

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

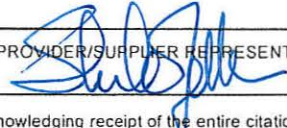
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050396	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/18/2016
NAME OF PROVIDER OR SUPPLIER <b>SANTA BARBARA COTTAGE HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 400 West Pueblo Street, Santa Barbara, CA 93105 SANTA BARBARA COUNTY		
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	<p>Complaint Intake Number: CA00426645 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 09666, HFE-N</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)</p> <p>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>Health and Safety Code Section 1279.1 (c)</p> <p>The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p> <p>Health and Safety Code Section 1279.1 (a)</p> <p>A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing</p>	12/21/14 Kachew	<p>The following constitutes the facility's response to the findings of the California Department of Health Services and does not constitute an admission of guilt or agreement of the facts alleged or conclusions set forth on the summary statements of deficiencies.</p> <p>These findings and the resulting plan of correction were reviewed, developed implemented by the Clinical Manager, Surgical Intensive Care Unit, Clinical Manager Medical Intensive Care Unit and Director, Acute Care Services, at the direction of the V.P. Clinical Services and CNO.</p> <p>a) The patient identified to have been affected by the deficient practice has expired; therefore, no action can be taken for this patient. However, other patients identified as having the potential to be affected by the same deficient practice are identified as any adult inpatient. The systemic changes that have been made are as follows:</p>	

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



TITLE

EVP/COO

(X6) DATE

11-30-16

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 9

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>urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law</p> <p>Health and Safety Code Section 1279.1 (b)(5) (D)</p> <p>(b) For purposes of this section, "adverse event" includes any of the following: (5) Environmental events, including the following: (D) A patient death associated with a fall while being cared for in a health facility.</p> <p>Title 22, California Code of Regulations, Division 5, Article 3, Section 70215, Planning and Implementing Patient Care.</p> <p>(a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitation of their licensure, certification, level of validated competency, and/or regulation.</p> <p>The facility failed to supervise and plan care for Patient 1 to provide for his safety while he</p>		(cont.) 1. Ensure hand-off communication between nursing-unit to nursing-unit when the patient transfers to another unit after having an operative or invasive procedure. This hand-off communication would be in addition to the hand-off that would be provided by the ancillary department that has performed the operative or invasive procedure. In 2015, the policy did not state which unit (sending or receiving) is responsible for initiating the hand-off. After informing the involved staff on June 9, 2015, a piloted hand-off process was completed for Neuro med-surg unit to SICU transfers. The Clinical Manager, Med-surg unit (Neuro) monitored the effectiveness of this pilot by staff interviews and discussed the results at a unit leadership meeting on July 8, 2015. The results of the monitoring revealed that the revised hand-off process was well received and that the Med-surg nurses were following up to ensure that the SICU nurse received the hand-off in the event that the registered nurse		

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	<p>was in the intensive care unit (ICU). This failure allowed Patient 1 to fall out of bed, unwitnessed, and sustain a subarachnoid hemorrhage (SH) (bleeding between the brain and the tissues covering it), which lead to his death six days later.</p> <p>Findings:</p> <p>Record review on 1/29/15 at 10:40 a.m. revealed that Patient 1 was a 71 year old man who had a stroke and was admitted to the facility on 12/18/14 for an advanced procedure to improve blood flow to his brain. Patient 1 was monitored in the facility for 14 days until he was stable for the advanced treatment of angioplasty and stenting of an artery in his brain (a long catheter is placed in an artery in the groin and advanced to the brain where a device is placed in an artery to improve blood flow). Nursing documentation prior to the procedure from 12/18/15 through 1/2/15 revealed Patient 1 had a history of falls, was weak on his left side, had periods of confusion, was forgetful, and did not know his limitations. Further review of nursing documentation prior to the procedure revealed Patient 1 was alert to self, place, and time, walked with a cane, ate meals, and could move in bed. Nursing staff also documented on 1/2/15 that Patient 1 was at high risk for falls, and required a bed alarm for safety (the bed alarm rings when there is a change in pressure indicating the patient may be trying to get out of bed without assistance), as he required assistance when getting out of</p>		<p>(cont.) registered nurse was not immediately available. Given that it is not always known the location that a patient will be transferred to the process was revised to state that it would be the receiving unit's responsibility to contact the sending unit for the hand-off information. On July 24, 2015 all nursing staff system-wide were educated on expectations for hand-off via the electronic education update by the Nursing Education Department at the direction of the Director, Acute Care Services.</p> <p>2. On February 10, 2015, revised policy titled "Admission and Discharge Criteria for the Adult Critical Care Units" and posted this policy on the employee portal for critical care nurse access in March 2015. Revisions to this policy include:</p> <ul style="list-style-type: none"> <li>clarify 1:1 care for recovery of patient to baseline based on documentation in the medical record;</li> <li>updated this policy to include recovery post-anesthesia</li> </ul>		

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	<p>bed.</p> <p>Review of the anesthesia record revealed that on 1/2/15 at 3:56 p.m. Patient 1 underwent the angioplasty and stenting of an artery in his brain under general anesthesia. Further review revealed that Patient 1 was transferred out of the procedure room at 5:53 p.m. and taken directly to the ICU. Patient 1 was admitted to the ICU on 1/2/15 at 6:00 p.m. for recovery and post-operative care.</p> <p>RN 1 documented an assessment of Patient 1 on admission to the ICU at 6:00 p.m. Review of the assessment revealed Patient 1 was drowsy, had memory impairment, was oriented to self only, had slurred speech, and was at risk for falls. Interview with RN 1 on 1/30/15, at 12:20 p.m. revealed when Patient 1 came back from surgery he was her only patient for the first hour until he recovered from anesthesia. He had four side rails up for safety and recent anesthesia; and she remained at his bedside. RN 1 indicated during this interview that Patient 1 was fully recovered to his pre-procedure baseline by 7:30 p.m. However record review revealed Patient 1 was not at his pre-procedure baseline, and was not oriented to self, place, or time, and could not tolerate fluids. Specifically, nursing staff documented prior to his brain procedure that Patient 1 was alert and oriented to person place and time, able to walk with his cane and assistance, could eat, and could make his needs known.</p>		<p>(cont.)from other procedural units such as interventional radiology; Verified that the RASS score is a valid and reliable sedation tool to assess the patient by the critical care nurse to assess the patient and thus no revision to the policy was made. Based on the American Society of Peri-Anesthesia Nurses (ASPAN) guidelines a "Post Anesthesia Recovery Scoring System" (PAS) tool was developed and piloted in August 2015. This tool was developed and implemented on August 24, 2015, to enhance the nursing assessment of the patient post-anesthesia or sedation. After the pilot, critical care nursing staff were educated on the use of this tool at the August 18, 2015 critical care competency day and by e-mail on August 20, 2015 by the critical care CNC at the direction of the Clinical Manager, Surgical Intensive Care Unit.</p> <p>3. On March 31, 2015 a revised Fall Prevention Bundle was implemented as part of patient care, which included the following</p>	

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	<p>An Interview was conducted with RN 2 on 1/29/15 at 12:58 p.m. RN 2 advised during the interview that she assisted RN 1 in caring for the patient after the procedure on 1/2/15 until the end of their shift at 7:30 p.m. RN 1 recalled during the interview that Patient 1 was kept flat with the head of his bed elevated, at least three side rails were up for safety, and the bed in the low position. Further, according to RN 2, a care plan was developed as Patient 1 was at risk for falls, although not at "high" risk, and an intervention to monitor Patient 1 was included in the care plan. RN 2 also advised during the interview that the bed alarm for Patient 1 was not turned on while Patient 1 was in the ICU, although it had been required for safety prior to the procedure.</p> <p>An interview and record review with RN 3 was conducted on 2/17/15 at 10:00 a.m. RN 3 advised that she had received a report from the day shift RN at the patient's bedside on 1/2/15 at 7:30 p.m. RN3 advised that the dayshift nurse reported that Patient 1 was fully recovered, was on every 15 minute monitoring, had a history of dementia, was drowsy, had been resting quietly, and was not safe to take fluids. During the interview, RN 3 recalled Patient 1 required stimulation to answer questions on 1/2/15 at 8:00 p.m. RN 3 also indicated she assessed Patient 1 to be at "high" risk for falls during that assessment on 1/2/15 at 8:00 p.m., and that he required four side rails for safety, but did not need a bed alarm.</p>		<p>(cont.) elements: a) Revised Patient Fall Prevention - Adult policy revisions include: (1) Upon admission, a patient is considered a high fall risk until the Morse scale is completed (2) Complete the Morse Scale Plus with ABCS (Age-greater than 80 or frailty; Bones-osteoporosis, history of fractures; Coagulation- on anticoagulant or coagulopathy; Surgery-within 24 hours) assessment, which will determine the patient's fall risk level. The presence of following: lines, drains, tubes, co-morbidity, anesthesia and sedatives will place the patient at high-risk for falls. Document the completed fall risk assessment in the electronic medical record. (3) Implement High Fall risk Precautions for all patients at risk for falls, including those with Morse Score 45 or greater and if has 2 or more of the ABCS. (4) Reference to Lippincott for procedures for fall prevention and fall management.</p>		

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	<p>Further review of the 8:00 p.m. assessment conducted by RN 3 on 1/2/15 indicated that Patient 1 was drowsy, had memory impairment, was oriented to self only, was confused, had slurred speech, and was weak on his left side. RN 3 also documented in this assessment that Patient 1 had some delirium. RN 3 determined that Patient 1 required monitoring and a yellow wristband to identify him as a fall risk. The bed alarm that is built into the bed was not used for safety even though it had been required prior to his brain procedure.</p> <p>An interview and concurrent record review was done with administrative staff and RN 3 on 2/17/15 at 10:00 a.m. of RN 1's 7:00 p.m. assessment on 1/2/15. During this interview it was determined that at that time Patient 1 was most likely in delirium as more time would be required to awake from anesthesia to his pre-operative condition, and that contrasted with her RN 1's assessment. (Delirium is a serious disturbance in a person's mental abilities that results in a decreased awareness of the environment and confused thinking.)</p> <p>RN 3 stated during the interview on 2/17/15 that she checked on Patient 1 at 8:30 p.m. and then went to care for another patient in isolation. Further interview revealed RN 3 was alerted by RN 4 that Patient 1 was found on the floor at 8:40 p.m. She then exited that patient's isolation room to assess Patient 1 with RN 4. RN 3 said that Patient 1 was on the floor</p>		<p>(cont.) a) Ensure patient safety and fall prevention measures are implemented nursing staff perform:</p> <p>(1) Purposeful hourly rounding including the four P's (pain, positioning, personal items, and potty)</p> <p>(2) Two-person safety checks per shift (paying particular attention to fall risk, yellow-fall wristbands, sign on door, bed alarm on, etc.)</p> <p>b) List of available products to consider for high risk injury patients, such as:</p> <p>(1) Hipsters to protect from potential bruising and fractures</p> <p>(2) Floor mats if patient is impulsive and/or at high risk for injury from fall.</p> <p>c) For patients over 75 years of age the Pharmacy Department will review the medications strongly associated with falls (benzodiazepines, antidepressants, and antipsychotics) and if the patient is on three or more, place them on high-risk fall precautions due to medications.</p>	

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	<p>parallel to the bed, was bloody, appeared in shock, did not speak, and had to be lifted back to bed by four staff. An interview with RN 3 on 2/23/15 at 1:40 p.m. revealed that RN 3 had not observed Patient 1 through the windows when she was in her other patient's room, but did see the empty bed after he fell.</p> <p>A telephone interview with RN 4 was conducted on 2/19/15 at 5:00 p.m. RN 4 advised that when she walked past Patient 1's room, he was not in the bed or chair. RN 4 said she saw Patient 1 on the floor next to his bed with the monitors attached reading stable heart rate, rhythm, oxygen saturation, and blood pressure; and no alarms were ringing indicating a problem. RN 4 stated she did not go into the room to assist Patient 1, but rather went to find RN 3. RN 4 said there was blood under Patient 1's head as he lay on his left side on the floor. RN 4 said she shined a light in Patient 1's eyes and indicated his pupils reacted normally.</p> <p>A review of RN 3's documentation from 8:58 p.m. after this fall out of bed revealed that Patient 1 was found on the floor with a large bruise noted on the left side of the back of his head. His percutaneously inserted central catheter (a catheter inserted under the skin, and into a vein in the arm and advanced until the tip rests above the heart) was found on the floor. He was lifted back to bed. The physician was notified and the patient was taken for a "STAT" (emergent) brain scan. The scan showed a traumatic SH (subdural</p>		<p>(cont.)a Communicate fall risk to all staff by:</p> <p>(1) Yellow fall risk wristbands (Yellow blanket in Emergency Department)</p> <p>(2) Yellow non-skid socks</p> <p>(3) Care board and door signs to communicate fall risk</p> <p>(4) Indicate high fall risk on "Ticket to Ride"</p> <p>(5) Communicate high fall risk during hand-off report and in change of shift huddles</p> <p>Nursing education of the Fall Prevention Bundle began March 13, 2015, and continued through implementation on March 31, 2015. All nursing staff system-wide were educated on the revisions made to the policy as well as the safety elements of the bundle in communication with their respective Unit Clinical Manager at department meetings and by educational e-mails sent on March 20, 2015.</p>	

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	<p>hematoma—bleeding in the brain) on both frontal lobes of the brain. A physician stitched a laceration behind the patient's left ear and a pressure dressing was applied.</p> <p>Record review and concurrent interview with RN 3 was conducted on 2/17/15 at 10:00 a.m. According to records as well as RN 3, a bed alarm was turned on for safety after the fall at 10:00 p.m. because Patient 1 became very agitated and combative. RN 3 documented that Patient 1 required restraints, and was hypertensive. RN 3 revealed that she had spoken with Patient 1's family and they informed her that Patient 1 had a history of episodes like this in the past. At 3:40 a.m. on 1/3/15, RN 3 documented that Patient 1 had a change in condition because Patient 1 was less responsive, nonverbal, and the physician was notified.</p> <p>Review of the results of Patient 1's second brain scan dated 1/3/15 at 5:00 a.m. revealed that the brain bleed had increased significantly. Review of physician documentation dated 1/3/15 revealed that Patient 1's chance of recovery was poor due to injury from the fall and he was placed on comfort care with no further active treatment of his head injury or stroke. Patient 1 died on 1/8/15, 6 days later.</p> <p>Review of the Coroner's report dated 1/9/15 revealed that the cause of death for Patient 1 was a brain bleed from blunt force injury to the head, due to the unwitnessed fall from bed.</p>		<p>b)The Clinical Manager for each nursing unit monitored two-person safety checks to verify that they were completed in accordance with policy, with a goal of 90%. This concurrent record review of 30-patients identified to be at high-risk for falls was conducted for 4-months beginning August 2015 and ending November 2015. The range of compliance was from 97% to 100% for all nursing units; this data was reported to the Fall Prevention HEAT as part of the quality improvement review process.</p> <p>c) There were several actions taken for this deficiency, the last of which was completed on August 24, 2015.</p>		

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	The facility's failure to provide adequate supervision and care to prevent this fall and death of Patient 1 is a deficiency that has caused, or is likely to cause, serious injury or death to the patient and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.3.				

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