

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2009
NAME OF PROVIDER OR SUPPLIER LAC+USC MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS ANGELES COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00172310.</p> <p>Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department of Public Health: [REDACTED], HFEN</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>CCR, Title 22 DIV5 CH1 ART3- 70223(b)(2) - Surgical Service General Requirements:</p> <p>(b) A committee of the medical staff shall be assigned responsibility for: (2) Development, maintenance and implementation of written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</p> <p>The above regulation was NOT MET as evidenced by:</p> <p>Based on record review and staff interview, the hospital failed to implement the existing</p>		<p>LAC+USC Medical Center maintains policy and procedure to assure compliance with Title 22 Div5 Ch1 Art3 regarding the general requirements of Surgical Services, specifically in relation to the prevention of retained foreign bodies after surgical intervention. In response to the events described in CDPH Statement of Deficiency LAC+USC Medical Center has done the follow.</p> <p>Action Within 24 hours of becoming aware of the event the Department of Quality Improvement initiated a root cause analysis. Through the RCA process the following issues were identified with accompanying corrective actions.</p> <p>The decision to utilize fluoroscopy instead of X-ray resulted from a miscommunication between the radiology technician and the primary team caring for the patient. The patient had a retained bullet from his initial trauma as well as 5 unintentionally retained sponges. The surgeon had requested imaging to look for both the sponges and the bullet. The Radiology Technician suggesting using fluoroscopy as it was more readily available in the new operating suit and would be the modality of choice for imaging a lead bullet (but not a retained sponge).</p>	12/14/08

Event ID:JDVO11

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(X6) DATE

Pete Delgado, Chief Executive Officer, LAC+USC Healthcare Network

7/20/09

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	<p>Continued From page 2</p> <p>would record and electronically sign the perioperative documentation.</p> <p>On "Incorrect closing count - Intentional & Non-intentional," it stated that surgeons should be notified of missing items and should be asked to search the wound. A physician's order should be requested for x-rays and the x-ray department should be notified for the x-ray films to be read by a radiologist. The circulating nurse would communicate to the Radiology Department the immediate need for the films to be read.</p> <p>Per clinical record review on 2/10/09, Patient Z was admitted to the hospital on 12/12/08 via ambulance due to a gunshot wound to the abdomen. Patient Z was taken to the operating room on an emergency basis due to low blood pressure attributed to losing blood.</p> <p>Review of the record of operation on 12/12/08 revealed that Patient Z entered the operating room (OR) at 2225 hours and left the OR area at 0549 hours on 12/13/08. The initial sponge/sharp/instrument count was performed at 2225 hours by Circulating Nurse #3 and Scrub #1. By 2300 hours, a shift change of OR nursing personnel occurred. A shift sponge/needle/instrument count was noted at 2325 hours on the record of operation; however, it was electronically entered late at a different date on 12/13/08, instead of 12/12/08, by Circulating Nurse #4 and Scrub #2. There was no other documentation presented that</p>		<p>when evaluate for possible retained foreign bodies after surgical intervention and that fluoroscopy is not sufficient or acceptable for this.</p> <p>The Operating Room Committee has agreed that the best method for prevention of retained sponges is through a Radiofrequency Device Retained Sponge Prevention Systems. Administration has approved the purchase of the Radiofrequency Device Retained Sponge Prevention System and the operating rooms are being prepared for implementation.</p> <p>Through the course of the RCA it became apparent that there was confusion between the Scrub Tech #2 and the Nurse #4 as to whether the count was 'Incorrect' or 'Correct and could not be confirmed' which resulted in a delay in documentation. The confusion resulted from the speed of the case and the complex nature of the patient's injuries which required a total of 85 sponges to control bleeding. These compounding factors made it impossible to simultaneously provide the patient care that was needed and also document in a timely fashion.</p> <p>In response to the delay in documentation the following policy and procedure was reviewed and rewritten to reflect actual practice.</p>	

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Sue

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	<p>Continued From page 4</p> <p>Z's abdomen. There was no documented evidence a radiologist read the fluoroscopy films as per the hospital's P&P.</p> <p>On 12/13/08, Patient Z was noted to have a fever and was slightly tachycardic (having fast heart rate). Further evaluation for a retained bullet ensued, a possible reason for fever and resulting fast heart rate.</p> <p>The trauma team's progress notes stated that by 1800 hours on 12/13/08, multiple plain abdominal x-rays were taken to locate the bullet without confirmation. However, foreign bodies were detected in the right and left upper abdomen. The concern was that the foreign bodies were laparotomy sponges. It was noted on the progress notes that it was discussed with the wife that the foreign bodies identified on the x-ray should be removed though they were not likely to be the bullet. A CT (computerized tomography) scan was requested by the patient's family to be expedited to confirm the location of the foreign bodies.</p> <p>By 2016 hours on 12/13/08, Patient Z entered the OR again for the second time for removal of foreign bodies in the abdomen. The second report of operation stated that the trauma surgeon's attention was first turned to the right upper quadrant where 2 radiopaque laparotomy towels were identified and removed. Subsequently, the surgeon's attention was focused to the left upper</p>		<p>The Operating Room Record will be randomly monitored on a bimonthly basis for compliance with ordering permanent X-ray films when indicated and the accuracy of nursing documentation. These reports will be provided to the Operating Room committee for review.</p> <p>Education The all nursing staff was educated over the course of several staff meetings to the P&P changes outlined above and how to use the cassette holding devices.</p> <p>Physicians were educated regarding the appropriate use of x-rays (not fluoroscopy) when evaluating for possible retained foreign bodies after surgery. This was done at departmental M&M meetings.</p> <p>Responsibility Chief Nursing Officer Chief Medical Officer</p>	4/09

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2009 JUL 27 PM 2:55
7/20/09
Jim

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Approved 7/20/09 *[Signature]*

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	<p>***AMENDED***</p> <p>The following reflects the findings of the Department of Public Health during investigation of COMPLAINT NO: CA00169178.</p> <p>Investigation was limited to the specific complaint(s) investigated and does not represent a full inspection of the hospital.</p> <p>Representing the Department of Public Health: Sanford Weinstein, MD.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>§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>§70215(c) Planning and Implementing Patient Care (c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family or other representatives when appropriate, and staff of other disciplines involved in the care of the patient.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on interviews, a review of a self-reported adverse event and review of a medical record, the nursing service failed to</p>		<ol style="list-style-type: none"> 1. Re-education with the nursing staff began the evening of 11/6/08 and was ongoing until all staff who would be assigned to care for a patient with an EVD had received re-education. 2. Immediate post-operative care for a patient with an EVD will occur in the Pediatric Intensive Care Unit. 3. Completed a review of national standards of best practice regarding care of the pediatric patient with an EVD and incorporated these standards into the CHOC Nursing policy and procedure. 	<p>11/21/08</p> <p>11/10/08</p> <p>12/12/08</p>

Event ID:M2J811

3/24/2009

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Sanford Weinstein

COO

4/12/2009

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ACC accepted S. Weinstein MD 4/16/09

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	<p>Continued From page 1</p> <p>ensure the development and implementation of policies and procedures for the accurate monitoring and reporting of output rates and critical values such as color, consistency and fluid volumes, from ventriculostomy drainage devices to the physician. The ventricles of the brain are the internal fluid filled chambers separating the brain hemispheres. Cerebrospinal fluid (CSF) is a clear fluid that circulates about the brain and spinal cord. Blockage or obstruction to flow of the CSF results in rising intracranial fluid pressure (hydrocephalus) with dilatation of the ventricles and compression of brain tissue. A ventriculostomy is a tube inserted into the ventricles of the brain to assist with proper drainage of CSF. In addition, the hospital failed to ensure the nursing staff properly implemented and evaluated the care of Patient A. The hospital failed to ensure the nursing staff promptly notified the physician when there was a change in the drainage from Patient A's ventriculostomy. As a result of these failures, Patient A's brain function changed and the patient was experiencing brain injury as a result for insufficient blood flow to the brain.</p> <p>Findings:</p> <p>On 11/14/08, a review of the medical record for Patient A revealed that Patient A came to the hospital emergency room on 11/06/08. The patient was alert and active. Patient A underwent a surgical procedure to remove ventriculo-peritoneal shunt hardware on</p>		<p>4. Mosby Pediatric Collection of online (electronic) Nursing policies, procedures, nursing skills and reference system purchased to assist in the development and maintenance of written policies.</p> <p>5. Mosby Pediatric Collection online system provides a competency and skill validation component for all policies and procedures which will be monitored on a quarterly basis by Nursing Service through the Nursing Committee Structure. Person Responsible for Correction: Executive Director Acute Care Services</p>	12/08

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	<p>Continued From page 2</p> <p>11/06/08. (A ventriculo-peritoneal shunt is a catheter inserted into the ventricle of the brain, connected to tubing that drains the internal fluid from the brain into the abdomen. The shunt is required and essential because of obstruction to normal flow of the fluid, usually resulting from a structural, congenital abnormality of the drainage system of the brain).</p> <p>Further review of the medical record revealed that following surgery, Patient A was taken to and observed in the PACU, from 1108 hours until 1230 hours. The PACU nursing notes revealed no documentation or recording of ventricular fluid drainage in the medical record. Interviews with the Director of Regulatory Affairs and documents provided by the Risk Management Department revealed that the neurosurgeon instructed nursing staff that little, if any drainage would be observed, since he had drained all the fluid from the brain, during insertion of the new ventricular catheter. However, there was no written documentation of communication with the nursing staff, physician orders, or a policy and procedure in place to direct nursing staff regarding the normal or usual output of ventricular fluid, appearance, or consistency of the fluid. There was no policy and procedure to provide guidance to the nursing staff about critical values for fluid volumes, color, consistency, and rates of fluid drainage to be reported to the physician.</p>		<ol style="list-style-type: none"> 1. Staff re-educated on the requirements of documenting in the electronic medical record information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, and evaluation. The content included discussing with the neurosurgeon their expectation regarding CSF drainage, since the amount of drainage expected is case specific. 2. Immediate post-op care for a patient with an EVD will occur once in the PICU since the volume of patients with an EVD is variable and actual cases in the neurosurgical department is less than 2 per month. The neurosurgical department as a whole has at least 2 to 3 surgical inpatient cases per week. 	<p>11/21/08</p> <p>11/10/08</p>

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	<p>Continued From page 3</p> <p>Patient A was then transported from the PACU to the nursing unit for post-operative care at approximately 1230 hours on 11/06/08. Observations documented by the nursing staff providing direct care for Patient A, of CSF/ventricular fluid drainage, indicated that 12.0 cc were noted at 1600 hours on 11/06/08, 4.0 cc at 1800 hours and 1.0 cc at 1900 hours. There was no documentation of drainage from the tube at 2000 hours. At 2100 hours 3.0 cc was documented. There was no output recorded for 2200 hours. When requested, the facility was unable to produce written guidelines or directives for nursing, to assess if these fluid volumes were normal.</p> <p>Interviews with the Medical Director of the hospital and the Risk Manager conducted on 11/14/08 at approximately 1100 hours revealed no nursing instructions or policy and procedures for the nursing staff to assess ventricular fluid output volumes, color, appearance that were in place to provide guidance for the hospital nursing staff. When asked regarding the number of cases with similar surgical procedures, it was stated by both representatives from the hospital, that ventricular drainage procedures were common at the hospital, with 2-3 such surgical cases in the neurological unit, each week. It was stated by both representatives that the nursing staff were trained, with documented competencies reviewed, to care for these patients. However, when asked to produce policies to manage and observe ventricular fluid volumes or critical</p>		<p>3. Mosby Pediatric Collection of online (electronic) Nursing policies, procedures, nursing skills and reference system purchased to assist in the development and maintenance of written policies.</p> <p>4. Mosby Pediatric Collection online system provides a competency and skill validation component for all policies and procedures which will be monitored on a quarterly basis by Nursing Service through the Nursing Committee Structure. Person Responsible for Correction: Executive Director Acute Care Services</p> <p>1. Recommendation made to Neurosurgical Department that surgeons placing an intraventricular shunt document in the operative report the presence of drainage post placement and/or document via imaging study proper placement within the ventricle. Person responsible for Correction: Chief Medical Officer</p>	<p>12/08</p> <p>12/12/2008</p>

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	<p>Continued From page 4</p> <p>values for the fluids or appearances of the fluids, the policy produced failed have written directives for the nursing staff about normal CSF fluids and output and abnormal results to report to the physician.</p> <p>According to interviews with the Risk Manager conducted at 1100 hours on 11/14/08, Patient A's ventriculostomy drainage tubes were clamped close to the patient's head (proximal) and farther down the tube (distal), in order for the mother of Patient A to hold and console Patient A on 11/06/08. According to the Risk Manager, the transfer of the patient from her crib to the mother occurred at approximately 2145 hours.</p> <p>During transfer of Patient A from her mother back to the crib, the registered nurse unclamped the distal clamp of the ventriculostomy drainage catheter at approximately 2200 hours, but did not unclamp the proximal clamp of the ventricular drainage tube. The Risk Manager stated that this portion of the drainage catheter remained fully clamped, preventing normal CSF flow into the external drainage collection bag.</p> <p>According to the Risk Manager, and the policy and procedure for ventricular drainage catheters, in place at the hospital, the nursing staff failed to open both stopcocks to ensure appropriate ventriculostomy drainage, to prevent hydrocephalus (buildup of fluid in the brain and increased intracranial pressure).</p>			2009 APR - 3 PM 1:37

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 053304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2008
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NAME OF PROVIDER OR SUPPLIER CHILDREN'S HOSPITAL OF ORANGE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 455 SOUTH MAIN STREET, ORANGE, CA 92868 ORANGE COUNTY
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(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>Continued From page 5</p> <p>At 2200 hours, nursing assessments in the medical record revealed that the patient was "lying quietly". A "late entry" recorded on 11/07/08 revealed "no CSF/Ventricular fluid drainage was noted at 2200 hours." "Solid matter was noted in the external ventricular drainage (EVD) system." "EVD lowered to floor to see if CSF moved in the tubing." "Patient noted to have slowed rate of breathing with deep gasps of air." A "Code White" for resuscitating Patient A was called at 2323 hours.</p> <p>According to interviews with the Risk Manager, the Medical Director of the hospital, and a review of the "Cardiopulmonary Resuscitation Flow Sheet" Patient A was being manually ventilated at the time of initiation of the Code. According to these interviews, the physician intubating Patient A observed that the EVD had dropped to the floor and no fluid drainage or movement was seen in the tubing. Patient A was intubated at 2342 hours.</p> <p>The physician who intubated Patient A ordered a "Stat CT Head Scan", to determine the location of the ventricular catheter. This procedure was performed at approximately 2352 hours. The written interval note by the physician revealed "Tip of EVD is in the brain parenchyma, not in the ventricular system." (This note indicated that the ventricular drainage catheter was not in the ventricle of the brain, but within the substance of the brain.</p>			2009 APR -3 PM 1:37

Event ID:M2J811

3/24/2009

11:54:33AM

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

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NAME OF PROVIDER OR SUPPLIER CHILDREN'S HOSPITAL OF ORANGE COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 455 SOUTH MAIN STREET, ORANGE, CA 92868 ORANGE COUNTY		
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	<p>Continued From page 6</p> <p>This indicated that, at some point, the ventricular catheter had been dislodged or pulled from its normal location within the lateral ventricle of the brain to a point in the brain tissue. No CSF/Ventricular fluid drainage was possible, since the tube was not in the desired location).</p> <p>MD #1, the attending neurosurgeon was notified at approximately 2400 hours, and came to the hospital. At approximately 0100 hours on 11/07/08, a bedside insertion of a new ventricular catheter was performed. The procedure note, dictated by MD #1 revealed "A new ventriculostomy catheter inserted with prompt return of CSF (cerebrospinal fluid) under markedly elevated ICP (intracranial pressure). (This note indicated that the brain was under severe pressure, with markedly elevated fluid pressure as a result of the fluid being unable to be drained externally).</p> <p>Following the procedure, Patient A remained obtunded. An MRI was ordered and performed on 11/08/08. This study revealed evidence of a "global hypoxic ischemic injury". (During the buildup of intracranial pressure, blood perfusion of the brain was impaired, leading to the hypoxic injury to the brain). Patient A was not responsive and an inpatient at the hospital on 11/14/08.</p> <p>The violation(s) has caused or is likely to cause, serious injury or death to the patient.</p>			2009 APR - 3 PM 1:38

Event ID:M2J811

3/24/2009

11:54:33AM

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DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/04/2009
NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN		STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
(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>The following reflects the findings of the Department of Public Health during investigation of COMPLAINT # CA00173787</p> <p>The inspection was limited to the complaint(s) investigated and does not represent a full inspection of the hospital.</p> <p>Representing the Department of Public Health: Lucy Yang, HFEN; Sanford Weinstein, MD</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>70213(d) Nursing Service Policies and Procedures (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff.</p> <p>70701(a)(4) Governing Body (a) The governing body shall: (4) Provide appropriate physical resources and personnel required to meet the needs of the patients and shall participate in planning to meet the health needs of the community.</p> <p>The above regulations were NOT MET as evidence by:</p> <p>Based on interview and record review, the hospital failed to ensure that the attending</p>		<p><u>Temporary and Permanent Actions Taken:</u></p> <ol style="list-style-type: none"> Staffing on the telemetry unit has been changed so that a designated Telemetry Technician/Clerical Coordinator (TT/CC) is able to maintain constant monitoring of the cardiac monitor, recognize changes, and inform the registered nurse of changes. This began on 12/30/2008. The volume on the cardiac monitoring system was adjusted to a clearly audible volume. This was completed on 12/31/2008. 	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">2009 MAR 20 PM 2:42</p> <p>12/30/2008</p>

Event ID:V22111

3/12/2009

9:29:10AM

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

Marilyn Long RN, JD Director of Patient Safety + Compliance

TITLE

(X6) DATE

03/27/2009

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Accepted 4/1/09 1700 Lucy Yang HFEN

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN		STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY		
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	<p>Continued From page 1</p> <p>physician's order for continuous cardiac monitoring was implemented as ordered, resulting in Patient A being at risk for undetected cardiac arrhythmias. Subsequently, Patient A was found to have suffered ventricular fibrillation, coded and expired.</p> <p>In addition the governing body failed to provide adequate physical resources to ensure that the monitor technician was sufficiently free of other duties to ensure Patient A, who was off the cardiac monitor for greater than 30 minutes, was observed and treated.</p> <p>Findings: On 2/4/09, Patient A's medical record was reviewed. The record showed on 12/28/08 Patient A came to the hospital ED (Emergency Department) complaining of chest pain. A review of the History and Physical report of 12/28/08 revealed the ED physician documented that Patient A had a history of Coronary Artery Disease with insertion of an intra-coronary stent. Patient A's ER electrocardiogram showed evidence of abnormal changes and the patient was diagnosed with an acute myocardial infarction. Patient A was taken directly to the cardiac catheterization laboratory for a left heart catheterization, a coronary angiography, and stent insertion.</p> <p>The Physician's Progress Notes of 12/29/08 showed the patient was monitored in the Coronary Care Unit, having episodes of</p>		<p>3. A wall mounted container with extra leads was placed in each patient room on the telemetry unit. This was completed on 01/31/09.</p> <p><u>Compliance and Monitoring:</u></p> <p>The Director or designee of the telemetry unit will conduct an audit of 10 patients per month for 3 months beginning March, 2009. Items to be audited include whether:</p> <ol style="list-style-type: none"> 1. The unit has a dedicated Telemetry Tech 2. Extra leads are available in the patient room. <p>100% of staff on the telemetry unit will be in-serviced on their roles and responsibilities related to cardiac monitoring and communication, including notification to the appropriate RN of alarms or arrhythmias. This will be completed by 04/30/2009.</p> <p>The Director or designee(s) of the telemetry unit will follow up on the audit results as applicable. The results of the audits will be tabulated and reported to the Enterprise Safety</p>	<p>2009 MAR 30 PM 2:42</p>

Event ID:V22111

3/12/2009

9:29:10AM

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NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY
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	<p>Continued From page 3</p> <p>telemetry unit on the day following insertion of the coronary artery stent. On that same day, Patient A was "apparently off the monitor for 35 minutes and during that time suffered an arrhythmic death."</p> <p>The printed strips of the cardiac monitor for Patient A showed on 12/30/08 at 0641 hours, the monitor did not register the patient's cardiac activity, and the strip went abruptly into a flat line. The medical record for 12/30/08 revealed no monitoring from 0641 hours to 0715 hours a duration of 34 minutes.</p> <p>On 2/4/09 at 1045 hours, interview with the Director of the telemetry unit was conducted. The Director stated the telemetry technician (TT) and clerical coordinator (CC) on 12/3/08 was the same person. The day shift started at 0700 hours. Before the new shift started at approximately 0630 hours, was the busiest time of the shift. The CC had many tasks to do including answering the telephone, answering patients' call-lights then paging the nurses for response, updating and writing the unit census, picking up laboratory reports and placing them on clipboards. These duties were in addition to the telemetry duties of watching the cardiac monitors and notifying the nurses of abnormalities. The TT assigned to watch the monitor on 12/30/08 was on his second night of working in the unit. The TT did not notify the patient's nurse or PCA when Patient A's cardiac monitor was not registering a rhythm. The alarm for the cardiac monitoring system</p>			2009 MAR 30 PM 2:12

Event ID: V22111	3/12/2009	9:29:10AM
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NAME OF PROVIDER OR SUPPLIER HOAG MEMORIAL HOSPITAL PRESBYTERIAN	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY
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	<p>Continued From page 4</p> <p>was not set on the highest volume.</p> <p>On 2/4/09 at 1100 hours during an interview, the PCA stated on the morning of 12/30/08, she walked into Patient A's room to check the vital signs. She found Patient A was not responding and the telemetry leads were off. She went to get a new pack of leads and came back to the patient's room. She called the Code Blue team.</p> <p>Review of hospital records showed a statement from the TT/CC that 12/29/08 night shift was the second night for the TT/CC on the telemetry unit. The TT/CC described that night as busy; there were many telemetry alarms going off. The assigned workload was 20% cardiac monitoring and 80% clerical work. The TT did not notify the nurse of when Patient A's cardiac rhythm was not registering and/or the monitor was alarming.</p> <p>The Telemetry Technician/Clerical Coordinator Job Description revealed the TT/CC should maintain constant monitoring of electrocardiogram patients throughout the entire shift, recognize changes in electrocardiograms and inform the registered nurse of changes. In addition to the above, the TT/CC worked as part of the patient care delivery team to maintain organization within the unit including:</p> <ul style="list-style-type: none"> * Coordinating patient schedules with other members of the patient care delivery team * Managing patient charts and prioritizing; and 			2009 MAR 30 PM 2:42

Event ID:V22111

3/12/2009

9:29:10AM

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	<p>Continued From page 5</p> <p>transcribing orders in an accurate, timely and efficient manner * Perform other duties as assigned.</p> <p>The violation(s) has caused or is likely to cause serious injury or death to the patient(s).</p>			2009 MAR 30 PM 2:42

Event ID:V22111

3/12/2009

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2009
NAME OF PROVIDER OR SUPPLIER SOUTH COAST MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 31872 COAST HIGHWAY, LAGUNA BEACH, CA 92651 ORANGE COUNTY		
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	<p>Continued From page 1</p> <p>wound of Patient #1. Patient #1 required another major surgery and the risks of general anesthesia to remove the retained sponges.</p> <p>Findings:</p> <p>On 1/27/09, review of the policy, "Sponge, Needle, and Instrument Counts," revealed the statement "When additional sponges, needles/sharps are added, they are counted and the number is added to the count documentation."</p> <p>Medical record review for Patient #1 revealed an operative report dated 6/6/07 documenting Patient #1 had undergone a laparoscopic, converted to open, appendectomy. Review of the operating room record revealed the documentation that the sponge counts were correct.</p> <p>Medical record review revealed an operative report dated 6/8/07 documenting that Patient #1 had undergone an exploratory laparotomy with control of bleeding and evacuation of hemoperitoneum. Review of the operating room record revealed the nurse documented that the sponge counts were correct.</p> <p>Medical record review revealed an operative report dated 6/13/07 documenting Patient #1 had undergone a re-exploration with removal of foreign bodies under general anesthesia. In the operative report, the surgeon documented that there were five laparotomy sponges that were seen on x-ray. All five laparotomy sponges were removed.</p>			2009 MAY -1 PM 2:56

Event ID: JJZZ11

4/8/2009

8:56:30AM

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