70214(a)(2) Nursing Staff Development
(a) There shall be a written, organized in-service education program for all patient care personnel, 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:

Based on medical record review, policy and procedure review, personnel file review, and staff interview, the hospital failed to ensure that only Registered Nurses with validated competencies and according to hospital policies, are allowed to cannulate the External Jugular (EJ) veins for intravenous (IV) catheter placement for patients. During hospitalization, Patient 501 had an EJ catheter placed by an RN without demonstrated competencies in the procedure. Patient 501 developed an air embolism during the course of the patient's stay in the hospital and expired. Insertion of an EJ catheter is associated with the risk of an air embolism if the insertion procedure is not performed correctly or the cannula orifice is not covered at all times (to prevent an air embolism).

**THE FOLLOWING EVENTS CONSTITUTED AN IMMEDIATE JEOPARDY (IJ), WHICH PUT THE**
HEALTH AND SAFETY OF ALL PATIENTS AT RISK WHEN NURSING STAFF FAILED TO IMPLEMENT THE HOSPITAL'S WRITTEN POLICIES AND PROCEDURES TITLED "CANNULATION OF THE EXTERNAL JUGULAR VEIN" AND INSERTED AN EXTERNAL JUGULAR CATHETER INTO A PATIENT WITHOUT THE REQUIRED DEMONSTRATED COMPETENCIES IN THE PERFORMANCE OF THE PROCEDURE.

Findings:

On 10/17/07 at 8:30 a.m., a review of Patient 501's record revealed that the patient was admitted to the hospital on August 18, 2007 with a diagnosis of altered level of consciousness. During the patient's course of stay in the hospital, the patient developed an air embolism and expired.

The record revealed that on 9/1/07 (no time documented) Staff RN I inserted an EJ catheter (a soft, flexible plastic tube that is inserted into a vein) in the patient's right EJ vein. The patient was receiving peripheral parenteral nutrition (PPN) via the EJ. On 9/11/07 the patient had a Computed Tomography (CT) scan of her chest, abdomen, and pelvis to rule out a peripheral embolism. The patient suffered a cardiopulmonary arrest during the CT scan procedure and expired on 9/14/07 at 3:25 a.m. from an air embolism.

On 10/23/07 at 4:42 p.m., Staff RN I stated during an interview that on 9/1/07 (could not remember the time) he had inserted an 18 gauge Angiocath (an Angiocath is a tube that can be inserted into a vein)
Continued From page 2

into the patient's right EJ. Staff RN I stated that he spoke with the attending physician regarding the placement of a central venous catheter (CVC, a catheter placed into a large vein the neck, chest or groin) or placement of a peripherally inserted central catheter (A PICC is inserted in a large peripheral vein and advanced towards the heart until the tip rests in the distal superior vena cava). The physician indicated that the a CVC or PICC was out of the question. The physician ordered on 9/1/07 (not timed) for an EJ to be placed. Nursing staff noted the order 9/1/07 at 1 p.m. Staff RN I stated, "...I am the pro of the hospital. The other nurses call me to put in IVs that they cannot get in. I have been trained to insert EJ..." Upon inquiry regarding training in the insertion of the EJ at this hospital, Staff RN I stated that he was trained in his home country, but not at this hospital. Staff RN I stated that he works on the Medical/Surgical units only. Staff RN I stated that he had not looked at the hospital policy regarding who can insert an EJ. Upon inquiry regarding if the patient was put into Trendelenburg position prior to the insertion of the EJ, Staff RN I stated that he could not remember if he had placed the patient in Trendelenburg. Staff RN I stated that the patient could not take a deep breath. Staff RN I stated that the patient was lying flat on her back. She was lethargic and was unable to follow verbal commands. Staff RN I stated that another RN assisted in the placement of the EJ. Staff RN I stated that he went to the head of the patient's bed to be behind the patient's head. "I inserted the catheter into the vein just like I would any other vein. There was a good blood return. The catheter was flushed with 3 cc NS (normal saline),

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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.
Continued From page 3

using a 3 cc pre-filled syringe. The PPN was
hooked up (connected) and infused without any
difficulties..."

On 10/24/07 at 9:45 a.m., Staff RN K stated that
she was the charge nurse on 9/1/07 on the day
shift (7 a.m. to 7 p.m.) shift. Staff RN I told me (RN
K) that he had gotten an order from the physician to
insert an EJ into Patient 501. Staff RN K asked
Staff RN I if he had been trained to insert an EJ and
had he been checked off to reflect competencies.
Staff RN I stated, "yes," and that he does this all
the time. Staff RN K stated that she was aware that
there was an Emergency Department (ED) nurse
specifically trained to put in an EJ. Staff RN K
stated that the patient was not placed in
Trendelenburg position for the procedure. The
patient did not have a pillow under her head.

Both Staff RN I and RN K's personnel files were
reviewed with administrative staff. There was no
documented evidence that either RNs had
competency in the insertion of an EJ.

During interview on 10/24/07 at 10:30 a.m.,
administrative staff stated that there were two (2)
registered nurses (RN) in the ED on 9/1/07 that had
competencies in EJ insertion. A review of the
competencies of the two (2) RNs revealed that one
(1) had a competency dated 11/5/03 and the
second RN had a competency dated 1/27/04.
Administrative staff stated that neither of the RNs
had current competencies documented in their
personnel files, making them not competent to
insert an EJ. Administrative Staff stated that the
RNs had not performed any annual EJ insertions to

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Continued From page 4

maintain competencies and to keep themselves current.

The policy and procedure titled “Standard Procedure # 1 - Cannulation of the External Jugular Vein,” dated 10/05, indicated that the required education and experience to perform external jugular cannulation, the ED RN must be IV competent per the hospital policy. The RN must complete a class on the anatomy of the vascular structure of the neck and be able to correctly identify each in the clinical setting. For the certification process the ED RN must perform three (3) successful external jugular cannulations under the direct supervision of an ED physician. The ED RN must perform a minimum of "(X)" number of procedures annually to maintain competency. The ED physician will be available for any questions and provide directions to the ED RN. Limitations on Setting: Standardized Procedure # 1 may be performed in the ED only by those ED RNs who have completed the requisite (required) education and training and have demonstrated competency. A written record of those certified to perform this procedure will be maintained in the ED and in the Education Department.

Upon inquiry regarding what number refers to "(X)," Administrative Staff stated that she did not know the definition of "(X)", in relationship to the number of procedures the RNs needed to perform annually.