The following reflects the findings of the Department of Public Health during an inspection visit:

Complaint Intake Number: CA00283972 - Substantiated

Representing the Department of Public Health:
Surveyor ID # 25338, 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 1280.1(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.

Title 22, California Code of Regulations, Section 70215 (a)(2) and (b):

(a) A registered nurse shall directly provide:

(2) The planning, supervision, implementation and evaluation of the nursing care provided to each patient.

(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.

Initial Comments:

Southwest Healthcare System received this Statement of Deficiency on August 18, 2014. The hospital reaffirms its commitment to ensure the planning and delivery of patient care includes all elements of the nursing process specifically assessments, intervention, and evaluation.

Submission of this plan of correction is not an admission by the hospital that the citations are correct or that the hospital violated the rules cited herein.

Action Taken:

1. Administration and Nursing Leadership reviewed the "Assessment and Reassessment in the Emergency Department" that addresses the elements of the nursing process, "Physician Orders" that includes the process for obtaining and processing physician orders and "Patient Flow and Capacity Management: Hospital Wide" policies and procedures. They also reviewed the 2/8/2011 ED Quality Review Committee investigation of the incident.

2. The Chief Medical Officer and the Director of Quality and Nursing re-reviewed Patient 1's care and...
Findings:

Based on interview and record review, the facility failed to ensure the planning and delivery of patient care included all elements of the nursing process, specifically assessments, intervention, and evaluation, when staff failed to provide for the individual patient care requirements of Patient 1. This failure resulted in delayed provision of nursing care for Patient 1. Furthermore, this failure resulted in delay of medication administration ordered by the physician, and delay in reassessment of Patient 1's condition. The cumulative effect of these failures was the direct proximate cause of Patient 1's death.

The medical record of Patient 1 was reviewed on July 26, 2011.

Patient 1, a 47 year old patient, came to the Emergency Department (ED) on 9/25/2011, at 9:42 p.m., via ambulance with complaints of weakness and leg pain. The patient's past medical history included pulmonary disease (including asthma and chronic bronchitis), diabetes (blood sugar disease), hypertension (high blood pressure), and kidney dysfunction.

The medical record showed that blood samples were obtained at 11:35 p.m. on 9/25/2011, and a critical potassium level (hypokalemia) of 8.8 mmol/L (millimoles per liter; normal level 3.6-5.1 mmol/L) was reported to ED Registered Nurse 2 (RN 2) on 9/26/2011 at 12:50 a.m. (Per Lextcomp Online, potassium levels greater than 6.5...)

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identified issues related to complying with physician orders, timely medication administration, handling of critical lab results, patient assessment, nursing documentation, addressing and reporting of changes in patient condition, addressing staffing issues when there is a change in patient care needs, utilization and understanding of the new computer system, and utilizing appropriate chain of command measures to effectuate the safe delivery of patient care.

Action plans were developed and implemented. This included educating nurses on key interventions such as handling critical lab results, timely implementation of physician orders, performing and documenting nursing assessments, interventions and evaluations based on patient condition, and chain of command procedures for requesting assistance and reporting issues.

3. The ED Nurse Manager met with the nurse caring for Patient 1 to discuss this case. This nurse has been counseled and placed in a remediation plan. The ED nurse also received remedial computer training; compliance with utilizing the electronic medical record was validated.

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4. Nurses were inserviced on the policies and on the RN's responsibility for supervising and evaluating the patient's care. Special emphasis was placed on: a) assessing the patient; and b) reviewing the medical record, including, but not limited to, the physician notes, orders, and test results. Nurses shall carry out physician orders and document their execution in the medical record (e.g., medication administration). Nurses shall also follow up to ensure that results are received from lab tests performed and that they are placed in the medical record or posted to the EMR, and if applicable, called to the physician (e.g., critical results). The nurse shall contact the physician if an order has not or cannot be implemented and obtain further orders, if applicable, that are documented in the medical record. Further emphasis was placed on the importance of communication between the clinical team responsible for care of the patient and on documentation in the medical record to allow for continuity of care.

5. The ED nurses received ongoing education and support in January 2011 at the time of the hospital's upgrade to the ED electronic medical record.
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The admitting orders from AP 1, dated _______ 2011, at 1.23 a.m. also included the following medication orders:

- Albuterol 2.5 mg and Atrovent 0.5 mg (milligrams) HHH (hand-held nebulizer) PRN (as needed) for shortness of breath;
- Aspirin 162 mg (blood thinner) PO (by mouth), NOW (if not given in ED), then daily;
- Lopressor 25 mg (medication for high blood pressure) PO, NOW (if not given in ED), then BID (twice a day) hold for heart rate <50, SBP (systolic blood pressure) < 90,
- Lasix 40 mg IVP BID (assists in eliminating potassium and also used for congestive heart failure [CHF - inability of the heart to provide sufficient pump action]),
- Kayexalate 30 gm (grams) po BID,
- Nitroglycerin Ointment (medication to treat chest pain and elevated blood pressure), 1 inch to chest wall (no frequency documented),
- Nitroglycerin 0.4 mg (medication to relieve chest pain) SL (sublingual - under the tongue) every 5 minutes x 3 for chest pain, and
- Normal Saline (an IV fluid [IVF]) at 100 ml per hour.

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- Normal Saline (an IV fluid [IVF]) at 100 ml per hour.
At 1:30 a.m., the Nursing Assessment indicated that Patient 1 complained of sternal chest pain with difficulty breathing, and breath sounds were noted to be diminished with expiratory wheezing. The patient described the chest pain as a 9 on a scale of 0 to 10 (with 10 being worst).

The next set of vital signs taken for Patient 1 were recorded at 2:30 a.m. (one hour and 40 minutes from the prior set of vital signs) - BP 213/193, Pulse 101, RR (Respiratory Rate) 30, Pain rating of 9 of 10 chest pain, O2 sat 95% (on 2 liters per minute [LPM] oxygen) There was no documented evidence that AP 1 was informed of these abnormalities.

At 2:30 a.m., Patient 1 was medicated with Xanax 1 milligram, by mouth (an anti-anxiety medication.)

There was no documentation of any interventions regarding Patient 1's critical potassium level (hyperkalemia) until 3:00 a.m., when Humulin R (Insulin Regular) (approximately one and a half hours after it had been ordered), and Dextrose 50% and Water (Dextrose) 25 grams IV (approximately one and a half hours after it had been ordered) were administered.

At 3:10 a.m., Nitroglycerin Ointment was administered (1 hour and 40 minutes after the patient complained of chest pain.)

At 3:38 a.m., EDP 1 documented, “.Patient here with significant hyperkalemia (elevated level of

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emphasizing their role in responding to the needs of the nursing staff when when patient care needs change and additional staff is required. The Nursing Supervisor shall be notified at times when there is significant increase in patient activity so as to obtain further assistance in the emergency room. Nursing Supervisors shall make frequent shift rounds to the emergency department to ensure sufficient staffing to meet the current needs of the patients and assist in resolving barriers to patient flow.

Monitoring:

1. The CNO or qualified designee review 50 ED medical records to ensure appropriate assessments and reassessments are documented. This review will occur for three months and then be re-evaluated.
2. The Director of P1 or qualified designees performed a concurrent record review of a minimum of 50 records monthly with the goal of achieving 100% compliance with implementing physician orders and following through on execution of orders.
3. The CNO shall take corrective action as necessary. Compliance shall be
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reported to the hospital PI Council, and report monthly through the hospital quality structure to the Board of Governors.

Persons Responsible:
Chief Nursing Officer
At 5:15 a.m., laboratory staff advised RN 1 of an additional critical potassium level of 9.2 mmol/L from blood that was drawn from Patient 1 at 4:20 a.m.

At 5:20 a.m. (one hour and 10 minutes from the last set of vital signs) - BP 171/63, Pulse 120, RR 17, Pain 0/10. 02 sat 100% (on BIPAP)

On 01/11, at 6:27 a.m., EDP 1 documented, even though the patient was admitted to the ICU, patient was still waiting in the ED for a bed. As I was walking by her bed I noticed that she had agonal respirations (a gasping sound that does not provide enough oxygen to the body and is not considered as actual breathing and is indicative of dying). We instituted ACLS (Advanced Cardiac Life Support-measures including chest compressions, medications, and mechanical breathing), protocol right away, but placed an emphasis on treatments for hyperkalemia as we noted that she was hyperkalemic earlier. Patient 1 was the subject of a code blue (emergency response) at 5:50 a.m., and was pronounced dead at 6:20 a.m.

There was no documented evidence that the Aspirin, Lopressor, Albuterol and Atrovent, and Normal Saline IVF were given before Patient 1 died at 6:20 a.m.

During an interview with the ED Manager (EDM) on
July 26, 2011, at 9:00 a.m., she stated that she could not explain the delay in administration of medications to Patient 1. She stated there was no documentation in the progress notes of any delay in the ED receiving the medications from the pharmacy, and that the timeframe of administering the medications was not acceptable.

The EDM stated that the vital signs of Patient 1 at 12:50 a.m. were very concerning, and waiting until 2:30 a.m. to subsequently recheck vitals of Patient 1 was too long. She stated for patients with critical conditions, vital signs should be checked as often as every 15 minutes.

During an interview with the Chief Nursing Officer (CNO) on July 27, 2011, at 3:20 p.m., she stated Patient 1's care was sent to the ED nursing leadership for review.

On July 27, 2011, a handwritten document of an interview conducted with RN 1 by RN 5, dated 2011 was reviewed. The document set forth the following notations: "Spoke with [RN 1] regarding the delayed meds (medications). Per [RN 1], he was extremely busy; he was unaware of med (medications) orders due to new process of computerized orders and he was not looking in computer for med orders. [AP 1] eventually came to [RN 1] and asked why the meds had not been given. Then [RN 1] gave the meds [RN 1] stated he asked for help from the charge nurse [RN 2], but due to the state of the department he was unable to get help."
A handwritten document regarding investigation of the incident involving Patient 1, dated __________ 2011, and signed by EDM was reviewed. EDM documented that during an interview with RN 2, RN 2 stated that RN 1 had asked for assistance due to a heavy assignment and she was assisting RN 1, "but it was very busy with heavy patients."

The EDM stated that when the charge nurse was unable to provide the required assistance, nursing staff was to go up the chain of command to obtain needed assistance, which consisted of the Emergency Lead or the House Supervisor.

During a review on July 29, 2011, of the facility policy entitled, "Physician's Orders" (revised March 2010; reviewed December 2010), indicated: "Physician's orders will be accurately processed and promptly followed."

During a review on July 29, 2011, of the facility policy entitled, "Assessment and Reassessment in the Emergency Department," (issued May 2010; reviewed September 2010), the policy set forth the following: "If a patient (Adult or Pediatric) is unstable, reassess blood pressure, pulse, respirations and condition at least every fifteen (15) minutes until stable."

The "Coroner's Investigation Report" for Patient 1, prepared on __________ 2011, indicated the following under "Cause of Death:"
A. Hyperkalemia - Hours
B. Chronic Kidney Failure - Years
The reports also set forth the following: "It was the opinion of the hospital physicians that (Patient 1's name) died as a result of severe Hyperkalemia for hours, due to chronic kidney failure for years, with other contributing factors of hypertension, Diabetes and obesity."

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 12801(c).