CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050444	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/29/2012
NAME OF PROVIDER OR SUPPLIER **MERCY MEDICAL CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **333 Mercy Ave, Merced, CA 95340-8319 MERCED COUNTY**		

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00305275 - Substantiated Representing the Department of Public Health: Surveyor ID # 28531, 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. Health and Safety Code Section 1279.1(c): "The facility shall inform the patient or the responsible party of the patient of the adverse event by the time the report was made." Health and Safety Code 1279.1(b) (5) (C) (b) For the purposes of the section, "adverse event" includes any of the following: (5) Environmental events, including the following: (C) A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility. Health and Safety Code 1279.1(b) (2) (B) (b) For the purposes of the section, "adverse event"		POC ACCEPTABLE YES NO Reviewed By: Name Fax: Original: 3015 Facility Notified Name: Date: 10/25/12 Time: 0952 Notified By: Name	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE President | (X6) DATE 10/19/12

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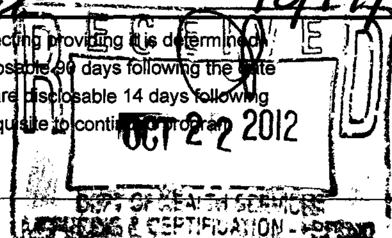

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	Continued From page 1 includes any of the following: (2) Product or device events, including the following: (B) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.			
	70215. Planning and Implementing Patient Care (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.		**Corrective Action**: 1. The employee using equipment for its unintended purpose received progressive disciplinary corrective action.	4-26-12
	DEFICIENCY CONSTITUTES IMMEDIATE JEOPARDY		2. All ED nursing staff were re-educated regarding pediatric standards of care including the use of equipment only for its intended use.	7-16-12
			3. Pediatric competencies were validated either through observation, return demonstration, verbal review or examination for all ED nursing staff.	7-16-12
	Based on staff interviews, clinical record and administrative document review, the hospital failed to implement the nursing process of assessment, evaluation, and intervention in the planning of care for a 2.5 month old infant (Patient 1) resulting in a third degree burn to infant's palm when: a) After numerous unsuccessful attempts to start an IV catheter (tubing inserted into a vein used to deliver fluids and medications) on Patient 1, hospital nursing staff continued to attempt to start an IV without assessing and evaluating the effectiveness of this intervention and contrary to hospital policy and procedure which limits each		4. The IV Therapy policy was reviewed and revised to include two attempts to cannulate and the procedure to follow once maximum attempts are reached. If unsuccessful at venous cannulation after two attempts, the RN requests another competent RN to assess patient for further attempts. He or she will make the determination to proceed and or consult with the LIP. No more than four attempts will be made by an RN. Additionally, the policy was reviewed and revised to include Vein Viewer and Venoscope as the only acceptable light sources for vein illumination.	8-14-12

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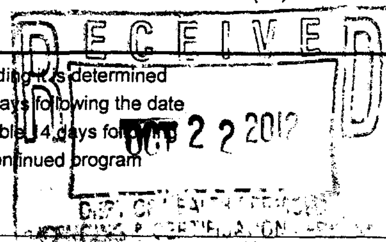

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	Continued From page 2 staff member to two attempts. The exact number of times staff inserted a needle into Patient 1 attempting to start an IV was not established and could not be verified in the clinical record. b) The ED Nurse Supervisor failed to assess and evaluate Patient 1's care needs when he used a vaginal light (without its protective cover) to illuminate the veins in the infant's hand, in the attempt to start an IV. The use of this device resulted in the palm of the infant's left hand being burned. The use of this light source as an intervention to illuminate the infant's veins was not in accordance with the manufacturer's directions for use. These failures resulted in Patient 1 receiving a third degree burn to the palm of her hand which ultimately required skin grafts. Findings: On [redacted]12 at 11:32 p.m., Patient 1 (a two month and twenty three day old baby) was brought into the Emergency Department (ED) by her parents because she had diarrhea (loose, watery, non-bloody stools) four to six times a day, for an estimated ten days. She also had one episode of vomiting on [redacted]12. Patient 1's Emergency Room Report, dated [redacted]12, in the History of Present Illness section indicated the infant was sluggish, had a decrease intake of fluids and a decrease in urination. Staff stated multiple attempts were made unsuccessfully to start an IV so that fluids could be given to the		5. Communicated with ED staff via ED Spindle (Electronic communication to disseminate information to all ED staff) the change in IV Therapy policy regarding the number of acceptable attempts to cannulate (two), the procedure to follow once maximum attempts are reached, and acceptable light sources (Vein Viewer and Venoscope) for vein illumination. 6. The ED nursing staff was provided with the revised IV Therapy policy and required to sign for receipt. **Monitor:** Forty random direct visualization audits completed per month in the ED to ensure adherence to policy regarding number of attempts and equipment use. If noncompliance is observed, the individual involved will receive counseling and re-education on the IV Therapy policy. Further noncompliance will result in progressive disciplinary corrective action. Results are reported monthly to the Quality Management Committee (QMC), Medical Executive Committee (MEC) and Governing Board until 100% compliance is sustained for four months and then quarterly for one year at which time frequency will be re-evaluated. **Responsible Person(s):** ED Director and Chief Nursing Officer	8-15-12 8-16-12 or prior to next shift worked 8-15-12 & ongoing

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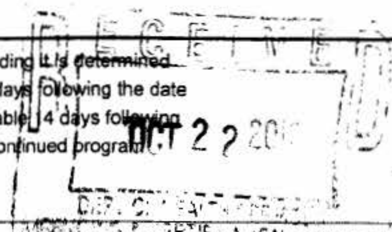

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infant. As a final effort, the ED Nurse Supervisor stated he used a vaginal light, without its attached speculum cover, in order to illuminate the veins in the infant's hand. Staff stated the use of this light source, (used for other than the manufacturer's intended purpose) was not perceived as a risk to patient safety. The use of this light resulted in third degree burns as indicated in Patient 1's discharge summary, dated [redacted]12, from hospital 2, which performed a skin graft to the burn.

On 6/28/12 at 3:22 p.m., Registered Nurse (RN) 1 pointed to the area in Patient 1's clinical record where IV documentation should have been recorded. RN 1 stated, "There's no record of IV attempts. Nothing was charted."

On 6/28/12, at 3:10 p.m., during a concurrent record review and interview, Registered Nurse (RN 1, the RN Supervisor in the ED on the night of [redacted]12) stated he used the vaginal light on Patient 1. RN 1 stated, "It never occurred to anyone that the practice [use of the light] was unsafe or painful." However, in two separate interviews, on 6/21/12 at 1:45 p.m. and 6/29/12 at 9:10 a.m. respectively, the Emergency Department Director (EDD) and the Registered Nurse (RN) 2 stated the bulb at the tip of the vaginal light gets very hot.

On 6/29/12 at 2:05 p.m., the Chief Nursing Officer (CNO) provided hospital P&P titled, "Patient Care Standards," which indicated, "Implementation Date 4/11," for review. The P&P indicated, "... Documentation for IV Therapy: Time and date of insertion, Location of insertion site..., Gauge

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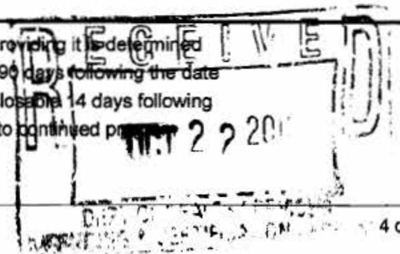

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length, and type of needle/catheter inserted, Number of attempts (if more than one) ...Client response to procedure. ...After two failed attempts, seek a more experienced person..." The CNO stated the staff lost awareness of the number of times the IV was attempted and never questioned the appropriateness of using the vaginal light without its speculum cover.

The manufacturer's instructions for the WelchAllyn "KleenSpec Vaginal Specula Illumination System contained the following under Warnings and Cautions: "Warning: Lamp is harmful to skin if touched. Allow lamp to cool for 5 minutes before replacing. Lamp generates heat and should remain off until just prior to and immediately after use. Do not place illuminator onto flammable surface if lamp is illuminated. ...Lamp is hot and can cause burn if used outside of the vaginal specula."

The discharge summary from hospital 2 where Patient 1 went for surgery to repair damage from the burn on her left palm, dated [redacted]12, was reviewed. The pre-op diagnosis (reason for the surgery) was "3rd degree burn to left palm. The post-op diagnosis was the same, with "Findings: ...of about 1.5 cm (centimeter) x 1 cm." The surgical procedure done was called "Tangential excision," meaning burned skin is removed in thin layers. A full thickness skin graft [requiring a donor site] was also performed.

The hospital failed to protect Patient 1 from a third degree burn when the "KleenSpec Vaginal Specula Illumination System" was used as a vein

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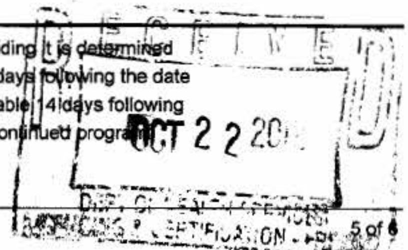

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	Continued From page 5 illumination source, against Manufacturer's instructions for use, to start an IV. This failure resulted in a third degree burn to the palm of Patient 1's left hand. This facility failed to prevent the deficiency(ies) as described 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 1280.1(c).			

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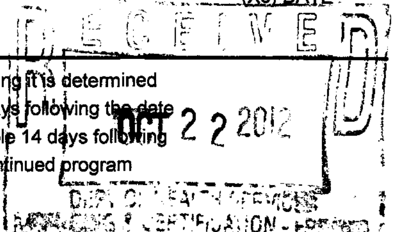

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