

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2007
NAME OF PROVIDER OR SUPPLIER LOS ANGELES COUNTY OLIVE VIEW-UCLA MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14445 OLIVE VIEW DRIVE, SYLMAR, CA 91342 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: CA00130348.</p> <p>Inspection was limited to the specific complaint(s) investigated and does not reflect the findings of a full inspection of the facility.</p> <p>Representing the Department: [REDACTED] [REDACTED], Health Facilities Evaluator Nurse</p> <p>HSC Section 1280.1 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>T22 DIV5 CH1 ART3-70203(a)(2) Medical Service General Requirements</p> <p>(a) A committee of the medical staff shall be assigned responsibility for: (2) Developing, maintaining and implementing</p>			

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11:17:40AM

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	<p>Continued From page 1</p> <p>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>T22 DIV5 CH1 ART7-70703(a) Organized Medical Staff</p> <p>(a) Each hospital shall have an organized medical staff responsible to the governing body for the adequacy and quality of the medical care rendered to patients in the hospital.</p> <p>These Regulations were NOT MET as evidenced by:</p> <p>Based on interview and record review, the hospital failed to ensure the attending medical staff followed policies and procedures for supervision of resident physicians, reporting of critical radiology test results and accepted responsibility for the adequacy and quality of medical care rendered to Patient A. As a result, Patient A developed sepsis and died. Findings:</p> <p>On 11/1/07, the hospital policies and procedures (P&P) were reviewed. P&P #310.2 for "DHS POLICY ON SUPERVISION OF RESIDENTS" stated in part:</p> <p>* The purpose of the policy is to promote patient safety and enhance quality of patient care...</p>			
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	<p>Continued From page 2</p> <ul style="list-style-type: none"> * These supervisory lines of responsibility for patient care shall take into account safety and well being of patients and their rights to quality care. * ...Attending physicians remain fully accountable for supervision of all residents. * An attending physician or supervisory resident shall be present with the patient for all operative or invasive procedures. * An attending physician must assure an operative or procedure note is written or dictated ...and shall sign the record of operation in all situations for which direct attending physician supervision is required. * The attending physician from the treating service shall assure that in all instances where consultations are requested, they are communicated to the consulting service in a timely manner. * An attending physician shall see and evaluate the patient at least every 48 hours and shall ensure the resident includes in the progress note the he/she has discussed the case with the attending <p>P&P # *87 for "NOTIFICATION OF IMAGING DIAGNOSIS" stated in part:</p> <ul style="list-style-type: none"> * All imaging diagnoses that require notification include those that are critical (immediate notification) and those that are abnormal, and require timely notification... * The results that require immediate notification (critical results) are to be called to the referring physician... <p>The medical staff failed to implement these policies</p>			
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	<p>Continued From page 3</p> <p>and procedures to ensure quality care for Patient A.</p> <p>On 11/1/07, a review of the medical record for Patient A showed the patient came to the emergency room on 10/8/07 with complaints of right upper abdominal pain, fever and nausea and vomiting. The patient was diagnosed with acute cholecystitis and admitted to the hospital on 10/9/07 under the care of the attending and resident physicians from the surgical service. The patient had a laparoscopic cholecystectomy (the gallbladder was removed through a flexible endoscope). The Post Procedure Note documented the surgery was difficult due to inflammation of the gallbladder and took four hours to complete. Patient A was discharged to home on 10/14/07.</p> <p>On 10/16/07 Patient A presented to the emergency room complaining of right upper quadrant pain, nausea and vomiting, and weakness. Patient A was admitted to the hospital under the care of the attending and resident physicians from the surgical service. The Discharge Summary documented that initial treatment of Patient A consisted of inserting a tube into the patient's abdomen. Bile was drained. To determine the reason for the leak of bile into the patient's abdominal cavity, a request was made to the physicians of the gastroenterology service for an endoscopic retrograde cholangiopancreatography (ERCP) study.</p> <p>The ERCP was attempted on 10/19/07. The fellow/resident physician had difficulty with the procedure and the attending physician (MD Y) took</p>			
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	<p>Continued From page 4</p> <p>over. The Post - Procedure Note dated 10/19/07 documented that bleeding was noted in the small intestine and there was a question that the patient's small intestine had been perforated. The procedure was terminated. The fellow/resident documented recommendations of an x-ray be taken of the abdomen, that serial abdominal examinations occur, and that the patient not have anything to eat or drink. There was no documentation of the procedure and/or complications by MD Y as required by the hospital's P&P. There was no documented evidence MD Y informed the attending surgeon (MD X) of the suspected perforation of Patient A's small intestine. There was no documented evidence MD Y spoke with MD X and/or the resident surgeons to discuss the severity of the possible perforation and/or the need for surgery. There was no documented evidence MD Y or the resident gastroenterology physician saw the patient again for evaluation of the effects of the suspected bowel perforation on Patient A.</p> <p>Eight hours after the ERCP, at approximately 2200 hours on 10/19/07, a CT scan of the patient's abdomen was ordered. The report of the results of the CT scan was not written until 0400 hours on 10/19/07. The results showed there was a high suspicion of a small bowel perforation. There was no documented evidence the radiologist called the surgeon to inform them of the critical results. At approximately 1400 hours on 10/20/07, Patient A required artificial support for respirations and blood pressure. At approximately 2200 hours on 10/20/07 Patient A was taken for emergency surgery. Before the surgery started, the patient</p>			
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	<p>Continued From page 5</p> <p>had a cardiac arrest. Resuscitation efforts were successful and the surgery was performed. It showed a large perforation of the lower portion of Patient A's small intestine. Post operatively, the patient remained critically ill and developed multi-system failure. Patient A died on 10/23/07.</p> <p>During an interview at 1420 hours on 11/1/07, attending surgeon MD X stated there was no communication from the attending gastroenterology physician (MD Y) about the ERCP procedure and the complication of the suspected perforated small intestine. MD X stated that if the perforation had been small and in the upper portion of the small intestine it could seal by itself but when he saw Patient A's abdominal CT scan, a large collection of fluid and air was seen in the retroperitoneal space of the patient's abdomen. This had not been reported by the radiologist. When the severity of the fluid and air collection was discovered by MD X the patient was taken for emergency surgery; however, the patient had to wait for another surgery to be completed by the surgical team. The patient was not able to recover and died.</p> <p>At 1000 hours on 11/2/07, MD Y was interviewed. The MD stated that during the ERCP procedure a lot of blood and changes in the mucosal lining of the bowel were noticed. This made MD Y pretty certain that there had been a perforation of the bowel. MD Y stated he knew Patient A would need immediate surgery to repair the perforation. It was not likely that the perforation would heal by itself. MD Y said he told the chief surgical resident this information. MD Y could not remember the name</p>			
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	<p>Continued From page 6</p> <p>of the resident he spoke with and stated he did not document the conversation or recommendation in the medical record for Patient A. MD Y stated he did not tell the attending surgeon (MD X) of his recommendation for immediate surgical repair of Patient A's perforated bowel. MD Y stated he checked on Patient A approximately one hour after the ERCP procedure, but did not go to see the patient again and did not have any further communication with the physicians from the surgical service. MD Y stated the fellow/resident physician saw the patient every day. MD Y stated he failed to ensure the fellow/resident documented assessments and/or recommendations in the patient's medical record.</p> <p>The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).</p>			

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