

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2014
NAME OF PROVIDER OR SUPPLIER DESERT REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 N Indian Canyon Dr, Palm Springs, CA 92262-4872 RIVERSIDE COUNTY		
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	<p>failure resulted in Patient A sustaining multiple air emboli (air bubbles) to the brain, causing irreversible brain damage and subsequently resulted in the patient's death.</p> <p>Findings:</p> <p>An unannounced visit was conducted on August 15, 2014, at 9:30 a.m., for the purpose of the investigation of an entity reported adverse event.</p> <p>During an interview with Senior Performance Improvement Analyst (SPIA), on August 15, 2014, at 9:30 a.m., the SPIA stated, on August 5, 2014, during the removal of Patient A's central venous catheter (CVC) line, the patient had a seizure (a surge of electrical activity to the brain). The SPIA stated the facility's preliminary investigation and test results indicated the patient sustained an irreversible injury to the brain, from air being introduced to the venous (blood) system when RN 1 removed the patient's CVC. (Central Venous Catheter-a flexible tube placed into a large vein, and used for the administration of medications and fluids).</p> <p>During an interview conducted with the Risk Manager (RM), on August 15, 2014, at 9:50 a.m., the RM stated the facility's preliminary investigation, included an interview with RN 1. This interview revealed RN 1 did not follow the facility's policy and procedure regarding the removal of a CVC. The RM stated RN 1 removed the patient's</p>		<p>the Lippincott Advisor procedure on the care and removal of a Central Venous Catheter (CVC) for direction on the care and maintenance of the CVC, safe removal, and monitoring of the patient pre, during, and post removal. The procedure as detailed in the electronic manually is clinically current and in compliance with current standards of care and practice. The Chief Nursing Officer and Nursing Leadership reviewed the Competency, Staff Education, and Continuing Professional Development Policy & Procedure (Policy stat # 641248) for compliance with current standards of care and practice. The policy required no revisions.</p> <p>Training: The Chief Nursing Officer reviewed the policy on Care of the Central Venous Catheter with all Nursing Directors at the Nurse Executive Committee on October 8, 2014 and directed the Nursing Directors to re-educate all nursing staff on the policy. The Director of Nursing Education re-educated 100% of nurses who care for patients with central venous catheters (CVC) on the care and discontinuation of the catheters which included complications of CVC removal and the importance of accurately documenting the procedure and patient response. In addition, the Director of Nursing Education developed and implemented a new competency assessment for the care, discontinuation, and associated potential complications with a CVC. Competency</p>	10/08/2014

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	<p>CVC while the patient remained sitting upright in a chair.</p> <p>During an interview with the Director of Progressive Care Unit (DPCU), on August 15, 2014, at 1:15 p.m., the DPCU stated the facility's policy and procedure for removing a CVC indicated the patient should be positioned for the CVC removal lying in bed, with the head of the bed in the lowest possible position. The DPCU stated positioning the patient's head in a low position reduced the chance of air getting into the blood stream and causing an injury to the patient.</p> <p>Positioning the patient in a supine (lying) position during the removal of a CVC decreases venous (vein) pressure. When the patient is in an upright (sitting) position, venous pressure is decreased, and the difference of pressure between the outside pressure, and the decrease of the vein pressure, favors the movement of air into the blood stream when venous pressure is less than atmospheric (outside) pressure.</p> <p>The DPCU stated competencies (assessment of knowledge) regarding care of CVC's was required for all RN's working in the unit. A concurrent review of the personnel file for RN 1 indicated RN 1 completed a competency assessment for CVC's on September 13, 2013.</p> <p>The hospital policy and procedure was provided by the Director of Clinical Quality Improvement (DCQI), on August 15, 2014, for review. The policy entitled, "Nursing Procedures" revised date August 1, 2005,</p>		<p>validation included return demonstration of sequencing steps for CVC removal. Annual skills lab has included CVC competency as a core component. 100% of nursing staff caring for patients with CVCs completed the new competency as of October 20, 2014. Currently competency is a part of the onboarding process of nursing orientation in units caring for patients with CVCs. As stated, the CVC competency is a part of annual re-orientation and skills lab.</p> <p>Monitoring: The Nursing Director of Education and the Nursing Directors will monitor completion of annual competencies for all nursing staff inclusive of CVC competency in applicable nursing units. Ongoing competency audits are reported to Nursing Leadership and employees failing to adhere to mandatory competency requirements are removed from the schedule in accordance with hospital policy until annual competency update is completed.</p> <p>Responsible Person(s): Chief Nursing Officer Director of Nursing Education Nursing Directors Director of Clinical Quality Improvement Quality Council Governing Board</p> <p>Policy & Procedures: The Chief Nursing Officer (CNO), Nursing Director of 2 Sinatra and the Director of Clinical Quality Improvement (DCQI) reviewed the</p>	<p>10/20/2014 and ongoing</p> <p>10/20/2014 and ongoing</p>

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	<p>indicates "Policy: It is the policy that (name of facility) will use the following reference for nursing care and procedures located in the LNA (Lippincott Nursing Advisory) Health Library online.</p> <p>The policy further indicated, "Lippincott Nursing Procedures, 5e Chapter 6: Intravascular Therapy...Removing a CVC. If you'll be removing the CVC, first check the patient's record for the most recent placement (confirmed by an x-ray) to trace the catheter's path as it exits the body. Make sure assistance is available if a complication (such as controlled bleeding) occurs during catheter removal. (Some vessels, such as the subclavian vein, can be difficult to compress.) Before you remove the catheter, explain the procedure to the patient. Place the patient in a supine position (lying down) to prevent an air embolism."</p> <p>The record for Patient A was reviewed. Patient A was admitted in August 2, 2014, with the diagnosis Abdominal Aortic Aneurysm (AAA- an enlarged area in the lower part of the Aorta, the major blood vessel that supplies blood to the body).</p> <p>The record indicated Patient A had an emergency surgical procedure to repair the AAA, on August 2, 2014. The record indicated a CVC was inserted in the right jugular vein by the anesthesiologist.</p> <p>A document entitled, "Progress Notes-Physician," dated August 5, 2014, at 6:45 a.m., indicated the following: "D/C (discontinue) IJ (internal jugular). D/C (discharge) planning for AM."</p>		<p>Disclosure of Outcomes to Patients (policy stat # 2156821) Policies for compliance with current standards of care and practice. The policies required no revisions at that time. The Disclosure policy was followed as noted.</p> <p>Training: The Nursing Director of 2 Sinatra met with the nurse and provided one on one discussion regarding the documentation requirements as per policy and professional licensure. Staff meetings included documentation training specific to this event and Disclosure policy. The Director of Nursing Education completed CVC competency training on October 20, 2014 for 100% of nursing staff caring for this patient population which was inclusive of required documentation.</p> <p>Monitoring: The Director of Clinical Quality Improvement in collaboration with Nursing Leadership implemented a CVC care and documentation monitoring audit on September 22, 2014. A minimum of 5 cases were audited on a weekly basis for a four month period. 90% compliance was met and sustained during the monitoring process with results reported out to Quality Council and the Governing Board. The audit components included accuracy of documentation of CVC removal inclusive of patient response and any complications if applicable.</p> <p>Other Corrective Actions: As per Centers for Medicare and Medicaid Services (CMS)</p>	<p>08/15/2014</p> <p>08/15/2014</p> <p>10/20/2014</p> <p>09/22/2014</p> <p>09/22/2014</p>

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	<p>A document entitled, "Orders", dated August 5, 2014, at 6:55 a.m., indicated the following: "Central Line Removal."</p> <p>A document entitled, "Nursing/Clinical Info (information)...Nursing Note, " dated August 5, 2014, at 10:54 a.m., indicated, "8:30 Pt (Patient A) sitting in chair A/O (awake/oriented) x 4. VSS (vital signs stable). Pt c/o (complained of) pain in left foot...8:40 a.m. Pt became stiff with labored breathing and unresponsive. Pt appears to be having a seizure. Charge nurse called for assistance with pt. Pt moved from chair to bed ...still unresponsive. Code Blue called." (A Code Blue is announced in a hospital when a patient's heart and/or breathing has stopped, to alert the necessary personnel.)</p> <p>The record indicated following the Code Blue, Patient A was placed on life support to include a ventilator (a machine used to assist and/or breathe for a patient), transferred to the Intensive Care Unit (ICU), and required multiple intravenous medications in order to sustain heart and lung function.</p> <p>The record further indicated Patient A remained in the ICU receiving numerous life sustaining treatments until August 11, 2015, at 12:10 p.m., when the patient was declared dead.</p> <p>The document entitled "Neurology" dated August 10, 2014, at 5:15 p.m. set forth the following: "...Absent pupillary response b/l (bilateral), Absent corneal response (b/l)...No motor response to pain,</p>		<p>survey results and corrective action submitted in September of 2014.</p> <p>Responsible Person(s): Chief Nursing Officer Director of Nursing Education Nursing Directors Director of Clinical Quality Improvement Quality Council Governing Board</p>	

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	<p>No eye opening...Above consistent with brain dead."</p> <p>A document entitled, "Death Summary," dated August 11, 2014, at 12:22 p.m., indicated, "Patient had a right internal jugular vein (CVC), which was inserted in the operating room by anesthesiologist. This was ordered to be discontinued by the nursing staff, while the patient sitting at the bedside, the internal jugular...(CVC) was removed by the nurse, immediately...(the patient) developed seizure activity."</p> <p>There was no nursing documentation in the record regarding the removal of the CVC.</p> <p>A phone interview was conducted with RN 1 on August 18, 2014, at 12:20 p.m. RN 1 stated she did not remember having competencies regarding the removal of a CVC, but she was very familiar with CVCs.</p> <p>RN 1 stated on August 5, 2014, she was working in the Progressive Care Unit (PCU) and was assigned to care for Patient A. She stated the unit was very busy. RN 1 stated she had also been assigned to care for Patient A on the prior day (August 4, 2014).</p> <p>She stated at approximately 8:00 a.m., she assisted Patient A into a chair at the bedside, for breakfast.</p> <p>She stated at approximately 8:30 a.m., she prepared to remove the CVC located in Patient A's</p>			

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	<p>right jugular vein (a blood vessel that carries blood from the head to the heart). RN 1 stated Patient A was positioned sitting upright in a "regular hospital chair." She stated she instructed Patient A to hold his breath, removed the CVC, held pressure to the site, waited for the bleeding to stop, and then applied a dressing to cover the removal site.</p> <p>RN 1, stated that approximately 10 minutes after the removal of the CVC, she observed Patient A in the chair having a seizure (a sudden surge of electrical activity in the brain).</p> <p>RN 1, stated, "In retrospect, I am really not sure what happened. I don't think I could have done anything different."</p> <p>A phone interview was conducted with the Deputy Coroner (DC), on August 18, 2014, at 2:15 p.m. The DC stated an autopsy had been completed. The DC stated Patient A's death was "ruled accidental related to the removal of the right jugular catheter leading to an air embolus."</p> <p>The facility failed to ensure RN 1 followed the facility's policy and procedure regarding patient positioning during the removal of Patient A's CVC. Patient A sustained irreversible brain damage from the introduction of air bubbles into the blood stream, during the removal of the CVC. This failed practice was directly responsible for Patient A's death.</p>				

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