

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>050045</b>                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/29/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>El Centro Regional Medical Center</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1415 Ross Ave, El Centro, CA 92243-4306 IMPERIAL 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:<br/>CA00464104 - Substantiated</p> <p>Representing the Department of Public Health:<br/>Surveyor ID # 1864, 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 1280.3(g): 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>Title 22 Regulations<br/>70213. Nursing Service Policies and Procedures.<br/>(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.<br/>(b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy.</p> <p>§ 70707. Patients' Rights.<br/>(a) Hospitals and medical staffs shall adopt a written policy on patients' rights.<br/>(b) A list of these patients' rights shall be posted in</p> |   | <p><b>RECEIVED</b><br/><b>CA DEPT OF PUBLIC HEALTH</b></p> <p><b>OCT 05 2018</b></p> <p><b>LICENSING &amp; CERTIFICATION</b><br/><b>SAN DIEGO DISTRICT OFFICE</b></p> <p>Title 22 DIV 5 CH 1 ART 7 {70707 {b} {2, 4, 9}</p> <p>On September 7, 2015 ECRMC failed to implement nursing care and assessment policies and procedures to meet the needs of a patient. Patient was not provided with appropriate and timely assessments and interventions related to chest pain symptoms during an emergency department visit. Patients repeated requests for treatment, related to chest pain symptoms, were not managed in a manner that maintained standard of practice and patient rights. California Department of Public Health (CDPH) completed an onsite visit on 12/06/16 to assess compliance with the standards identified in this 2567.</p> | 9/07/15  |

Event ID: J8M411

6/25/2018

11:07:44AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
**CEO**

(X6) DATE  
**10/4/18**

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 15

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.

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|  | <p>both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to:</p> <p>(2) Considerate and respectful care.</p> <p>(4) Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand.</p> <p>(9) Reasonable responses to any reasonable requests made for service.</p> <p>Based on observation, interview and record review the hospital failed to implement nursing care and assessment policies and procedures to meet the needs of a patient (Patient 1). Patient 1 was not provided with appropriate and timely assessments and interventions related to chest pain symptoms during an Emergency Department (ED) visit. Patient 1's repeated requests for treatment, related to chest pain symptoms, were not managed in a manner that maintained standards of practice and patient rights.</p> <p>Patient 1 was diagnosed with a cardiac (heart) emergency, which ultimately required critical care (specially equipped and trained staff for high risk situations) transportation to a higher level of care for an emergent cardiac procedure. This deficient practice delayed diagnosis/treatment and failed to provide care that respected the patient's right to an immediate response to symptoms of an emergent cardiac condition, which had the potential to cause serious harm and/or death.</p> <p>Findings:</p> |  | <p>Prior to receiving this patient grievance ECRMC had identified opportunities in the triage process. 9/16/15 triage competency process was reviewed and redefined to meet current standards.</p> <p>On 10/05/15 ECRMC received a grievance from the patient related to patient care. Quality immediately initiated the grievance process.</p> <p>On 10/06/15 this case was flagged by the quality department for quality of care concerns and sent to Peer Review. Case was reviewed by the Emergency Department Chair. The physician involved in this event received 1:1 education on dating, timing and signing of all EKGs.</p> <p>On 10/07/15 the EDA that performed the initial EKG was re-educated on the importance of showing the EKG to the lead provider, documenting the provider reviewed the EKG and communicating the result of that review to the triage nurse.</p> <p>On 10/07/15 the triage and intake RNs involved in this incident were retrained on the process of Assessment/Reassessment, EKG timeliness, physician notification in the Chest Pain patient and immediate placement of ESI II Chest Pain patient following ESI best practice.</p> | <p>9/16/15</p> <p>10/05/15</p> <p>10/06/15</p> <p>10/07/15</p> <p>10/07/15</p> |  |

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7/12/2018

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|  | <p>During an interview on 11/19/15 at 10:40 A.M., Patient 1 described an encounter at Hospital A's ED, which began the evening of 9/7/15 at 10:18 p.m. Patient 1 stated the onset of chest pain prompted her ED visit. Patient 1 stated that ED staff did not respond appropriately to her complaints of severe chest pain. Patient 1 stated that she was sent from the reception area to a waiting area despite repeated complaints of severe chest pain, difficulty breathing and "needing to lie down". Patient 1 stated that an ED physician did not see her for over an hour and that after a heart problem was identified, a Cardiologist (physician specialized in treatment of the heart disorders) was not consulted "until 5:00 in the morning". Patient 1 stated she then required transfer to Hospital B by means of emergency helicopter transportation. Patient 1 stated she then required an emergent heart procedure due to a "heart attack".</p> <p>During a joint observation and interview with the Director of Quality Risk Management (DQRM), on 12/10/15 at 11:00 A.M., the ED reception and triage areas were observed. The reception and triage areas were adjacent to the ED patient entrance and waiting area. Patients were observed as they entered the area and were assessed by a Registered Nurse (RN) for symptoms and chief complaints. Some patients were escorted to the main ED area, some were provided with initial screening tests in an adjacent treatment room, and some were triaged to the waiting area. The DQRM stated that a patient who presented to the ED with complaints of "severe" chest pain would be sent to</p> |   | <p>On 10/05/15 the following policies and procedures were reviewed "Triage," "Care of the Cardiac Patient", "Assessment/Reassessment and Vital Sign", "Emergency Standards of Nursing Practice and Standards of Patient Care", "Pain Assessment and Management" and no changes were required. Policy and procedure "Triage Intake Standing Orders Emergency Department," this policy was modified prior to the event and was going through the committee process for approval. Final revisions were approved on 10/27/15.</p> <p>10/23/15 the first triage class was initiated and 100% of full time triage and intake RNs were re-educated and demonstrated competency in the triage process by 11/9/15. This education included "Assessment/reassessment of the patient, "Emergency Severity Index (ESI) triage levels, "Triage Intake Standing Orders" and "Care of the Chest Pain Patient".<br/>{Appendix-A} Ongoing education and reinforcement of triage expectations conducted monthly at staff meeting<br/>{Appendix-B} and daily during huddles.<br/>{Appendix-C}</p> <p>Monitoring activities for compliance with assessment/reassessment of the triage patient, EKG signed and timed by provider within 10 min of arrival and documentation of EKG completion in the medical record by the EDA were conducted monthly by the director of the Emergency Department.</p> | <p>10/05/15</p> <p>10/27/18</p> <p>10/23/15</p>        |

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|  | <p>the main treatment area within the ED.</p> <p>Patient 1 presented to Hospital A's ED on 9/7/15 at 10:18 P.M. with a complaint of "chest pressure" per the Patient Information form. The hospital record Nurse's Notes, dated 9/7/15 at 10:17 P.M., included "Acuity: ESI (Emergency Severity Index) 2". [The ESI is a patient classification tool, which assigns a numerical value to ED patients' based upon a patient's chief complaint/signs/symptoms in order to establish the priority of emergency assessment and care. The ESI numerical value classifies patients from a level 5, which is non-urgent to a level 1, which is critical (life threatening).] Patient 1 was classified as ESI 2, which indicated an emergent need. The same notes included Patient 1 stated the chest pressure had started 20 minutes prior to arrival in the ED. The same notes also indicated that the patient was hyperventilating (breathing very rapidly).</p> <p>A review of the Nurse's Notes ED Triage Assessment, dated 9/7/15, at 10:18 P.M., included Patient 1's description of pain, documented as "chest pressure" with a severity of "10 out of 10" (0=no pain to 10=worst pain). "Appears in no apparent distress, uncomfortable...Behavior is agitated, anxious..." No pain medication or physician exam was provided at that time. On 9/7/15 at 10:22 P.M., Patient 1 also complained of nausea, arm numbness and was quoted as stating "I can't breathe...my family has a history of strokes and MI (myocardial infarction or heart attack)". The ED Course notes, dated 9/7/15 at 10:18 P.M., included "Patient placed in waiting room Patient</p> |  | <p>Monitoring activities and compliance with assessment/reassessment of the triage patient, EKG signed and timed by provider within 10 min of arrival and documentation of EKG completion in the medical record by the EDA is the responsibility of the director of Emergency Department.</p> <p>Beginning on Nov. 10, 2015 the EDA role in the Chest Pain process related to timing of the EKG, documentation of the completion and verification by ERMD was initiated with all EDA staff. 100% of full time EDA staff were trained by Dec. 23, 2015. {Appendix-B}</p> <p>On 1/11/16 patient contacted ECRMC disputing her bill. Her bill was immediately placed on hold until the conclusion of the investigation. On 6/1/16 this patient's entire ECRMC bill was written off.</p> <p>Results of monitoring were reported monthly at Emergency Department throughput committee, Emergency Department staff meeting and quarterly at the Quality Council and Board Quality. Compliance for monitoring for these standards were achieved and sustained by Nov. 2016 with goal of 90% or greater compliance for three consecutive months. {Appendix- E}</p> | <p>11/10/15</p> <p>01/11/16</p> <p>06/01/16</p> <p>11/30/16</p> |  |

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|  | <p>notified of wait time. Labs ordered per protocol. X-ray ordered. EKG (electro-cardiogram, printed image of the heart rhythm) done per protocol." Patient 1 was then sent to the waiting area to wait for an ED treatment room assignment.</p> <p>The initial laboratory blood tests included a troponin level (measurement of protein levels found in the body after possible heart damage. Higher troponin levels can appear up to six hours after a heart attack). The initial troponin level was "&lt;0.012", which was within normal range. The mechanical interpretation of the initial ECG (same as EKG) indicated "low QRS voltage Borderline ECG". There was no evidence of a physician interpretation of the ECG or verification that Patient 1's printed ECG results were shown to an ED physician.</p> <p>No pain medication was administered to the patient until 9/8/15 at 1:45 A.M. when Nitroglycerin (medication used to treat heart muscle pain) 0.4 mg (milligram) Sublingual (under the tongue) was provided. The same medication and dose was repeated at 1:49 A.M. on 9/8/15.</p> <p>A review of the "Nurse's Notes Assessment", dated 9/8/15, at 1:52 A.M., included "Appears in no apparent distress...Complains of pain in anterior (front of body) aspect of left upper chest. Pain radiates to thoracic (mid chest) area Severity 10 out of 10 on a pain scale...Chest pain is described as severe...began 4 hours prior to arrival." This assessment was timed over three hours after the patient's initial ED assessment. At 2:28 A.M. on 9/8/15, Dilaudid (narcotic pain medication) 1 mg IV</p> |  | <p>In Jan. of 2016 ECRMC engaged in conversation with the American College of Cardiology (ACC) to pursue Chest Pain Accreditation. ECRMC instituted evidence based protocols for care of the Chest Pain patient. This accreditation was achieved on Dec. 22, 2017. ECRMC is currently an accredited chest pain center. {Appendix-D}</p> | <p>01/01/16</p> <p>12/22/17</p> |  |

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|  | <p>(intravenous) was administered to the patient. At 3:07 A.M. on 9/8/15 the Nurse's Notes indicated "pain decreased", over 4 hours after arrival in the ED with complaints of severe chest pain.</p> <p>During an interview on 12/17/16, at 8:30 A.M., Registered Nurse (RN) 1 stated he was assigned as triage nurse at the time Patient 1 presented to the ED. RN 1 recalled that Patient 1's symptoms included chest pressure, anxiety, and hyperventilation. RN 1 stated he initiated the usual ED diagnostic tests, assessed the patient's ESI at level 2 and sent the patient to the intake area for the ordered diagnostic tests. RN 1 stated "usually" patients assessed as ESI level 2 would be placed in an ED treatment room, but if beds were not available, the ED physician and charge nurse would decide if the patient could wait. RN 1 did not recall speaking to an ED physician or charge nurse about the patient's symptoms. RN 1 stated it was the "intake nurse" responsibility to reassess patients who were in the waiting area. RN 1 recalled seeing the patient "periodically" in the waiting area and that she "appeared anxious and jittery".</p> <p>A review of Hospital A's ED policy and procedure titled "Triage", effective 10/27/15, under the section titled "Policy", "It is the policy of [facility] Emergency Department to use the Emergency Severity Index (ESI) triage tool and system. This system promotes: 1. Immediate and appropriate intervention to all patients in the Emergency Department. 2. Timely and orderly flow of patients through the Emergency Department. 3. Appropriate utilization of ED resources. 4. Patient safety and</p> |  |  |                          |  |

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|  | <p>well-being while they are waiting to be seen by a physician..."</p> <p>"Appendix B. ESI Triage Algorithm, v.4", indicates that if a patient is in severe pain/distress then check vital signs and potentially move to ESI Level 3. The "Notes" section for ESI level 2 indicates that a "High risk situation is a patient you would put in your last open bed, Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 or 0-10 pain scale."</p> <p>Under section Vital Signs and Reassessment: Level II-Emergent: "Guidelines - Acuity Level II patient vital signs are documented on arrival to care area, then measurement periodicity increases as per patient condition, chief complaint or hemodynamic stability. Vital signs every 2 hours minimum and as patient condition requires.</p> <p>"EKG is performed on all patients with a chief complain of chest pain to rule-out ACS - will be ordered. EKG is to be shows to physician immediately on completion."</p> <p>Under the section "Patient requiring MD triage": "The triage RN will confer with the Emergency Department physician for any patient, which they are unsure of their classification or how to classify. The MD will be notified and MD triage completed immediately." Under "Triage Standardized Procedures": "... Pain medication will be addressed on a case-by-case basis in consultation with ED physician will be notified of patients presenting with a pain level of greater than 5 to expedite pain</p> |  |  |                          |  |

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|  | <p>management interventions."</p> <p>A review of Hospital A's ED policy and procedure titled "Triage Intake Standing Orders; Emergency Department", under "TEXT" section B(3), effective 1/22/13 included, "Patient conditions to notify physician: The emergency department physician shall be informed whenever the patient exhibits adverse reactions or sign/symptoms develop that require immediate medical intervention." Then under Chest pain (over 30 y/o) or Shortness of Breath, "EKG- [ECG] shown to ERMD [ED physician] less than 10 min [and] Medications per chest pain protocols and MD [medical doctor] orders."</p> <p>During an interview on 12/17/16 at 9:00 A.M., RN 2 stated that she was the "intake nurse" at the time Patient 1 presented to the ED. RN 2 stated that Patient 1 was "hyperventilating, anxious, agitated and complained of dizziness". RN 2 stated she sent the patient to the waiting area, after the initial ECG and laboratory blood tests were completed. RN 2 acknowledged she did not inform the ED physicians or charge nurse of Patient 1's symptoms of hyperventilating, anxiety or pain level of 10. RN 2 stated "usually", waiting patients would be reassessed by a nurse every 2 hours. In addition, RN 2 stated the charge nurse would be made aware of waiting patients who were assessed at ESI 2 level. RN 2 stated that she did not see or assess the patient again and did not know if any other nurse had reassessed the patient. RN 2 was not aware if the charge nurse was informed of the patient's ESI 2 assessment.</p> |  |  |                          |  |

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|  | <p>During an interview and joint record review on 12/10/15 at 2:15 P.M., ED physician (MD 1) stated that she was one of two physicians on duty in the ED on the night shift of 9/7/15 to 9/8/15. MD 1 stated she first encountered Patient 1 in an ED treatment room at 2:12 A.M. on 9/8/15. MD 1 stated she was not informed of the patient's status prior to this encounter time. MD 1 stated she did not recall viewing the patient's initial ECG until that time, 2:12 A.M., and would have initialed/signed the ECG if she had reviewed it earlier. MD 1 acknowledged that if she had been informed of the patient's presenting symptoms, pain assessment of 10, and had seen the initial ECG, she would have prioritized the patient to be seen earlier. MD 1 stated that the patient's stated pain description was "atypical" and that she consulted with the on call cardiologist (physician specialist for heart disorders) after the troponin levels increased.</p> <p>During an interview and joint record review on 12/10/15 at 3:10 P.M., the Emergency Department Aide (EDA) stated her job responsibility included performing ECGs as directed by the ED nursing/physician staff. The EDA stated that she was also responsible to show completed ECG's to an ED physician and to document the same in the patient medical record. The EDA acknowledged that she performed Patient 1's initial ECG at 10:22 P.M. on 9/7/16. The EDA was unable to recall if she showed the ECG to either MD 1 or MD 2. In addition, the EDA acknowledged she had not documented, in the patient record, whether or not she had showed the ECG to either ED physician.</p> |  |  |                          |  |

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DEPARTMENT OF PUBLIC HEALTH

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| NAME OF PROVIDER OR SUPPLIER<br><b>El Centro Regional Medical Center</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1415 Ross Ave, El Centro, CA 92243-4306 IMPERIAL COUNTY</b>                |                          |  |
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|  | <p>During an interview on 1/13/16 at 8:30 A.M., RN 3 stated that she was assigned as the charge nurse in the ED at the time Patient 1 presented to the ED on 9/7/15. RN 3 stated her responsibilities included the coordination of staff and the oversight of patient flow through the ED. RN 3 stated that patients presenting with complaints of chest pain would be triaged to an open ED treatment bed or to the intake nurse for an immediate ECG. RN 3 stated in either case, the ECG would then be shown to an ED physician, in less than 10 minutes. RN 3 stated the ED physician would then make a determination if a patient could wait or needed an immediate medical exam. RN 3 stated an ED treatment bed would be made available if the physician determined a patient needed immediate attention. RN 3 stated that patients triaged to the waiting area were to be reassessed by an RN "every 30 to 60 minutes" and that non-narcotic (mild medications for pain) could be administered to waiting patients. RN 3 stated patients with continued severe pain would be moved to an ED treatment room. RN 3 stated she had no recall of Patient 1's ED visit or communication from staff about the patient's symptoms or care needs.</p> <p>A record review of the Nurses Notes ED Course, dated 9/8/15, indicated that Patient 1's pain was reassessed as "10 out of 10" at 12:16 A.M. and that no pain medication was provided. A second in a series of troponin level results was "0.115...above high normal" was reported by the laboratory at 12:38 A.M. At 12:58 A.M. the patient was "moved" to a treatment bed in the ED; over 2 hours after presenting ED with complaints of severe chest pain. A second ECG was performed at 1:28 A.M. and the</p> |  |  |                          |  |

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|  | <p>mechanical interpretation of the ECG indicated "sinus rhythm with sinus arrhythmia Low voltage QRS (wave form) Septal infarct (possible heart damage due to decreased blood flow), age undermined Abnormal ECG". At 1:39 A.M., the patient's pain level was again documented as "10 out of 10".</p> <p>On 9/8/15 at 1:45 A.M., the ED medication administration record (MAR) indicated the patient was provided Nitroglycerin (a medication used to treat angina (heart pain and/or chest pain) 0.4 mg (milligram) sublingual (under tongue). The same medication and dose was repeated at 1:49 A.M. The patient was then examined by ED physician (MD 1), at 2:11 A.M. The MAR indicated Patient 1 was then given Dilaudid (a narcotic pain medication) 1 mg IVP (intravenous push, through a needle in the vein) at 2:28 A.M. A pain assessment at 2:39 A.M. indicated that the patient's pain level was 4 out of 10. Patient 1 was not provided with pain intervention for more than 3 hours after presenting to the ED with complaints of severe chest pain and was not examined by a physician until a second ECG demonstrated changes and an elevated troponin level was reported, more than 3 1/2 hours after presenting to the ED.</p> <p>A continued record review of the Nurse's Notes ED Course indicated a second dose of Dilaudid was administered on 9/8/15 at 5:19 A.M.; however, a pain level assessment was not found in the record at the time the medication was administered. In addition, a third troponin level result of "1.730...Above upper panic limits" was documented</p> |  |  |                          |  |

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|  | <p>by the laboratory at 5:22 A.M. The Nurse Notes ED Course indicated that the MD 1 was informed of the "critical value" and that a consultation and ECG had been ordered. The mechanical interpretation of the ECG at 6:15 A.M. indicated "Sinus rhythm with sinus arrhythmia Septal infarct age undetermined Abnormal ECG". Again, the ECG result was verified in the notes as shown to MD 1 and the ECG was initialed by MD 1.</p> <p>A record review of the ED Physician Documentation, dated 9/07/15 at 4:40 A.M. included "Differential diagnosis: acute myocardial infarction, pneumonia, pulmonary embolus, unstable angina". The same documentation included that MD 1 contacted the on call cardiologist at "6:59 A.M." and the on call Cardiologist recommended "maximal therapy and transfer for higher level of care".</p> <p>A record review of copies of the three ECGs performed on Patient 1 during the ED visit included the on call Cardiologist's handwritten interpretation notes and initials. The notes on the initial ECG performed at 9/7/15 at 10:21 P.M., included "Anterior STEMI" (an abnormal variation/elevation in a segment of a recorded heartbeat, known as PQRST, shown on an electrocardiogram or tracing of heartbeats Specific changes in height/width, of the PQRST segment tracings, could indicate an MI myocardial infarction or heart attack). The second ECG performed on 9/8/15 at 1:28 A.M. included "worsening ST elevation anterior leads with reciprocal changes of inf [infarction] (Decreased blood flow)". The third ECG included the mechanical interpretation and the Cardiologist's initials.</p> |  |  |                          |  |

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|  | <p>A continued record review of the ED course indicated that Patient 1's pain was assessed at 8:18 A.M. as "5 out of 10" and again at 8:30 A.M. as "7 out of 10". No further administration of pain medication was documented in the record. A critical care transportation provider was contacted by Hospital A at 7:15 A.M. and arrived at 8:16 A.M. Patient 1 was transferred via critical care helicopter to Hospital B at 8:55 A.M.</p> <p>A review of Hospital B's Cardiovascular Admission History and Physical, dated 9/8/15, included "Impression and Plan...Acute lateral/? anterior ST elevation MI (an abnormal variation/elevation in a segment of a recorded heartbeat, known as PQRS, shown on an electrocardiogram or tracing of heartbeats. Specific changes in height/width, of the PQRS segment tracings, could indicate a MI (myocardial infarction or heart attack)...Plan Emergent coronary angiography (an invasive procedure which uses dye and special x rays to show the inside of coronary arteries, which supply oxygen-rich blood to the heart)".</p> <p>A review of Hospital B's Procedure note, dated 9/8/15 included "Procedures Performed: Selective coronary angiography. Percutaneous coronary transluminal angioplasty (a procedure performed on the heart to restore of blood flow)... "Post-Procedural Diagnosis: ST elevation myocardial infarction due to 100% proximal LAD due to 100% proximal LAD occlusion (left anterior descending artery blockage)". The LAD is one of the main arteries which supplies oxygen to the heart, which when</p> |  |  |                          |  |

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|  | <p>occluded, could cause severe injury to the heart muscle and/or death.</p> <p>A review of Hospital A's policy and procedure titled "Standard of Nursing Practice and Standards of Patient Care", effective 10/27/15, included "Assessments and patient needs are communicated to the health care providers who are responsible for the care and treatment of the patient...Patient assessments are used to identify patient needs and problems...The patient will receive appropriate nursing care and emergency interventions to meet his/her assessed needs...The patient will be continually assessed (reassessed)...The nurse serves as a patient advocate...with regard to health care and personal dignity...The nurse collaborates with the patient and communicates his/her concerns and goals/needs to other members of the multidisciplinary team..."</p> <p>A review of Hospital A's policy and procedure titled "Rights and Responsibilities; Patient", effective 3/24/15, included "Purpose [name of hospital] respects the rights of the patient, recognizes that each patient is an individual with unique health care needs, and, because of the importance of respecting each patient's personal dignity, provides considerate, respectful care focused upon the patient's individual needs...Patient Rights...To receive considerate and respectful care, and to be made comfortable...To receive reasonable responsible response to any reasonable requests made for service...To receive appropriate</p> |  |  |                          |  |

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|  | <p>assessment and management of their pain,<br/>information about pain, pain relief measures...To<br/>receive care in a safe setting..."</p> <p>During an interview, after a joint record review on<br/>12/17/15 at 9:30 A.M., the DQRM acknowledged<br/>Patient 1 did not receive ED care and treatment<br/>appropriate to the patient's chief complaint and<br/>presenting symptoms. The DQRM acknowledged<br/>hospital procedures were not followed to<br/>communicate and document vital patient<br/>assessment and symptom information to the<br/>appropriate care providers. The DQRM further<br/>acknowledged that Patient 1 was not monitored and<br/>re-assessed in a manner that provided patient<br/>advocacy and safety. In addition, the DQC<br/>acknowledged that Patient 1's right for appropriate<br/>services and care were not respected.</p> <p>This facility failed to prevent the deficiency(ies) as<br/>described above that caused, or is likely to cause,<br/>serious injury or death to the patient, and therefore<br/>constitutes an immediate jeopardy within the<br/>meaning of Health and Safety Code Section<br/>1280.3(g).</p> |  |  |                          |  |

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