public Health: Surveyor ID # 27294, 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. Penalty Number: 110011404 E 291 T22 DIV5 CH1 ART3 - 70215(a)(1) Planning & Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the 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. This RULE is not met as evidenced by:		Abbreviations: BOT – Board of Trustees CBO – Competency Based Orientation CQC – Clinical Quality Council CMO/COO – Chief Medical Officer/Chief Operating Officer CNO – Chief Nursing Officer MSEC – Medical Staff Executive Committee MSQC – Medical Staff Quality Council RT – Respiratory Therapy/Therapist ** Findings related to this event were corrected following a Federal Complaint Validation Survey **Immediate / Follow Up Actions:** **E 291 T22 – 70215(a)(1)** Planning and Implementing Patient Care Debriefing of all involved medical staff and nursing staff commenced on 10/06/13. 1. The CMO/COO and Nursing Leadership including the CNO, 2North Nursing manager, Director of Cardiovascular services, Director of Staff Education, Advanced Clinical Nurse Practitioner (ACNP), and representatives for Performance Improvement (PI), and Risk Management commenced an intense investigation and a Root Cause Analysis to review these events on 10/6/13. It was identified that education and process changes were needed to improve patient assessment-reassessments and documentation, plan of care documentation and implementation, physician notification, and staff competencies for patient(s) having multiple / complex facial fractures including wired jaw. A focused education and training	2/28/14

Event ID:EWKP11 7/24/2015 11:55:26AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Susan Stanton RN Vice President Patient Care/CNO 8/6/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 8

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. Plan of Correction Reviewed & accepted

State-2567 Mary Fiddler RN - manager of Regulatory Compliance informed. 1/19/16 @ 2:10 pm / B. Nelson RN HFEN Page 1 of

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	See - E 292 E 292 T22 DIV5 CH1 ART3 - 70215(a)(2) Planning & Implementing Patient Care (a) A registered nurse shall directly provide: (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 limitations of their licensure, certification, level of validated competency, and/or regulation. Based on staff, family interviews, record review, and document review, the hospital failed to ensure that nursing staff provided ongoing assessments for Patient 1's change of condition for increased anxiety, airway patency (maintaining open airway), bleeding, and trouble breathing and these changes were reported promptly to the physician for one patient (Patient 1). These failures delayed recognition of Patient 1's deteriorating medical condition that resulted in Patient 1 to bleed down the back of her throat, had a respiratory arrest and sustained an anoxic brain injury. (Adequate oxygen is vital for the brain. When oxygen levels are significantly low for four minutes or longer, brain cells begin to die and after five minutes permanent brain injury can occur. Anoxic brain injury is a serious, life-threatening injury). Patient currently is in a persistent vegetative state. These failures were violations of Section 70215 (a)(1)(2) of Title 22 of		plan was developed and implemented to ensure: a. patient needs are met by ongoing assessment of patients' needs b. The patient's plan of care: • is based on assessing the patient's nursing care needs • develops appropriate nursing interventions in response to identified nursing care needs, and • is kept current by ongoing assessments and documentation. c. physicians will be notified about significant change in patients' condition in a timely manner. d. sufficient numbers, types, and qualifications (training and experience) of nursing personnel are available to respond to the appropriate nursing needs and care for the patients with multiple/complex facial fractures including jaw wiring. e. the medical center provides nursing services for patients with multiple/complex facial fractures including jaw wiring 24 hours a day, 7 days a week. 2. A Mandatory education plan was developed for applicable 2North/Telemetry/Step Down unit, Post Anesthesia Care Unit (PACU), and Intensive Care Unit (ICU) nursing staff to ensure nursing staff have competencies to provide ongoing assessments-reassessments which recognize patient's change of condition; thereby, ensuring changes are reported promptly to the physician and the patient's care plan is individualized to address the patient's needs. This education plan included the following elements:	2/28/14

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	the California Code of Regulations and were deficiencies that caused or were likely to cause serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a). Findings: Patient 1 was admitted to the telemetry (portable heart monitor) unit on 10/02/13. Patient 1 had surgical repairs on 10/02/13 of facial fractures with nasal packing (Gauze, foam, or cotton that has been packed into the nose) and Patient 1's jaws were wired closed. Patient 1 was readmitted to the telemetry unit (portable heart monitor) post-operatively. Patient 1 was alert, oriented and Patient 1 communicated by writing, due to her jaws wired closed. During interview on 11/05/13 at 4:00 p.m., Family Member 3 stated Patient 1 had learned how to self-suction because she had fears of choking and thought the nurses might not make it to her room in time when she needed to be suctioned, so she was doing it herself. Family Member 3 stated on 10/05/13 at 1:30 p.m., Patient 1 was having difficulty with increased secretions and was complaining of not being able to breathe very well. Family Member 3 stated Patient 1 had been self-suctioning even before her surgery, because she had difficulty swallowing and had "fears of choking." Family Member 3 stated she was worried about Patient 1 and felt there was a disconnect with Patient 1 and the nurses. Family Member 3 stated she was worried about Patient 1		a. Mandatory TeamSTEPPS training: • a 4 hour class teaching an evidence-based teamwork system to improve communication and teamwork skills among health care professionals. • Course facilitators / trainers included ACNP, AHA Training Center Coordinator, and Registered Nurse, Staff II from ICU. • training commenced on 12/11/13 and concluded on 01/30/14 for applicable nursing staff on 2North. b. Mandatory education titled, "Assessment / Reassessment and Plan of Care Important Practice Reminders" includes: • a HealthStream (an electronic education and tracking system) module developed to review nursing practice related to patient assessment and reassessment, plan of care documentation, standards of care, and patient education. • emphasis on the requirement to re-assess patients as indicated by a change in the patient's level of care, diagnosis, condition, response to treatment, change in condition, as well as the patient's and/or family's needs and the care they are seeking. • emphasis on the need to notify the physician / allied health professional (AHP), throughout the patient's stay, in a timely manner about pertinent changes in the patient's condition utilizing SBAR (communication/hand-off report utilizing Situation, Background, Assessment, and Recommendation).	

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	and told the nurses of her concerns before she went home that evening at 6:30 p.m. Family Member 3 stated Patient 1 was more anxious, weak, and tired and was unable to relax. During an interview on 10/10/13 at 4:00 p.m., and on 11/06/13 at 8:00 a.m., Licensed Staff D stated on 10/05/13 at 7:00 p.m. that Patient 1 and Family Member 2 were anxious. Licensed Staff D stated that on 10/05/13 at 9:00 p.m., Patient 1 needed to be suctioned again and at that time Licensed Staff D noted a small blood clot in Patient 1's right nostril. She stated she checked the left nostril and mouth and did not see any blood. (patient's jaws were wired closed.) She stated Patient 1 was still anxious and complained of not being able to get the secretions out of the back of her throat. There was no documented evidence of a nursing assessment of why Patient 1 was exhibiting anxiety. The physician was not notified. During an interview on 11/06/13 at 8:00 a.m., Licensed Staff D stated that she should have notified the physician sooner after the first small blood clot in the right nostril was noted and the wires should have been cut sooner. During an interview on 10/10/13 at 4:00 p.m., and on 11/06/13 at 8:00 a.m., Licensed Staff D stated that on 10/05/13 around 9:30 p.m., Family Member 2 came out of the room and stated Patient 1 was having a nosebleed from the left nostril. Licensed Staff D stated when she went into the room the nosebleed had stopped and Patient 1 was still very anxious. There was no documented evidence of a		• Education commenced on 12/11/13 and concluded on 01/30/14 for applicable nursing staff on 2North, ICU, 3North, 1South units and the Nursing Float Pool. Completion required by 01/30/14. c. Mandatory education titled, "Critical Thinking and Clinical Judgment" is a HealthStream (an electronic education and tracking system) module developed to review: • Rapid Response Standardized Procedure; Condition Help (Condition H); • telemetry and computerized monitoring standards of care; • documentation for ongoing assessments in critical environments; • identify supplies required to care for patients with a wired jaw; and • interventions required while caring for a patient with a wired jaw. This education is required before attending the mandatory 1.5 hour scenario training. Education commenced on 12/11/13 and concluded on 01/30/14 for applicable nursing staff on 2North. Education commenced on 01/20/14 for Post Anesthesia Care Unit (PACU) and ICU nursing staff. Completion for all PACU and ICU nursing staff was completed on or before 02/28/14. d. Mandatory education titled, "Scenario / Critical Thinking and Clinical Judgment" commenced on 12/11/13 for applicable nursing staff on 2North and was completed on or before 01/30/14 for all 2N staff. Education for PACU and ICU nursing staff commenced on 01/20/14 and was completed on or before 02/28/14. Course content included:	

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	nursing assessment of why Patient 1 was exhibiting anxiety and a nursing assessment of Patient 1's nosebleed of the left nostril. The physician was not notified. During an interview on 11/05/13 at 1:15 p.m., Family Member 2 stated that on 10/05/13 around 10:00 p.m., Licensed Staff F helped Patient 1 to the bedside commode, and also helped Patient 1 orally suction out a 2 inch blood clot. During an interview on 10/28/13 at 4 p.m., and on 11/06/13 at 11:30 a.m., Licensed Staff F stated she informed Licensed Staff D of the nosebleed. The physician was not notified. There was no documented evidence of a nursing assessment of Patient 1's bleeding. During an interview on 11/06/13 at 8:00 a.m., Licensed Staff D stated on 10/05/13 in the evening that she was in Patient 1's room at least every 15 - 30 minutes. She stated she was not too worried about Patient 1 even though Patient 1 was anxious and kept saying she was having difficulty getting the secretions out and stated she was not able to breathe. Licensed Staff D stated Patient 1's oxygen saturations were 94%-95 % on room air (percentages oxygen in the blood and the normal ranges are 90% - 100%), skin color was good, she was talking, and her lung sounds were good. Licensed Staff D stated she was unsure why Patient 1 was so anxious. During an interview on 11/05/13 at 1:15 p.m., Family Member 2 stated on 10/05/13 at 11:00 p.m., Licensed Staff F helped Patient 1 to the commode		◦ 1.5 hour scenario discussion, critical thinking role play, review of care of the patient with facial fracture and jaw wiring, and review of the wired jaw tool box. e. To ensure that nursing personnel obtain appropriate education, experience, and competence prior to being assigned to provide nursing care for patients with multiple/complex facial fractures including wired jaws, education on the following topics was provided and validated: • Patient family anxiety • Care of patient with nosebleed • Continued bleeding • Patient signs and symptoms including difficulty swallowing and difficult breathing • Documentation requirements • Notification to physician regarding change of patient's condition • Critical thinking and interpretation of patient behaviors and physiological changes as essential assessment skills. f. Successful completion of Critical Thinking and Clinical Judgment module and the Scenario / Critical Thinking and Clinical Judgment education is required. Following completion, the nursing staff's competency is validated by the ACNP noting that competency has been successfully met and can be performed independently. This competency validation is documented and placed in the employee's file.	

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	and while she was on the commode Patient 1 began having another nosebleed. Patient 1 was put back to bed and she stated the nosebleed was "just dripping" after that. There was no documented evidence of a nursing assessment of Patient 1's bleeding. During an interview on 10/28/13 at 4:00 p.m. and on 11/06/13 at 2:05 p.m., Licensed Staff F stated on 10/05/13 at 11:30 p.m., she was called into the room again by Licensed Staff D, who needed help. Family Member 2 and Patient 1 were very anxious. Family Member 2 wanted the physician called right away. Licensed Staff F told Licensed Staff D to call the hospitalist. During interviews on 10/10/13 at 9:10 a.m., and on 11/07/13 at 11:00 a.m., Licensed Staff E stated that on 10/06/13 at 12:20 a.m., she saw a trickle of blood in Patient 1's mouth and a small amount in her left nostril. She stated Patient 1 was alert, very anxious, communicating, and swallowing a lot. Patient 1 told her she was having a hard time breathing. Patient 1's oxygen saturation was at 95 % and Licensed Staff E stated she put her on oxygen anyway. She stated that Patient 1 was swallowing more. She stated shortly after that may be 2 or 3 minutes later Patient 1 became unresponsive, and was not breathing, Licensed Staff E stated CPR was initiated and a code blue was called. There was no documented evidence of nursing assessments from 10/06/13 at 7:30 p.m. to 10/06/13 at 1:00 a.m., that indicated Patient 1 was		E 292 T22 – 70215(a)(2) (Planning and Implementing Patient Care To ensure that a registered nurse shall directly provide the planning, supervision, implementation, and evaluation of the nursing care provided to each patient, the Medical Center's policy titled "Assessment/Re-Assessment of Patients" was reviewed. This policy was in effect at the time of this event. Elements of the policy were not followed including documentation of ongoing assessments, level of care transitions, changes in patient condition, care needs and response to interventions. 1. A focused review identified that reinforcement education and process changes should be implemented to ensure compliance with the following elements of the Assessment/Re-assessment policy / procedure. Process changes include: a. Nursing care planning starts upon admission, is reviewed daily and as needed, and is developed in collaboration with other disciplines as their assessments are completed. b. The patient's Care Plan is individualized to the patient's condition and needs. c. The patient's care plan is prioritized relative to the patient's condition and needs. d. The patient's Care Plan is kept current by documentation of assessed needs, assessments / re-assessments, and the patient's response to care, treatment/interventions, and services at least daily and as needed. e. Education commenced on 12/11/13 with completion on or before 01/30/14 for applicable nursing staff on 2North, education	2/28/14

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	having difficulty with increased secretions, increased anxiety, difficulty swallowing, bleeding, or trouble breathing. During an interview on 11/06/13 at 8:00 a.m., Licensed Staff D stated she was so busy that shift she was not able to look at Patient 1's chart for physician orders, or Patient 1's history. She stated as far as the lack of documentation from 10/05/13 at 7:30 to 10/06/13 at 1:00 a.m., she stated she was so busy and everything got so hectic, that she was unable to document anything. During an interview on 10/09/13 at 11:00 a.m., Administrative Staff C stated that Licensed Staff D had no documentation of all the events that occurred from 7:30 p.m. on 10/05/13 until Patient 1's code blue on 10/06/13 at 12:36 a.m. She stated she expected the nurses to document any change of condition and notify the physician immediately. Review of the Hospital's policy and procedures for Nursing assessments and re-assessments, revised 11/09, indicated page 1 #2-(b); using the nursing process, the RN will assess relevant physical, functional, psychological needs of the patient. This process begins with the RN's first encounter with the patient and is reassessed throughout the stay as conditions warrants. Review of Clinical Nursing Skills and Techniques, 8th edition, 2010, Chapter 6, titled "Health Assessments;" indicated nurses perform physical assessments on a regular basis. In an Acute Care setting the assessments are more comprehensive.		for ICU, 3North, 1South units and the Nursing Float Pool completion occurred on or before 02/28/14. f. Following successful completion of Critical Thinking and Clinical Judgment module and the Scenario / Critical Thinking and Clinical Judgment education, the nursing staff's competency was validated by the ACNP noting that competency had been successfully met and can be performed independently. This competency validation documentation is placed in the employee's file. 2. "Caring for a patient with a wired jaw" competency has been added to the "RN Basic Competencies – ICCU" CBO and the "RN Basic Competencies: Progressive Care-Step Down Unit/ICU Cross Training" CBO; thereby, ensuring annual competencies are completed by all applicable nursing staff and during orientation for new nursing staff on these units. 3. To ensure that nursing personnel obtain appropriate education, experience, and competence prior to being assigned to provide nursing care for patients with multiple/complex facial fractures including wired jaws, education on the following topics were provided and validated: a. Airway Compromise, threatened airway and respiratory distress b. Acute changes in breathing c. Critical interventions necessary to reach the patient's treatment goals. d. Patient and family education e. Oral care f. Pain and nausea management g. Anatomy Review	2/28/14 2/28/14

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	Nurses are often the first to detect changes in the patient condition. The ability to think critically and interpret patient behaviors and physiological changes are essential. The physical assessments are tools used to detect both subtle and obvious changes in a patient's health. These failures to ensure that nursing staff provided ongoing assessments for Patient 1's change of condition for increased anxiety, airway patency, bleeding, and trouble breathing and these changes were not reported promptly to Patient 1's physician. These failures delayed recognition of Patient 1's deteriorating medical condition that resulted in Patient 1 to bleed down the back of her throat, had a respiratory arrest and sustained an anoxic brain injury. These were violations of Section 70215(a)(1)(2) of Title 22 of the California Code of Regulations and deficiencies that caused or were likely to cause serious injury or death to the patient, and therefore constitutes an Immediate Jeopardy within the meaning of Health and Safety Code 1280.1(a). 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 1280.1(c).		h. Facial Fracture Stabilization i. Bedside supplies j. Secretions and suction k. Wire cutters l. Cutting Wires in an emergency 4. In collaboration with the Medical Staff and Nursing, written instructions titled, "How to care for a patient with a wired jaw" were developed and are available to nursing staff. To ensure availability when caring for a patient with a wired jaw, a copy of these written instructions are included in the Jaw Wire Kit. 5. In collaboration with the Medical Staff and Nursing, written instructions titled, "Patient Care Instruction After Corrective Jaw Surgery" were developed and are available to patients, family, and nursing staff. 6. To ensure safe and appropriate nursing / patient care assignments, a Shift Lead Checklist was developed noting essential items that must be completed each shift by all leads / relief charge nurse on 2North nursing unit including: a. review all complex patients on unit. b. confirm that the plan of care is updated. c. confirm that staff has resources to care for patient d. confirm patient education is completed e. make assignments for oncoming shift, ensuring that staff with appropriate competencies are assigned to each patient f. Shift lead checklist is signed, dated, and presented to Department manager for review and actions if needed.	1/30/14 1/30/14 1/30/14

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	Nurses are often the first to detect changes in the patient condition. The ability to think critically and interpret patient behaviors and physiological changes are essential. The physical assessments are tools used to detect both subtle and obvious changes in a patient's health. These failures to ensure that nursing staff provided ongoing assessments for Patient 1's change of condition for increased anxiety, airway patency, bleeding, and trouble breathing and these changes were not reported promptly to Patient 1's physician. These failures delayed recognition of Patient 1's deteriorating medical condition that resulted in Patient 1 to bleed down the back of her throat, had a respiratory arrest and sustained an anoxic brain injury. These were violations of Section 70215(a)(1)(2) of Title 22 of the California Code of Regulations and deficiencies that caused or were likely to cause serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a). 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 1280.1(c).		Monitoring Process 1. 2N nursing staff assignments were reviewed to ensure staff with appropriate competencies are assigned to each patient. Audits of staff competencies and patient assignments occurred on 2 North and 2 Northwest, including assignments from each shift. Audit/review commenced on 11/01/13. Audit data resulted in 100% compliance with requirement that "employee file reflects completed competencies applicable to the patient population assignment". 2. Medical records will be audited for compliance with hospital policies to confirm nursing staff provide assessment and re-assessments, including documentation that could prevent delayed recognition of a deteriorating medical status and applicable notification to physicians. Audits will occur on 2North and will include samples for each shift. Audits will be monthly to include a minimum of 35 records. This audit will commence on 08/17/15. Following four (4) continuous months of compliance, this audit may be reduced to quarterly monitoring until sustainable corrections are assured. Audit Indicator: • Care plan is individualized to the patient's condition and needs • Care plan is current – reviewed daily and as needed • Assessments / reassessments and the patient's response to care/treatment/ interventions is documented Responsible Person(s): Director / 2N Manager Actions for the above Plan of Correction were evaluated for effectiveness. Audit data and	9/17/15

extra page inserted pg 9

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	Nurses are often the first to detect changes in the patient condition. The ability to think critically and interpret patient behaviors and physiological changes are essential. The physical assessments are tools used to detect both subtle and obvious changes in a patient's health. These failures to ensure that nursing staff provided ongoing assessments for Patient 1's change of condition for increased anxiety, airway patency, bleeding, and trouble breathing and these changes were not reported promptly to Patient 1's physician. These failures delayed recognition of Patient 1's deteriorating medical condition that resulted in Patient 1 to bleed down the back of her throat, had a respiratory arrest and sustained an anoxic brain injury. These were violations of Section 70215(a)(1)(2) of Title 22 of the California Code of Regulations and deficiencies that caused or were likely to cause serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a). 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 1280.1(c).		analysis was reported to Involved staff, Patient Safety Council, Administration, Nursing Leadership, MSQC, CQC, and BOT for tracking, improvements as needed, and integration into the hospital's quality assurance program.	

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