CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050407	A. BUILDING _____ B. WING _____	02/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHINESE HOSPITAL	845 JACKSON STREET, SAN FRANCISCO, CA 94133 SAN FRANCISCO COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00217996 - Substantiated Representing the Department of Public Health: Surveyor ID # 17300, 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. Title 22 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. This regulation was not met as evidenced by: Based on interview and record review, the facility failed to implement the P & P (policies and procedures) for the NGT (nasogastric tube a feeding tube inserted through the nose into the stomach) placement verification before		70213(a) Responsible Person: DON Revised Policy #6170-2.08, "Policy and Procedure for Gastroenteral Tube Insertion," to include radiological verification of NG tube placement. [Completion Date: 02/10; subsequent revisions: 05/10, 11/10, 02/11] Revised Policy #6170-2.08, "Policy and Procedure for Gastroenteral Tube Insertion," to reflect abdominal radiological verification must be done for blindly inserted NGT to confirm placement for medication, feeding, or fluid administration. [Completion Date: Revised Policy 03/25/11; Board of Trustees Approval 04/26/11] Revised Policy #6170-2.08, "Policy and Procedure for Gastroenteral Tube Insertion," to include measurement for proper placement (with pictorial diagram) in stomach and to avoid placement in lung. Measure tube for insertion distance from patient's nose to proximal earlobe and then down to xyphoid process/tip of sternum. Mark distance on tube by placing piece of tape at that point. RNs have been educated. [Completion Date: 02/28/11, revised form and re-inserviced RNs: 03/25/11] Responsible Person: DON (Pgs 2 thru 4) Nursing staff educated on revised policy #6170-2.08, "Policy and Procedure for Gastroenteral Tube Insertion" on 03/10 (Nurse Practice Team Mtg & Staff Mtg),	02/10 05/10 11/10 02/11 03/25/11 04/26/11 02/28/11 03/25/11 03/10

C.D.P.H. APR 12 2011 L&C DIV DALY CITY

4/13/11 K POC accepted

Event ID:0GW211 3/28/2011 10:57:35AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE

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	Continued From page 1 feeding one patient (Patient 1). This failure resulted in the placement of the NGT into the left lung of Patient 1 on [redacted]/10. Patient 1 died the next day due to aspiration pneumonia (inflammation of the lungs and/or bronchial tubes from breathing in foreign materials usually food and/or liquids). Findings: Patient 1 was admitted on [redacted]/10 with diagnoses including pneumonia (a disease characterized by inflammation of the lungs) and chronic obstructive pulmonary disease (COPD, a descriptive term for diseases characterized by obstruction of the small airways). During an interview on 2/25/10 at 10:30 AM, the Nurse Manager stated that on [redacted]/10, two registered nurses (RN 1 and 2) inserted the NGT into Patient 1 and started the tube feeding in the afternoon. There was no examination by a physician and x-ray after the NGT insertion to verify NGT placement. On [redacted]/10, after a chest x-ray, the nasogastric tube was found in the left lung. There was no documentation of competency validation and/or in-service training for NGT insertion in the last 12 months for RN 1 and RN 2. During an interview on 2/25/10 at 10:45 AM, RN 1 stated that Patient 1 was unable to tolerate oral intake for two days. Physician 1 ordered NGT insertion on [redacted]/10 and feeding. After NGT insertion, RN 1 and RN 2 attempted		04/10 (Staff Mtg), and 05/10 (Staff Mtg). RN1 and RN2 educated on NGT placement during Root Cause Analysis Mtg (02/18/10). Annual Gastrointestinal Tube Competency included in Nursing Annual Competency. [Initiation Date: 01/11; Completion Date: 02/11] Another competent RN will monitor competency of RN1 & RN2 on all NG tube placement for 1 year or 6 cases/RN, whichever is greater. [Completion Date: 03/12 or upon completion of 6 cases, whichever is greater] Annual Gastrointestinal Tube Competency revised to include measurement for proper placement (with pictorial diagram) in stomach and to avoid placement in lung. Measure tube for insertion distance from patient's nose to proximal earlobe and then down to xyphoid process/tip of sternum. Mark distance on tube by placing piece of tape at that point. RNs have been educated. [Completion Date: 02/28/11, revised form and re-inserviced RNs: 03/25/11] RN1 competency completed: 01/29/11 and re-inserviced 03/17/11. RN2 on extended sick leave since 01/10/11; will complete upon return to work: 04/10/11 est. Responsible Person: DON Revised Policy #6170-2.08, "Policy and Procedure for Gastroenteral Tube Insertion," to include initiation and maintenance of an appropriate care	04/10 05/10 02/18/10 02/11 03/12 02/28/11 03/25/11 01/29/11 03/17/11 04/10/11

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	Continued From page 2 to verify the placement of the NG tubing by insertion of air and they heard a very loud sound. RN 1 and RN 2 aspirated through the NG tubing in an attempt to verify NGT placement but there was no residual stomach content detected. On [redacted]/10, a chest x-ray was done. The NG tube was found in the left lung. During an interview on 2/25/10 at 11:10 AM, RN 2 stated, "Tried to insert air. Pulled out [and hearing] a click and inserted back and heard a very loud sound. No coughing. Inserted water; no distress. Feeding connected by 3 PM." There was no documentation that RN 1 and RN 2 had NGT placement verification before starting the tube feeding on [redacted]/10 at 3 PM. During an interview on 2/25/10 at 11:25 AM, RN 3, the night shift nurse for Patient 1, stated that during the night, "Placement check by listening air infusion. No sign and symptom of distress. Breathing OK. No other procedure was done to verify NGT placement. Physician made rounds at 6:30 AM and ordered chest x-ray." RN 3 heard a sound when infusing air through the NGT. RN 3 did not use any other procedure to verify NGT placement. The clinical record of Patient 1 was reviewed on 2/25/10. The "Critical Care Flowsheet" dated [redacted]/10, at 2:30 PM indicated, "Inserted NG tube at L (left) [nasal]. (P (after) several attempts - Pt (patient) keep on coughing during N/G tube insertion [and] shakes his head). NG tube placement with two nurses." At 3 PM,		plan, documentation and hand-off communication for the NGT. Additional revisions include, documentation and hand-off communication regarding NGT should include but not limited to, reason of NGT, type and size of tube, method of placement confirmation, description of gastric contents, which naris used and patient's response. Initial insertion should also include verification of patient identification, physician's order, and exact number of attempts made to insert. [Completion Date: 02/10; subsequent revisions: 05/10, 11/10, 02/11, 03/11] Update Annual Gastrointestinal Tube Competency to include initiating and maintaining NG care plan on MCCP (Multidisciplinary Continuing Care Plan). [Completion Date: 03/31/11] An expanded retrospective review of Yr 2010 to 03/18/11 cases showed care plan was present on all cases of NGT placement for medication, feeding, or fluid administration. [Completion Date: 03/21/11 & ongoing] Revised Policy #6170-2.08, "Policy and Procedure for Gastroenteral Tube Insertion," to emphasize patient has the legal right to make informed decisions about patient care, treatment and services and to refuse medical care/ treatment, -- even when that care would help the patient, that at any point of the procedure if patient shows indication of refusal whether verbal or non-verbal, RN	02/10 05/10 11/10 02/11 03/11 03/31/11 03/21/11 Ongoing

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	Continued From page 3 "Started NG feeding with 'Pulmocare' at 50 mL/hour as ordered." On [redacted]/10 at 8:15 AM, "NG feeding with 'Pulmocare' 50 ML/hour. No residual noted... At 9:15 AM, Physician 2 (radiology), called in that patient's NG tube is in the left lung. D/C (discontinued) NG feeding right away. Aspirated about 30 mL (milliliter) feeding material out from NG---tried to aspirate again---only air come out... At 9:25 AM, Injected 30 mL air through with positive gurgling sound at epigastric area (the upper and middle part of the abdominal surface)." There was no documentation that RN 1 and RN 2 informed Physician 1 that Patient 1 kept coughing and shaking the head during NGT insertion and they took several attempts to insert the nasogastric tube. Review of the "Discharge Summary" dated [redacted]/10, written by Physician 1 indicated, "On [redacted]10 NG tube initiated with 'Pulmocare' at 50 mL/hour. On [redacted]/10 a.m. chest x-ray was done at 8:00 and 8 minutes and radiologist's read at 9:20 report... This patient had interval placement of NG tube into the left lower lobe with prominent opacification (blocking light) consistent with pneumonia. The patient expired (died) on [redacted]/10 at 11:35 AM and Physician 1 called the family and informed the family... that the patient had NG tube placed in lungs and has aspirated respiratory failure, pneumonia..." Review of a report faxed to CDPH on 9/30/10 by the county medical examiner's office for		will stop and confer with patient, surrogate, and/or physician, and proceed only when consent is reconfirmed, or notify the physician if patient / surrogate withdraws agreement to NGT insertion, that no more than two attempts at nasogastric tube insertion should be made by any one nurse at any one time. After total of 4 attempts, physician must be notified. Placing tubes underwater to assess for "bubbling" for placement confirmation has been deleted from policy. In accordance with Lippincott Manual of Nursing Practice: Ninth Edition 2010; Lippincott's Visual Encyclopedia of Clinical Skills 2009; and Lippincott's Nursing Procedures Fifth Edition 2009, abdominal radiological verification must be done for blindly inserted NGT to confirm placement for medication, feeding, or fluid administration. For subsequent placement verification, the nurse will check for placement before putting anything down the NG tube and at least every shift for patient with continuous feedings, observing for signs of respiratory distress, such as choking or cyanosis, verifying tube placement by aspiration of 20ml minimum gastric contents, and by auscultation of air entering the stomach. If the nasogastric tube is inadvertently removed, or placement is unsure, and NGT therapy is to continue, x-ray confirmation of tube placement will be done. [Completion Date: Revised Policy 03/25/11; Board of Trustees Approval 04/26/11]	03/25/11 04/26/11

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	Continued From page 4 Patient 1 indicated, "Cause of death: complications of aspiration pneumonia due to: nasogastric tube placement into left lung." Review of Facility's "Policy and Procedure for Gastroenteral Insertion" dated 9/89 and "Current review/Effective Date: 11/09" indicated, "Verify placement by: 1. Aspirate contents of the stomach and discard. 2. Absence of bubbles from the end of the tube when place in water; if it bubbles, it is in the lung and must be removed immediately." The facility failed to follow the policy and procedure for gastroenteral insertion verification when: 1. RN 1 and 2 did not place the end of NGT in water to test for bubbles. 2. RN 1 and 2 did not verify stomach content was aspirated through the NG tubing. 3. There was no evidence of competency evaluation and in-service training for NGT insertion in the last 12 months for RN 1, RN 2 and RN 3. 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).		Responsible Person: DON & NM Annual Gastrointestinal Tube Competency revised to include measurement for proper placement (with pictorial diagram) in stomach and to avoid placement in lung. Measure tube for insertion distance from patient's nose to proximal earlobe and then down to xyphoid process/tip of sternum. Mark distance on tube by placing piece of tape at that point. RNs have been educated. [Completion Date: 02/28/11, revised form and re-inserviced RNs: 03/25/11] RN1 competency completed: 01/29/11 and re-inserviced 03/17/11. RN2 on extended sick leave since 01/10/11; will complete upon return to work: 04/10/11 est. Other RNs including RN3 completed Annual Gastrointestinal Tube Competency. [Completion Date: 02/28/11; revised form and re-inserviced RNs: 03/25/11] Responsible Person: DON Practices used for tube verification has been revised. Placing tubes underwater to assess for "bubbling" has been deleted from policy. In accordance with Lippincott Manual of Nursing Practice: Ninth Edition 2010; Lippincott's Visual Encyclopedia of Clinical Skills 2009; and Lippincott's Nursing Procedures Fifth Edition 2009, abdominal radiological verification must be done for blindly inserted NGT to confirm placement for medication, feeding, or fluid administration. [Completion Date: Revised Policy 03/25/11; Board of Trustees Approval 04/26/11]	02/28/11 03/25/11 01/29/11 03/17/11 04/10/11 02/28/11 03/25/11 03/25/11 04/26/11

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