5/20/11 POC accepted - [redacted]

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION
	CA070000149	A. BUILDING _____ B. WING _____

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA CLARA VALLEY MEDICAL CENTER	751 SOUTH BASCOM AVENUE SAN JOSE, CA 95128

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E 000	Initial Comments The follcwing reflects the findings of the California Department of Public Health during an investigation of an Entity Reported Incident conducted from12/2/10 to 12/22/10. For Entity Reported Incident CA00249262 regarding Quality of Care/Treatment, State deficiencies were identified (see California Code of Regulations, Title 22, Section 70215(a)(1) and California Health and Safety Code, Section 1280.1(c)). Inspection was limited to the specific Entity Reported Incident investigated and dces not represent the findings of a full inspection of the hospital. Representing the California Department of Public Health was 28767, 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 likely to cause, serious injury or death to the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY.	E 000	CALIFORNIA DEPARTMENT [illegible] JAN 28 2011 L & C DIVISION SAN JOSE	
E 291	T22 DIV5 CH1 ART3-70215(a)(1) Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of	E 291		

Licensing a[redacted]

LABORATO[redacted] EPRESENTATIVE'S SIGNATURE

Interim Executive Director TITLE

1/27/11 (X6) DATE

California Department of Public Health

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E 291	Continued From page 1 the patient when he/she is transferred to another patient care area. This Statute is not met as evidenced by: Based on interview and record review, nursing failed to provide ongoing assessments of a chronic ventilator dependent patient (Patient 1) who was transferred from the emergency department to the transitional care neurological unit (TCU) without assisted ventilation. The patient had no pulse or respirations when he arrived at the TCU. Findings: Patient 1 was assessed in the hospital's emergency room (ER) on [redacted]10 for complaint of chest pain. Review of Patient 1's medical record on 12/2/10, indicated Patient 1 resided in a skilled nursing facility prior to his hospital admission. The skilled nursing facility's records indicated Patient 1 was alert, responsive, and had no "limitations with movement." Patient 1's medical history included hypertension and amyotrophic lateral sclerosis (a disease of the nerve cells in the brain and spinal cord that control voluntary muscle movement). Further review of the medical record indicated Patient 1 had a tracheostomy (surgically created hole at the front of the neck going into the windpipe) and was ventilator (a machine that keeps air moving in and out of the lungs of a patient who cannot breathe unaided) dependent. Patient 1 was transferred to the hospital on [redacted]10 for complaints of chest pain. Review of ER records indicated Patient 1 arrived to the ER on [redacted]10 at 12:26 p.m. with complaints of chest pain. On arrival to the ER	E 291	On 11/11/10-The Emergency Department (ED) Nurse Manager completed the following actions to immediately reinforce the "Practice of Safety"-regarding need for frequent re-assessment of patients--In this case it involved a chronic ventilator dependent patient who was transferred from the Emergency Department to the Transitional Care Neurological Unit (TCNU) without assisted ventilation. The patient had no pulse or respirations on arrival to TCNU. The ED Nurse involved in the incident, failed to provide accurate, ongoing assessment of the patient's ventilator status, removed the patient's ventilator without a physicians order (Patient had been on a ventilator the previous shift). The patient was transferred by a transport technician who was not qualified to transport a ventilator patient without nursing assistance. The ED Respiratory Therapist was not notified of patient admission. These actions resulted in serious injury or death for the patient-Constituting Immediate Jeopardy.	Com-pleted 11/12/10

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E 291	Continued From page 2 Patient 1 was placed on a ventilator. Physician's ER notes indicated the patient was alert, cooperative, and "trying to talk". Nursing ER notes indicated the patient was able to nod "yes" when asked if he was feeling okay. At 7:03 p.m., the physician wrote orders to admit Patient 1 to the Transitional Care Neurological Unit (TCU) for acute coronary insufficiency. A physician's note on [redacted]10 at 5:35 p.m., documented Patient 1 "likely will be in the hospital less than 48 hours". Physician holding orders included full code status (all possible measure are taken to revive a person and sustain life), cardiac monitor, patient off monitor for transport (patient's vital signs and oxygen level would not be monitored during transport), and oxygen therapy per protocol to keep oxygen saturations greater than 95%. During a telephone interview with ER nurse 1 (RN 1) on 12/3/10 at 2:45 p.m. RN 1 stated on [redacted]10 from 7 p.m. to 11:20 p.m., Patient 1 was under his care. RN 1 stated Patient 1 remained on a ventilator while under his care. On [redacted]10 at 10:50 p.m., RN 1 called report to the nurse in the TCU who was to receive the patient. Report information included Patient 1 was from a nursing home, nonverbal, mental status unknown, and that the patient was "trached" (patient had a tracheostomy). Patient 1 was not transferred to the TCU before RN 1's shift ended and therefore RN 1 gave report to the oncoming ER nurse (RN 2). RN 1 stated he gave report to RN 2 at 11:20 p.m., report information included "patient was vent and trached" (patient was ventilated and had a tracheostomy), "mental status unknown," and the "patient was ready to go up to the floor."	E 291	Continued: Immediate Plan of Action: 1) On 11/12/10-The ED Nurse Manager verbally counseled the nurse regarding the failure to provide an accurate and ongoing assessment of the vent dependent patient 2) On 11/12/10-The ED Nurse Manager sent a "Manager Update" E-mail to the staff outlining the expectation of assessing a vent dependent patient who may have orders to go off monitor during transport—as to whether or not it is the right move for the patient **(Attachment-I)** 3) On 11/15/11 &11/20/11-During the ED Staff Meeting--"A Practice of Safety" handout was given to the ED staff for read and sign-focus was on frequent re-assessments based on patient safety **(Attachment-II)** 4) On 11/15/11 & 11/20/11- ED Staff Meeting-Nursing Forum--the following were discussed: a) Primary Care Nurse will call report, b) Timely transfer of patients to their respective units instituted -if indicated use the escalation process if transfer is delayed, c) Walking rounds are required at shift change, and d) Respiratory therapy (RT) In-Service-RT will go with all vent patients and will check Oxygen Tank Levels prior to transfer **(Attachment-III)** 5) On 11/18/10-Root Cause Analysis was	Com-pleted 11/12/10 Com-Pleted 11/12/10 Com-pleted 11/15/10 11/20/10 Com-pleted 11/15/10 11/20/10

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E 291	Continued From page 3 RN 1 stated when transferring a ventilated patient, the nurse, respiratory therapist, and a certified nurse assistant are part of the transfer team. The respiratory therapist "bags" (the use of a hand-held device used to ventilate patients) the patient, the nurse watches the monitors, and the nursing assistant assists with the bed transport. RN 1 stated arrangements were not made with the respiratory therapist to transfer the patient. During a telephone interview with the ER respiratory therapist (RT 1) on 12/3/10 at 1 p.m., the RT 1 stated he cared for Patient 1 from 6:30 p.m. to the time the patient left the ER. Patient 1 was on a ventilator throughout the shift. RT 1 was not aware Patient 1 was being transferred to a different floor. RT 1 was not consulted to participate in Patient 1's transfer to the TCU. RT 1 stated he would have called report to the receiving RT, if he had known the patient was being transferred. RT 1 did not know the exact time the patient left the ER and stated, "I was shocked no one told me the patient was being transferred." During a telephone interview with RN 2 on 12/3/10 at 11 a.m., RN 2 stated he received change of shift report from RN 1 on [redacted]10 at 11:15 p.m. Report information incluced Patient 1 was admitted from a nursing home with chest pain. Patient was "trached and vented", report had already been called to the TCU nurse receiving the patient and the patient was "ready to go up to the TCU." RN 2 stated he reviewed the physician orders, saw Patient 1 could be transported off monitor and assumed the patient could be taken off the	E 291	Continued: conducted. 6) On 12/17/2010-Emergency Department Nurse reported to the Board of Registered Nurses **(Attachment IV)** 7) On 1/29/11-Emergency Department Nurse placed on suspension until 2/26/11 **(Attachment-V)** 8) New Intrahospital Transport of Patients Policy (draft) **(Attachment-VI)** 9) TheTransport Guidelines have been updated--regarding an escalation plan for moving a patient they believe should not be moved (draft) **(Attachment-VII)** Monitoring: Responsible Parties: ED Nurse Manager and the Chief Nursing Officer. The ED Nurse Manager is responsible for auditing 20 patient charts per month for 3 months or until 100% compliant for 3 months. The charts will be selected at random, to assure accurate assessment and re-assessment of ventilator dependent patients, completed documentation of assessment of these patients--as well as: a) did the primary nurse call report, b) was the transfer of the patient done within 1 hour or less, and c) was Respiratory Therapy called prior to transport. Risk Management (will review PSN Occurrence Reports for 6 months regarding ventilator dependent patient transfer issues).	Com-pleted Com-pleted 2/1/11 2/1/11

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E 291	Continued From page 4 ventilator for transfer. RN 2 disconnected Patient 1 from the ventilator. RN 2 stated he placed an oxygen mask at 15-16 liters of oxygen over Patient 1's tracheostomy to "hyperoxygenate" (the use of high concentration of inspired oxygen) the patient. RN 2 stated after 10 minutes of observation he was "confident to send patient up". At 11:40 p.m. RN 2 had a hospital transporter (HT) transfer the patient up to the TCU. RN 2 stated, "I should have assessed the patient better" before transferring the patient from the ER. During a telephone conversation with the HT on 12/10/10 at 10:40 a.m., the HT stated he arrived in the ER at approximately 11:30 p.m. to transport Patient 1 to the TCU. HT stated Patient 1's head was slightly tilted to the left and had his eyes open. When he spoke to the patient, the patient did not respond or look at him. HT stated he did not recall seeing the patient move his arms or legs. HT was told by RN 2 the patient was nonverbal. HT saw RN 2 place an oxygen mask over Patient 1's tracheostomy and connect the mask to a portable oxygen tank. From his nine year experience transporting patients, HT stated he had never seen a tracheostomy patient have an oxygen mask placed over their "trach" during a transport. This "concerned" him and he asked another ER nurse (RN 3) if it was safe to transport Patient 1. HT stated RN 3 told him it was "OK" to transport the patient and not to worry about the transport. HT responded to RN 3 "What should I do if something happens during transport?" RN 3 responded, "Nothing will happen". During a telephone interview with RN 3 on	E 291	Continued: The Chief Nursing Officer is responsible reviewing. The results will be reported to the Executive Nursing Council, and the Patient Safety Committee on a monthly basis.	

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E 291	Continued From page 5 12/17/10 at 8:30 a.m., RN 3 stated she was asked by HT to look at Patient 1. HT asked her if it was ok to take the patient up to the floor. RN 3 responded by saying "it is normal for people to go up like that if they are not vent dependent." RN 3 stated patient looked "fine" but did not know the patient's medical history when making the statement to the HT. HT proceeded to transport Patient 1, arriving to the TCU six to ten minutes after leaving the ER. HT stated he notified the nursing station of the patient's arrival. When entering the room, HT touched Patient 1's arm and felt the patient's skin was cold. HT looked at Patient 1 and noticed his eyes were rolled up, and his lips were blue. HT was not able to feel the patient's pulse and alerted the nursing station. The transitional care nurse (TCN 1) arrived immediately to the patient's room. During a telephone interview with the TCN 1 on 12/13/10 at 3:30 p.m., TCN 1 stated when entering Patient 1's room she noticed the patient was pale and called a rapid response (medical emergency) code. When she assessed Patient 1 there was no pulse and the patient was not breathing. A Code Blue (rapid response alert for a cardio-pulmonary arrest) was called, and cardiopulmonary resuscitation (CPR) was initiated immediately. TCN 1 could not give an approximate time of the incident. TCN 1 stated she received report for Patient 1 from the evening nurse and was aware the patient needed to be on a ventilator. TCN 1 stated she paged the TCU respiratory staff at the beginning of the shift (11 p.m.), but did not receive a call back.	E 291		

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E 291	Continued From page 6 During a telephone interview with the TCN RT (RT 2) on 12/3/10, RT 2 stated she was not aware she was receiving a patient from the ER who needed a ventilator. RT 2 stated if she would have known she was receiving a "vent" patient she would of coordinated care with RT 1. Review of Patient 1's Cardio-Pulmonary Arrest sheet indicated the code blue was called on [redacted]10 at 11:57 p.m., and the code team arrived at 11:59 p.m. When the code team arrived Patient 1 had no pulse or cardiac electrical activity (flatline). Patient 1 was resuscitated and was transferred to the intensive care unit. Patient 1 died five days later after the family made the decision to discontinue life support. Patient 1 was removed from a ventilator by an ER nurse without a physician's order. The patient was then transported from the ER to another unit in the hospital by a technician who was not qualified to transport a ventilator patient without nursing assistance. Nursing's failure to provide accurate, ongoing assessment of the patient's ventilatory status caused, or was likely to cause, serious injury or death for the patient, therefore constituting an immediate jeopardy within the meaning of Health and Safety Code, Section 1280.1(c).	E 291		