

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ 2013 OCT 21	(X3) DATE SURVEY COMPLETED  7/25/12 10 3 55
NAME OF PROVIDER OR SUPPLIER <b>St. Joseph Hospital</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 W Stewart Dr, Orange, CA 92868-3849 ORANGE COUNTY</b>		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00317257 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 25720, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.1(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>Health &amp; Safety Code Section 1280.1(c):</p> <p>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>Health and Safety Code Section 1279.1(c): The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p>		<b><u>This Page Intentionally Left Blank</u></b>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mindy G. Smith* TITLE: *Director Regulatory & Accreditation* (X6) DATE: *10/21/12*

By signing this document, I am acknowledging receipt of the entire citation packet, *Page(s) 1 thru 13*

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.

*POC accepted 10/22/13 Surveyor 25720*

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	<p>Deficiency Constituting Immediate Jeopardy:</p> <p>T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.</p> <p>T22 DIV5 CH1 ART3-70215(b) Planning and Implementing Patient Care (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>T22 DIV5 CH1 ART3-70215(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 patient's medical record.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on interview and medical record and hospital document review, the hospital failed to ensure nursing assessments were conducted per the guidelines of the hospital's P&amp;P (policy and procedure) for Patient A and failed to ensure critical intervention and advocacy by the RN (registered nurse) on behalf of the patient by notifying the</p>		<p><b><u>This Page Intentionally Left Blank</u></b></p> <p style="text-align: right; color: blue;">2013 OCT 21 PM 3 55</p>	
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	<p>physician of a change in the patient's medical condition. The patient's level of red blood cells was reported by the laboratory as abnormally low prior to the cesarean section procedure (a surgical delivery of an infant through a surgical cut in the abdomen) on [REDACTED] 12. During the post-operative recovery period the patient's blood pressure had decreased and the heart rate had increased from the pre-operative baseline values; however, the physician was not contacted. After a change of shift in the post-operative recovery room, the oncoming RN was unaware of the patient's pre-operative laboratory results and did not review the patient's pre-operative vital signs (blood pressure and heart rate) or any vital signs taken prior to the change of shift. The patient was assessed as low risk for hemorrhage and met the criteria for discharge from the recovery room and was transferred to the Mother-Baby Unit. On the Mother-Baby Unit, the patient's blood pressure remained at a low level and the heart rate remained elevated over the next four hours. The physician was not contacted and frequent vital signs were discontinued. There was no further documentation to show the patient's status until the hospital's Medical Emergency Team was called at 1750 hours. The patient had a seizure, required ventilation, and was transferred to the ICU (Intensive Care Unit) where the patient had a cardiac arrest at 1831 hours. Laboratory blood work results showed a dangerously low number of red blood cells and the patient was in a DIC crisis (disseminated intravascular coagulation, a serious medical condition that develops when the normal balance between bleeding and clotting is disturbed, and</p>		<u><b>This Page Intentionally Left Blank</b></u>	2013 OCT 21 PM 3 55
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	<p>excessive bleeding and clotting injures body organs and causes anemia or death). The patient's condition deteriorated and she passed away on [REDACTED] 12.</p> <p>Findings:</p> <p>The medical record for Patient A was reviewed beginning on [REDACTED] 12, during an onsite visit to the hospital. Patient A was admitted to the Labor Delivery and Recovery Unit on [REDACTED] 12 at 1901 hours. Review of the nurses' notes showed the patient was sent from the obstetrician's office for evaluation for edema (swelling caused by fluid retention) and high blood pressure.</p> <p>Review of Patient A's pre-natal record and the physician's H&amp;P (history and physical) faxed to the hospital previous to the patient's admission on [REDACTED] 12, showed the patient was a term pregnancy with complications of a large infant, 4+ edema (very deep pitting, 8 mm indentation, lasting about 2-5 minutes) of the bilateral lower extremities and 1+ edema of the abdomen (slight pitting, 2 mm indentation, disappearing rapidly), and pregnancy induced hypertension (high blood pressure greater than or equal to 140/90 mmHg during pregnancy). The patient's blood pressure in the obstetrician's office was documented as 150/80 (the average blood pressure for pregnancy is 110/70 and the average normal blood pressure for adults is 120/80).</p> <p>Review of the Labor and Delivery Admission Assessment dated [REDACTED] 12 at 1948 hours, showed RN E documented the patient's blood pressure as</p>		<p><b><u>Plan of Correction 70215(b) &amp; 70215(d)</u></b></p> <ol style="list-style-type: none"> <li>1. All current post anesthesia care patients in Labor and Delivery Recovery will be immediately assessed to ensure they meet discharge criteria prior to transfer.</li> <li>2. For post anesthesia care patients in Labor and Delivery (L&amp;D), baseline blood pressure (B/P) and pulse rate (PR) will be standardized as the initial PR and B/P obtained by the anesthesiologist prior to the procedure. All L&amp;D and MBU staff will be educated on the process</li> </ol> <p><b>Responsible Party: Manager L&amp;D</b></p> <p><b>Responsible Party: Manager L&amp;D &amp; Manager Mother Baby Unit</b></p> <p><b><u>Monitoring</u></b> See Below</p>	<p>7/25/12</p> <p>2013 OCT 21 PM 3 55</p> <p>8/24/12</p>

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	<p>154/97 and the heart rate as 72 at the time of admission (normal adult heart rate is 60-100 beats per minute). RN E documented the patient had 3+ edema (deep pitting, 6 mm indentation, lasting more than 1 minute) of the bilateral upper and lower extremities with edema going up the thigh to the abdomen.</p> <p>Patient A's blood was drawn for laboratory blood tests including a hemoglobin (hemoglobin is the protein contained in red blood cells responsible for delivery of oxygen to the tissues. The normal level for women is 12g/dl to 16 g/dl) and hematocrit (hematocrit measures the volume of red blood cells compared to the total blood volume. The normal level for women is 36% to 48%) on [REDACTED] 12 at 1949 hours. Patient A's hemoglobin was reported as 7.6 g/dl and the hematocrit was 22.6%. Low levels of hemoglobin and hematocrit are indicative of blood loss, internal bleeding, or anemia.</p> <p>Patient A's cesarean section procedure was performed on [REDACTED] 12 at 0435 hours. Review of the Anesthesia Record showed an initial blood pressure of 160/82 and heart rate of 90 was documented at 0400 hours, prior to the cesarean section. At the end of the procedure, the patient's blood pressure was 140/78 and a heart rate of 80 at 0525 hours.</p> <p>Review of the Post-Op (post operation) Recovery form dated [REDACTED] 12, showed Patient A was admitted to the recovery room at 0528 hours. The patient's blood pressure was recorded as 149/77 and the heart rate as 69 at 0535 hours. The</p>		<p>3. For post anesthesia care patients the L&amp;D RN will document the baseline B/P and PR on the Shift Summary Report and/or the SBAR Transfer Report Document. In addition, the RN will calculate the +/- 20% for B/P and PR and document it on the Shift Summary Report and/or the SBAR Transfer Report Document. (Note this will be completed manually until the electronic documentation system can be updated)</p> <p><b>Responsible Party:</b> Manager L&amp;D &amp; Manager Mother Baby Unit</p> <p><b>Monitoring</b> See Below</p> <p>4. Shift Summary and/or SBAR Transfer Report Document will be printed and reviewed by the off-going/transferring RN and the on-coming/receiving RN and will be signed by both.</p>	<p>2013 OCT 21 PM 3 55</p> <p>8/24/12</p> <p>8/24/12</p>

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	<p>patient's vital signs were measured every 15 minutes and recorded into the electronic medical record. The patient was documented as a "low" on the hemorrhage risk assessment at 0601 hours. The location of the uterine fundus (top of the uterus) was documented as two finger breadths above the navel (the uterus should remain firm at or about the navel immediately after birth to begin the process of involution back to the pre-pregnancy size. A rise in the height of the uterus could be a sign of a possible post-partum hemorrhage).</p> <p>Patient A's blood pressure was recorded as 149/83 and the heart rate was 76 at 0631 hours, in the recovery room. At 0646 hours, the patient's heart rate had risen to 96, but the blood pressure was unchanged. At 0700 hours, change of shift, the patient's blood pressure had decreased to 111/76 and the heart rate increased to 116. Assessment of the fundal height of the uterus remained two fingers above the navel. There was no documented evidence the physician was notified of the patient's low blood pressure and increased heart rate to determine if further medical treatment was needed. Low blood pressure and increased heart rate are indicative of moderate or severe bleeding which depletes an individual's body of blood.</p> <p>At 0725 hours, RN F assumed care of Patient A in the recovery room at the change of shift. The patient's blood pressure recorded at 0732 hours had now decreased to 101/76 and the heart rate had increased to 128. The patient's fundus remained at two fingers above the navel. There was</p>		<p><b>Responsible Party: Manager L&amp;D &amp; Manager Mother Baby Unit</b></p> <p><b>Monitoring</b> See Below</p> <p>5. Most recent Hemoglobin and Hematocrit will automatically populate to the Shift Summary Report and the SBAR Transfer Report Document and will be printed and reviewed by the off-going/transferring RN and the on-coming/ receiving RN and will be signed by both.</p> <p><b>Responsible Party:</b> Manager L&amp;D and Manager MBU</p> <p><b>Monitoring</b> See Below</p> <p>6. Labor and Delivery Staff will be educated on or prior to their next shift on the revised process, document changes and expectations as listed above.</p>	<p>2013 OCT 21 PM 3 55</p> <p>8/24/12</p> <p>8/24/12</p>

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	<p>no documented evidence the physician was notified of the patient's low blood pressure and increased heart rate and the unchanged fundal height at two finger breadths above the navel 2 hours after the cesarean section procedure.</p> <p>Review of the anesthesiologist's recovery orders dated [REDACTED] 12, showed to discharge Patient A from the recovery room by "discharge criteria."</p> <p>The hospital's P&amp;P titled Discharge Criteria for Post Anesthesia Care, revised date of 9/11, showed the purpose of the policy was to outline the nursing responsibilities in providing a safe and appropriate discharge of the patient for transfer to the appropriate nursing unit. Nursing was directed to notify the anesthesiologist and obtain orders prior to discharge for patients who have any deviations from expected outcomes or who have not met the discharge criteria.</p> <p>The P&amp;P showed patients may be considered ready for discharge when they meet the following criteria (in part) as assessed by the RN: blood pressure and heart rate within 20% of baseline values and the fundus is firm at the navel or below. If criteria are not met, a physician's order must be written to discharge the patient.</p> <p>At 0740 hours, the discharge assessment conducted by the RN prior to the transfer of Patient A from the recovery room to the Mother-Baby Unit showed the patient's blood pressure was "within range for patient; there was no history of unstable BP [blood pressure] from baseline; and the</p>		<p><b>Responsible Party:</b> Manager L&amp;D</p> <p><b>Monitoring:</b> See Below</p> <p>7. Labor and Delivery Staff will be reeducated educated on or prior to their next shift on Phase 1 post anesthesia care discharge criteria including need for notification of anesthesiologist for B/P and PR outside the +/- 20% variance prior to transfer.</p> <p><b>Responsible Party:</b> Manager L&amp;D</p> <p><b>Monitoring:</b> See Below</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">2013 OCT 21 PM 3 55</p> <p>8/24/12</p>

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	<p>patient's fundus was two finger breadths above the navel." RN F documented the patient was transferred to the Mother-Baby Unit in stable condition. The patient's vital signs recorded prior to discharge at 0746 hours, showed the blood pressure had decreased to 97/77 and the heart rate was 126. The patient's blood pressure recorded at the time of discharge showed a greater than 30% decrease from the pre-operative baseline blood pressure (154/97). The heart rate recorded at the time of discharge showed an increase of more than 35% from the patient's pre-operative baseline heart rate (72). There was no documented evidence the physician was notified of the patient's low blood pressure and increased heart rate which were above 20% of baseline values as per the P&amp;P for further medical evaluation.</p> <p>Review of the SBAR Standardized Communication report signed off by RN F and RN D on the Mother-Baby Unit, showed Patient A was a "low risk" for hemorrhage. Both RNs signed acceptance of the above recovery room assessment.</p> <p>Review of Patient A's admission assessment on the Mother-Baby Unit dated [REDACTED] 12 at 0828 hours, showed the uterine fundus was documented at four finger breadths above the navel. The question "history of BP plus or minus 20 mmHg from baseline" in the electronic record was answered as "no." The patient was documented as a "low" on the hemorrhage risk assessment. There was no documented evidence the RN had notified the physician of the patient's increased fundal height at four finger breadths above the navel 4 hours after</p>		<p><b><u>Monitoring for # 2,3,4 &amp;5</u></b></p> <p>Manager and or Designee will complete a minimum of 10 chart audits per month on Post Anesthesia Care patients for 3 Months to ensure the anesthesiologist was notified prior to transfer from the recovery room for any patients not meeting discharge criteria, baseline B/P and PR are documented, +/- 20% variance is calculated and documented, most recent hemoglobin and hematocrit are documented, and the Shift Summary Report and/or the SBAR Transfer Report Document is signed by both RN's. Any identified Fall-outs will be reported to the Quality Safety Committee of the Medical Staff for further recommendation</p>	2013 OCT 21 PM 3 55

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	<p>the cesarean section procedure.</p> <p>The patient's blood pressure and heart rate were recorded every hour on [REDACTED] 12, from 0800 hours until 1100 hours as follows: at 1000 hours, the blood pressure was recorded as low as 87/63 with a heart rate of 121 and at 1100 hours, the blood pressure was 91/77 with a heart rate of 119. Again, there was no documented evidence the RN had notified the physician of the patient's continuously decreased blood pressure and increased heart rate after the cesarean section procedure.</p> <p>There was no further documentation to show the patient's vital signs were taken from 1600 hours to 1700 hours and the fundal height was assessed by the Mother-Baby Unit RN from 0830 hours to 1730 hours.</p> <p>The next documentation showed the hospital's Medical Emergency Team was called on [REDACTED] 12 at 1740 hours. Documentation showed the patient had a seizure, was vomiting, and had a decreased pulse oximetry (a non-invasive method allowing the monitoring of the saturation of a patient's hemoglobin, normal values are 95-100%) reading of 85%. The patient required oxygen and assisted ventilation with intubation (placement of a flexible plastic tube into the windpipe to maintain an open airway) and was transferred to the ICU.</p> <p>Laboratory blood work drawn at 1805 hours showed Patient A's hemoglobin was reported as 2.6 g/dl and the hematocrit was 8.9%.</p>		<p>8. B/P and PR Baseline +/- 20% variance will be added to the criteria for the Mother Baby Assessment RN in assessing the patient's stability and need for additional interventions. The SBAR Transfer Report will be utilized as the baseline +/- 20% B/P and PR variance.</p> <p><b>Responsible Party:</b> Manager MBU</p> <p><b>Monitoring</b> See Below</p> <p>9. Mother Baby Unit Staff will be re-educated on or prior to their next shift on the revised process on expectations for assessment and re-assessment of post anesthesia care patients and requirements for documenting and reporting changes.</p> <p><b>Responsible Party:</b> Manager MBU</p> <p><b>Monitoring</b> See below</p>	<p>8/24/12</p> <p>2013 OCT 21 PM 3 55</p> <p>8/24/12</p>
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	<p>Review of a physician's Consultation report dated [REDACTED]12, showed Patient A had a cesarean section on [REDACTED]12, "following which the patient started to bleed, had hemorrhagic shock and cardiac arrest x 2 and went into multisystem organ failure, including brain injury and eventually declared brain dead on [REDACTED]12." The patient passed away on [REDACTED]12.</p> <p>RN F was interviewed on 7/18/12 at 1500 hours. RN F stated she assumed care of Patient A in the Labor and Delivery recovery room on the day shift of [REDACTED]12 at approximately 0715 hours. RN F stated the night shift RN reported the patient was admitted the night before with a slightly elevated blood pressure of 140/80-140/90 and the patient had swelling over the entire body. The RN F stated she was unaware the patient's hemoglobin level was very low prior to the cesarean section procedure. RN F stated when she assessed Patient A for discharge criteria from the recovery room, she compared the patient's discharge blood pressure to the first blood pressure measured on the day shift. The RN F also stated Patient A was medicated for pain near the time of discharge and she assessed "that would be normal for any cesarean section patient who had received pain medication."</p> <p>When RN F was asked if she had reviewed Patient A's vital signs recorded in the electronic record prior to her shift on [REDACTED]12, the RN F stated she could review the vital signs by accessing the "vital signs history;" however, that was not something she did as a routine. When asked if she was concerned about the patient's heart rate of 126 beats per minute at the time of discharge from the</p>		<p><b><u>Monitoring for #8&amp;9</u></b></p> <p>Manager and or Designee will complete a minimum of 10 chart audits per month on Post Anesthesia Care patients for 3 Months to ensure compliance with use of baseline +/- 20% B/P and PR variance and completion and documentation of assessments and re-assessments when circumstances require. Any identified fall-outs will be reported to the Quality Safety Committee of the Medical Staff for further recommendations</p>	2013 OCT 21 PM 3 55

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DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  7/25/12
NAME OF PROVIDER OR SUPPLIER <b>St. Joseph Hospital</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 W Stewart Dr, Orange, CA 92868-3849 ORANGE COUNTY</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>recovery room, RN F stated a patient's heart rate was usually elevated somewhat at that time as the patient was moved and turned for clean-up. When asked if the patient's low hemoglobin prior to surgery was communicated to the Mother-Baby Unit RN at the time of transfer, the RN F stated no because she was not aware of the lab results herself.</p> <p>RN D was interviewed on 7/17/12 at 1005 hours. RN D stated she was assigned to care for Patient A on [REDACTED] 12, on the Mother-Baby Unit. The RN D stated she received report from the Labor and Delivery RN the patient was admitted with an elevated blood pressure and pregnancy induced hypertension. The RN D confirmed she had assessed the patient's fundus location as four finger breadths above the navel. The RN D stated both she and the Labor and Delivery RN had agreed the fundal position was a little higher than in recovery room; however, the patient did not have increased vaginal bleeding and the fundus was firm.</p> <p>When asked how she determined the baseline blood pressure for Patient A, RN D stated she looked at the patient's last two to three sets of vital signs in the recovery room. RN D stated she thought the blood pressure and heart rate at the time of transfer to the Mother-baby Unit were normal for that patient. The RN D stated she thought the patient's blood pressure had improved after the baby was delivered.</p> <p>RN D stated she assessed Patient A at approximately 1230 hours on [REDACTED] 12. RN D stated</p>		<b><u>This Page Intentionally Left Blank</u></b>	2013 OCT 21 PM 3 55

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	<p>the patient's fundus had returned to a position of two fingers above the navel and there was only scant bleeding; however, RN D stated she did not document the assessment. RN D stated the patient's family visited with her in the afternoon until about 1530 hours. The patient complained of feeling tired.</p> <p>RN D stated when she assessed Patient A at 1630 hours, the patient complained of feeling dizzy and had a gush of vaginal blood when she was assisted to sit up at the side of the bed. RN D stated the patient appeared "pale, dizzy and out of it." RN D stated she called the physician and left a message for him to return the call. The RN D stated as she returned to the room the patient's pulse oximeter was alarming as the patient's heart rate was 150 beats per minute. RN D stated the physician arrived and the hospital's Medical Emergency Team was called for assistance.</p> <p>The Executive Director of Women' Services and the Manager of Labor and Delivery were interviewed on 7/23/12 at 1115 hours. Both staff were asked to review the P&amp;P for Discharge Criteria for Post Anesthesia Care and asked to define a patient's "baseline vital signs." The Manager stated the baseline vital signs would be the patient's pre-surgical vital signs. When asked to state the criteria for assessment of a patient's risk for post-partum hemorrhage, the Manager stated there were "drop-down" guidelines in the electronic record for hemorrhage risk. Review of Table 1 of the guidelines showed Patient A met the criteria for low risk; however, staff was directed to implement Table</p>		<u><b>This Page Intentionally Left Blank</b></u>	2013 OCT 21 PM 3:56
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	<p>2 guidelines per physician's order if there was a greater than 15% change from the admission baseline vital signs or the heart rate was greater than or equal to 110. Table 2 guidelines showed to notify the obstetrician, charge nurse, activate the post-partum Resource Team, and notify the anesthesiologist. Both staff were unable to show documentation the change in Patient A's vital signs was addressed at the time of discharge from recovery room and on the Mother-baby Unit until the patient showed signs of obvious distress.</p> <p>The facility's failure to ensure nursing assessments were conducted per the guidelines of the hospital's P&amp;P (policy and procedure) for Patient A and failure to ensure critical intervention and advocacy by the RN (registered nurse) on behalf of the patient by notifying the physician of a change in the patient's medical condition is a deficiency that has 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).</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 1280.1(c).</p>		<b><u>This Page Intentionally Left Blank</u></b>	2013 OCT 21 PM 3 55	

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