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
	050075	A. BUILDING _____ B. WING _____	06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaiser Foundation Hospital - Oakland/Richmond	275 West MacArthur Boulevard, Oakland, CA 94611-5641 ALAMEDA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00471992 - Substantiated Representing the Department of Public Health: Surveyor ID# 2343, 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 1280.3(g): 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. The state regulation violated: California Code of Regulations, Title 22, Section 70213(a) (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Based on observation, interview, and record review. the hospital failed to follow the policy and procedures (P&P) for maintaining cardiac (heart) rhythm monitoring and emergency response (Code Blue) for one (Patient 1) of 18 patients on cardiac monitors. This resulted in the staffs' failure to respond to Patient 1's lethal heart rhythm, asystole (flat line, no electrical activity). Subsequently, the patient was found dead in a chair.		Kaiser Foundation Hospital Oakland/Richmond takes complaints made by staff, patients and/or family members regarding patient safety and provision of care very seriously. In response to the concern identified in the complaint number **CA00471992**, the hospital has identified the following corrective actions which collectively address the telemetry system and the concern of a failure to respond to an abnormal heart rhythm. [LEFT BLANK]	

Event 10:060411 10/17/2017 12:32:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X5) DATE

Jeffrey A Collins — Sr. V.P./Area Manager — 11/3/17

By signing this document, I am acknowledging receipt of the entire citation packet *Page(s)1 thru 7*

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.

Acceptable PC Deneen Cole 11/6/17

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	1280.3 (g) 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. This adverse event constituted an Immediate Jeopardy (IJ) when staff failed to respond to a cardiac emergency as required. This resulted in the patient's death without the benefit of medical emergency interventions. Definition: Telemetry Unit-is defined as a unit organized, operated, and maintained to provide care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval, and display of cardiac electrical signals. Findings: "The P&P dated and revised on 10/14, "Cardiac Monitoring," indicated the telemetry box is a device that has leads and electrodes applied to the patient's chest and connect to a transmitter box which the patient wears in a pocket or on a holder around the neck. The transmitter box picks-up cardiac rhy1hm impulses from the patient and transmits to the central monitoring station for display. The registered nurse (RN) carrying the pager/phone for providing remote notification of changes in any selected operating parameters measured at the central monitor. The telemetry		[LEFT BLANK] **Corrective Action Item #1** The staff assignment form was revised to assure clear documentation of the phones assigned to each room. Additionally, Assistant Nurse Managers or designees implemented a new process to conduct phone calls or send texts every shift to verify the correct phone assignments. This testing process is documented every shift in a standardized process. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Monthly	01-08-2016 Ongoing

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	alarm device is designed to ensure that arrhythmias (abnormal rhythms) are promptly detected and transmitted. This is an alarm management and event notification system that helps ensure that critical information is sent rapidly to the assigned caregivers on a personal communication device. The policy requires the RN carrying the pager/phone to ensure that the pager/phone is on and the alarm is at the audible level. All alarms are to be answered promptly; however, all critical/red alarms (asystole) are to be answered immediately (within 90 seconds). Red alarms are sent to: Level 1 Primary RN, Level 2 Alternate RN. and Level 3 Manager. Red Alarm is sent to all levels immediately until answered. All Reds alarm at the central station. Policy: Red (Crisis) and Staff Response: Validate/respond immediately. Activate Rapid Response Team or Code Blue (personnel trained in emergency resuscitation) as necessary. Acknowledge and clear alarms from central station." Record review on 1/12/16 reflected Patient 1's admission to the hospital on 1/4/16 for acute respiratory failure and history of reproductive organ cancer that spread to other parts of the body. On 1/4/16 at 1650 (4:50 PM). Patient 1 was admitted to the hospital's telemetry unit for continuous heart monitoring. The physician notes dated 1/7/16 reflected Patient 1 "desires everything to be done, except intubation" (tube inserted into the windpipe that would likely result in the patient being placed on a breathing machine) for life-sustaining treatment.		**Corrective Action Item #2** The Emergin system alarm monitoring data for the 24-hours surrounding the event was reviewed for system issues. The assessment indicated that the system operated as designed. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Completed **Corrective Action Item #3** The policy for Cardiac Monitoring was reviewed and deemed appropriate. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Completed **Corrective Action Item #4** During shift huddles on all three shifts, nursing staff on all telemetry units and ICU were reeducated on the policy and expectation that the primary nurse acknowledges the cardiac alert, assesses the patient, and responds to the identified needs of the patient. This continued three times a day for 14 days. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Completed	01-09-2016 01-09-2016 01-22-2016

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	In an interview, on 1/29/16 at 2:39 PM, the physician (MD 1) stated that during his morning rounds on 1/8/16 which he could not recall the exact time, he found the patient slumped in the chair unresponsive, pulseless, not breathing and dusky in appearance. "The patient was cold, dead in the chair...no circulation for a while." MD 1 said he viewed the monitor screen mounted on the wall outside of the patient's room to confirm asystole, and expected staff to monitor for any unstable rhythm and respond. The "Death Note/Death Certificate" by physician (MD 1) dated 1/8/16 indicated Patient 1's pronouncement of death at 9:25 AM. Record review of the electrocardiogram (ECG) strip that records the electrical activity of the heart dated 1/8/16 showed Patient 1 developed asystole at 9:02 AM. The elapsed time between Patient 1's lethal asystole rhythm and the pronouncement of death was 23 minutes without an emergency response. During an interview on 2/8/16 at 4:49 PM, the Level 1 Primary RN (RN 1) assigned to care for Patient 1 stated he did not receive or hear any critical (red) alarm on his phone, and was administering medications for another patient during that time. RN 1 said he is trained to concentrate on medication administration pass in order to avoid medication errors. The P&P dated 2115, "Medication Administration," indicated on the Medical-Surgical Telemetry unit,		**Corrective Action Item #5** To reinforce information shared in the post event huddles, a course was created and deployed for telemetry and ICU nurses to be re-educated on the Cardiac Monitoring policy, with focus on the expectation to respond to alarms within standard timelines, and to assess the patient and intervene as needed. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Completed **Corrective Action Item #6** To prevent alarm fatigue revised physician order sets were implemented. A Best Practice Alert (BPA) was included in the order sets as a reminder for nurses to consult with the physician, after 24 hours of monitoring, on the need for continuous cardiac monitoring for each patient. In addition to the standard order sets, telemetry necessity is discussed regularly at the daily Hospital Based Physician Huddles and Multidisciplinary Rounds. **Responsible Party** Assistant Chief of Staff **Frequency of Monitoring** Completed	2-25-2016 01-21-2016

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	the nurse wears a sash or vest that signals no one should interrupt, except for an emergency. In an interview, on 11/12/16 at 4:20 PM, the Level 2 Alternate (RN 2) responsible for accepting and acknowledging the red alarm when the Primary RN has not responded stated she also did not receive or hear Patient 1's red alarm and was on break. Record review of RN 2's employee time card dated 1/8116 indicated her break began at 9:13 AM and on duty 11 minutes before Patient 1's asystole. On 2/18/16 at 4:12 PM, RN 2 clarified she did not have time to test the phones before distributing them to staff that day because it was busy, and did not know how to review for missed alarms on her phone. The nurse's assignment sheet dated 1/8/16 reflected 18 patients were placed on cardiac monitors, and had the potential for other patients to be affected from the failure to test the phones. The P&P dated 10/14, "'Cardiac Monitoring," indicated the following RN responsibility and procedures: a. All pagers/phone must be set to audible at all times. Never on vibrate. b. Ensure that pager/phone is correctly set-up how with assigned patients. and all required alarms (red and yellow (non-lethal) and inoperative (battery, ECG leads off, etc.) are activated. c. Test the pager/phone to assure it is in audible alert status and ensures delivery of pages within 10 seconds. Any delays or problems when performing		**Corrective Action Item #7** In 2016 the Patient Care Services Education and Simulation team updated its focus areas to increase Mock Code Blue and Rapid Response Team Training with all ICU and telemetry nurses. Drills cover a variety of skills and simulations including: • Rapid recognition of cardiac rhythm changes, cardiac arrest, or impending cardiac arrest. • Knowledge of monitoring and resuscitation equipment. • Clinical Alarm Response simulation Drills are conducted monthly with debriefing and feedback to all involved, and coaching if any skill gaps are identified. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Quarterly	03-2016 Ongoing

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	this test must be escalated up to management and clinical technology immediately. In an interview, on 1/12/16 at 11:56 AM, the Level 3 Assistant Nurse Manager (ANM) stated she received Patient 1's red alarm and waited to conclude a meeting that took 10 minutes before she left to respond. ANM said the critical alarm expectation is for the primary or break nurse to respond and we (managers) check as soon as possible about the red alarm. On 2/18/16 at 9:52 AM, ANM stated she did not hear a Code Blue announcement paged overhead on 1/8/16. The P&P dated 4/15, "Code Blue" indicated a "Code will be called by clinical staff and other staff when some or all of the following are present: Progressive or total loss of consciousness. Abnormal heart rhythm and respiratory distress which is life threatening. Absence of pulse. Telecommunications: Announce overhead "Code Blue" for adult, the room number and/or location." The pager/phone training records dated 6/27/14 for RN 2 and ANM, and dated 2/6/15 for RN 1. reflected all received in-services on how to test, identify alarms, and how to receive and view new messages. During an observation, on 2/18/16 at 2:23 PM, the Biomed engineering staff tested the central monitor located at the nurse's station and showed no malfunctioning. In an interview, on 2/19/16 at 12 PM, the Manager for the Device Integration Services (MDIS) for the		**Corrective Action Item #8** Under the oversight of the Risk Management Patient Safety committee an interdisciplinary alarm responsiveness task force (including physicians and front-line staff) was established in 2017 to develop strategies aimed at improving responsiveness to cardiac alarms and prevention of alarm fatigue. **Responsible Party** Area Quality Leader **Frequency of Monitoring** Bi-annually **Corrective Action Item #9** All telemetry and ICU nurses have validated EKG and cardiac monitoring competencies and receive unit based orientation upon hire, and have ACLS certification as a condition of employment. **Responsible Party** Chief Nurse Executive **Frequency of Monitoring** Monthly	Ongoing Ongoing

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	phone stated red alarms do not go to all three levels. MDIS stated the red alarm goes first to the Level 1 responder, and if no response in 30 seconds, it escalates to the Level 2 responder. If there is still no response in 30 seconds, it finally escalates to the Level 3 responder. MDIS stated the phone system did not malfunction for Levels 1 and 2, and the only person who accepted and acknowledged Patient 1's red alarm on 1/8/16 was Level 3 ANM. Record review of the Death/Discharge Summary dated 1/8/16 at 10:37 AM reflected Patient 1 "suddenly died from cardiopulmonary arrest." 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 1280.3(g).			