STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA070001357	A. BUILDING _____ B. WING _____	C 10/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANFORD HOSPITAL	300 PASTEUR DRIVE STANFORD, CA 94305

(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident conducted on 8/31/10 to 10/5/10. For Entity Reported Incident CA00233606 regarding Quality of Care, a State deficiency was identified (see California Code of Regulations, Title 22, Section 70213(a) and California Health and Safety Code, Section 1280.1(c)). Inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the hospital. Representing the California Department of Public Health: [redacted] Health Facilities Evaluator Nurse. HSC 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 like to cause, serious injury or death to the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY	E 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH DEC 10 2010 L & C DIVISION SAN JOSE	
E 264	T22 DIV5 CH1 ART3-70213(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 Statute is not met as evidenced by: Based on documentation, a nurse failed to implement the hospital's policy on removing	E 264		

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E 264	Continued From page 1 sutures anchoring a patient's tracheostomy tube (a device that allows a person to breathe without use of their nose or mouth). The nurse was not qualified to do the procedure. Removal of the sutures allowed the tube to become dislodged causing a hypoxic (deprived of adequate oxygen) episode resulting in brain injury. Findings: The hospital policy regarding the removal of staples and sutures, under Standardized Procedures stated, "this standardized procedure is to allow the nurse practitioner or physician assistant, after training and demonstration of competency, to safely remove surgical staples and sutures." Patient 2 was admitted to the hospital [redacted]10 for treatment of a Type B aortic dissection (tear in the heart). A stent (a device placed into a blood vessel to aid in blood flow) was surgically placed in the patient on [redacted]10 and he was transferred to the surgical intensive care unit (ICU) for further care. During his stay in the ICU he began to decompensate with respiratory failure necessitating the insertion of a tracheostomy tube on [redacted]10. On [redacted]10 at 12 noon, Nurse A provided care to Patient 2's tracheostomy tube. In a letter to the hospital dated September 1, 2010, Nurse A wrote there were large amounts of secretions around the tracheostomy tube. When the patient coughed secretions were also coming out around the tube. She further wrote she cut the tracheostomy sutures in order to completely clean around the site and apply a trach dressing (gauze cover). She stated she cut the sutures without first obtaining a physician's order and did	E 264		

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E 264	Continued From page 2 not document what she had done (cut the sutures) in the medical record. On [redacted]10 at 10:40 a.m., the patient went into respiratory arrest (stopped breathing) and a code (medical emergency) was called. Although Patient 2 was revived, he expired on [redacted]10. The physician's post arrest note documented the tracheostomy tube had apparently dislodged. The physician did not observe the original sutures were in place to appropriately secure the trach tube. He further wrote it was unclear why the sutures from the trach were removed and this likely explained why the trach exited the airway. According to the hospital autopsy report, the patient's respiratory problems were a post operative result of pneumonia requiring a tracheostomy and ventilator support. Thereafter, he suffered a hypoxic episode from disconnection of the tracheostomy resulting in anoxic brain injury. Nurse A was not a nurse practitioner nor a physician's assistant. She was prohibited by both the Nurse Practice Act and hospital policy from acting independently to remove tracheostomy sutures. There was no evidence that Nurse A demonstrated any qualifications through training or competencies to safely remove tracheostomy sutures. Nurse A violated the Nurse Practice Act and hospital policy by removing the tracheostomy sutures without physician authorization, by failing to report her conduct to the supervising nurse or physician, and by failing to document her removal of the sutures in the patient's chart. By failing to timely report her conduct, Nurse A caused inexcusable delay in patient treatment. These actions caused or are likely to have caused, serious injury or death for the patient and	E 264	•The involved staff member was re-educated about the policy which states that there is a requirement to obtain a physician order prior to carrying out an intervention related to the removal of trach ties. Completed August 31, 2010 •Tracheostomy Care Policy was revised to include the following language: Tracheostomy ties should NOT be changed within the first 5 post operative days after surgery. If changing is necessary, request the physician to do so. A physician order is required for removal of the original post-op trach ties and sutures. Notify the physician/service who performed the tracheotomy if the trach ties or sutures are too loose, trach tube is not stable or if the trach ties are too tight and causing skin irritation/ulceration under neck plate. Completed September 30, 2010 •All RNs in NICU were educated during staff meeting regarding this patient event and safety measures when caring for patients with a tracheostomy. Completed July 30, 2010 •All RNs in NICU were educated regarding the changes in the Tracheostomy Care Policy. Completed October 29, 2010 •Trach Sign, stating Fresh Trach Guidelines, will be posted above the head of the bed for all fresh trachs. Implemented November 1, 2010. •One hundred percent of all patients in NICU with a tracheostomy requiring sutures will be audited for compliance with policy through first quarter 2011. Completed April 1, 2011.	10/29/10

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E 264	Continued From page 3 therefore constituting an immediate jeopardy within the meaning of Health and Safety Code, Section 1260.1	E 264		