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
	050393	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIH Hospital - Downey	11500 Brookshire Ave, Downey, CA 90241-4917 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00460600 - Substantiated Representing the Department of Public Health: Surveyor ID # 33448, 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. Title 22, California Code of Regulations, section 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. Based on staff interviews and patient record review, the facility failed to develop, maintain, and implement policies and procedures consistent with the nursing process related to cardiac telemetry monitoring which had the potential to contribute to the death of Patient 1. Patient 1 was found without		Preparation and submission of this Plan of Correction does not constitute an admission or agreement by PIH Health Hospital-Downey (the "Hospital") of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Hospital is submitting this Plan of Correction as required by state and/or federal regulations. This Plan of Correction documents the actions by the Hospital to address the alleged deficiencies. The Plan of Correction constitutes credible evidence of compliance with the cited regulation. **Title 22 CCR, Section 70213 (a)** Written policies and procedures for patient care shall be developed, maintained and implemented by nursing services. **Temporary Corrections** 1. The **Handoff Communication Policy** (# AD–14) was revised to provide a clearer understanding regarding handoff responsibilities of all patient-care staff when patients are admitted or returned to the Telemetry Unit. The policy was communicated to staff and posted on the Intranet. Person(s) Responsible: Chief Nursing Officer Completion Dates: Policy approved and disseminated 2. An educational module was developed and implemented for patient-care staff regarding Person-to-Person Communication and the handoff process. All nursing staff were required to complete the new educational module. Person(s) Responsible: Chief Nursing Officer Completion Dates: Module implemented Education completed	10/08/15 10/30/15 12/31/15

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Event ID: S4SI11

Judy Pugach CNO 6/23/2016 4:14:34PM

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

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 6

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing is it determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the above findings and plans of correction 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.

7/15/16 APOC TC.

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a heartbeat while not being monitored by central telemetry (monitors and displays the electrical activity of the heart designed to alarm when an irregular heart rhythm is captured) while on the telemetry unit.

Findings:

Record review of the Face sheet (A one-page summary of important information about a patient. It includes patient identification, past medical history, insurance status, or other pertinent information) revealed Patient 1 was admitted to the facility on 9/25/15, with a diagnoses that included Pneumonia (lung infection), and Exacerbation of Congestive Heart Failure (a worsening of a condition in which the heart is no longer able to pump blood effectively throughout the body). Patient 1 had a history of chronic respiratory failure (a condition in which not enough oxygen passes from your lungs into your blood and/or your lungs cannot properly remove carbon dioxide [a waste gas] from your blood), atrial fibrillation (an irregular and often rapid heart rate that can increase your risk of stroke, heart failure, and other heart-related complications), myocardial infarction (death of all or part of the heart muscle), and pulmonary hypertension (high blood pressure in the arteries of the lungs).

Review of Physician's orders dated 9/27/15 indicated an MRI (Magnetic Resonance Imaging, a diagnostic test which uses a magnetic field and pulses of radio wave energy to provide pictures of your body) was ordered for Patient 1.

Permanent Corrections

1. A new **Transfer and Transport of Patients Policy (# PC–1)** was developed, approved and implemented. The policy addresses the transfer and transport of patients to all nursing and ancillary departments, specifically:

- Patients will be transferred and transported in a safe manner;
- All cardiac-telemetry-monitored patients that are hemodynamically stable will be transported off a monitor, unless otherwise ordered by a physician;
- All patents will be placed back on telemetry by the Registered Nurse upon arrival to the Unit, and rhythm will be reestablished to the central monitor; and
- Confirmation of establishment of rhythm at the central station will be documented by placing a rhythm strip in the medical record.

The **Transfer and Transport of Patients Policy** was developed and reviewed in partnership with Nursing Leadership and Medical Staff Leadership, specifically the Chief of Cardiology. All patient-care staff on the Telemetry Unit, both licensed and unlicensed, were educated on the policy by a mandatory computer-based training module.

Person(s) Responsible: Chief Nursing Officer; Chief of Cardiology

Completion Dates:
Policy approved 06/23/16
Staff education 06/24/16

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	On 10/6/15 at 1:30 p.m., during an interview, the Director of Quality Management (DQM) stated Patient 1 returned from MRI to her room on the telemetry unit but did not get placed back on the central telemetry monitor system where a monitor technician (person trained to recognize irregular heart rhythms) watches all the telemetry monitors for the unit. The DQM stated the monitor technician was never informed the patient had returned to the floor and on 9/28/15 at 11:25 a.m., Patient 1 was found asystole (without a heartbeat) in her room. On 10/6/15 at 1:50 p.m. during an interview, the Nurse Manager (NM 1) stated the Nursing Assistant (NA 1) who assisted Transporter 1 (transports patients by assisting and/or lifting them on and off beds, moving them to and from special service and treatment areas using wheelchairs or moveable beds) in returning Patient 1 to her room, did not inform the monitor technician the patient was back so that she could be reconnected to the central telemetry monitor. She stated it was the responsibility of the person who placed the telemetry leads (electrodes pick up electrical currents of the heart and are placed on the chest of a patient) on the patient to notify the monitor technician the patient was back so they can recapture their telemetry monitoring. On 10/6/15 at 2:50 p.m. during an interview, Registered Nurse (RN) 1 stated that Patient 1 had a previous rapid response (emergency situation) so she was aware that the patient needed to be watched closely. RN 1 stated she noticed Patient 1		2. A new **<u>Cardiac Telemetry: Notification and Documentation of Rhythm Strips Policy (# PC–2)</u>** was developed as a guideline for ensuring safe nursing care for patients on continuous cardiac monitoring. The policy addresses requirements for documentation of rhythm strips for patients who are admitted to the Unit, and/or have been transferred from the Unit, subsequently returned, and require the reestablishment of telemetry at the central nursing station. The policy establishes that the RN will contact the monitor technician when the following occurs: • Admission of new patient; • Discharge of patient; • Patient removed from Telemetry Unit for patient care or procedural reasons; • Return to the Unit from another patient care area; or • Change in patient's code status. The **<u>Cardiac Telemetry: Notification and Documentation of Rhythm Strips Policy</u>** was developed and reviewed in partnership with Nursing Leadership and Medical Staff Leadership, specifically the Chief of Cardiology. The staff of the Cardiac Telemetry Unit, both licensed and unlicensed, were educated on the policy by a mandatory computer-based training module. <u>Person(s) Responsible</u>: Chief Nursing Officer; Chief of Cardiology <u>Completion Dates</u>: Policy approved Staff education	 06/23/16 06/24/16

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had returned to her room at approximately 10:30 a.m., noting she had her telemetry leads on but did not notice if the patient was being captured by the central telemetry monitor. RN 1 left for a break at approximately 11:00 a.m. after endorsing Patient 1 to another nurse.

A policy for placing telemetry patients on the central monitor was requested and the facility was unable to provide one.

On 10/21/15 at 1:30 p.m., during an interview, Transporter 1 stated he brought Patient 1 back to the telemetry unit on 9/28/15 at approximately 9:45 a.m. He stated he dropped off her chart at the nurse's station and announced, "Bed 22 is back" but did not know if anyone heard him. He stated this was his normal routine. He stated he assisted the Nursing Assistant (NA 1) place the telemetry leads on the patient before leaving the room.

On 10/22/15 at 2:30 p.m., during an interview, RN 2 stated she assumed care of Patient 1 when RN 1 left for break at approximately 11 a.m., and RN 1 gave her a brief report of Patient 1. RN 2 stated she saw Patient **1** sitting in the recliner chair in her room but did not notice the patient was not being centrally monitored. RN2 stated any patient in their rooms should be captured on the central telemetry monitor. RN 2 stated the person that places the leads on the patient tells the monitor technician so the patient is captured on the central telemetry monitor.

On 10/22/15, and again on 11/4/15, the Root Cause

3. Per the **American Heart Association Scientific Statement For Practice Standards For Electrocardiographic Monitoring In Hospital Settings**, the Hospital has established protocols to govern the roles and responsibilities at all staff levels regarding cardiac monitoring. The **Scope of Service for the Cardiac Telemetry Unit** was reviewed and revised to ensure that is consistent with the American Heart Association Practice Standards.

The Scope of Service for the Cardiac Telemetry Unit was reviewed and revised in partnership with Nursing Leadership and Medical Staff Leadership, specifically, the Chief of Cardiology. The staff of the Cardiac Telemetry Unit, including licensed and unlicensed staff, were educated on the revised Scope of Service in multiple staff meetings, and staff acknowledgment of revised Scope of Service is reflected by signatures on file.

Further, the Scope of Service for the Cardiac Telemetry Unit is required to be reviewed and acknowledged by all new employees as a component of new employee department level orientation. The Scope of Service was presented at the Department of Medicine Medical Policy Committee, the Quality Management Systems Committee, and the Medical Executive Committee. In addition, the document was presented to the Board of Directors as part of its oversight responsibilities.

Person(s) Responsible: Chief Nursing Officer; Chief of Cardiology; Department Clinical Directors; and Education Department.

Completion Dates:
Revised Scope of Service approved 06/23/16
Staff education 06/24/16

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	Analysis was requested from the DQM and was informed it was not yet complete. On 10/28/15 at 8:30 a.m., during an interview, NA 1 stated he assisted Transporter 1 place Patient 1 in her recliner chair and put the telemetry leads on. NA 1 stated the Transporter tells the nurses station the patient has returned when he drops off the chart and they make sure the patient is captured by the central telemetry monitor, he does not tell the monitor technician. On 10/28/15 at 9:05 a.m., during an interview, RN 2 stated she found Patient 1 on 9/28/15 without a heartbeat in her room without any alarms sounding at approximately 11:25 a.m. and called the code (emergency), called for help, and began Cardiopulmonary Resuscitation (potentially lifesaving technique in an effort to preserve life). Review of the Physician "Discharge Summary" dated 2/16/16 indicated Patient 1 was intubated (a plastic tube placed down the throat to allow a machine to breathe for someone who isn't breathing on their own) on 9/28/15, and transferred to the intensive care unit. On 10/2/15 a family meeting with the medical staff concluded to withdraw care due to Patient I's poor condition and prognosis, Patient 1 expired in the intensive care unit on 10/4/15 at 1:55 p.m. Review of the Medical Doctor "Critical Care Progress Note" dated 9/28/15 12:01 p.m., indicated, "...This am recently returned from MRI and found slumped over in chair (not on monitor)..."		Monitoring: 1. Monitoring of the Transfer and Transport of Patients Policy and the Cardiac Telemetry: Notification and Documentation of Rhythm Strips Policy will take place via monthly audits, consisting of a review of the charts of 30% of those patients who have been transferred from, and subsequently returned to, the Telemetry Unit. The randomly selected medical records will be reviewed, to determine whether a telemetry strip was printed and placed in the record upon the patient's return to the Unit. The monthly audits will continue until there is 100% compliance for 3 consecutive months. The audit data will be presented and reviewed at the following meetings: • Department of Medicine Medical Policy Committee (monthly); • Quality Management Systems Committee (quarterly); • Medical Executive Committee (monthly); and • Board of Directors (quarterly as part of Quality Assurance program). 2. Monitoring of the Scope of Service for the Cardiac Telemetry Unit will take place via quarterly audits of new employee files conducted by the Department Clinical Directors in partnership with the Director of Human Resources. The audit data will be presented and reviewed at the following meetings: • Quality Management Systems Committee (quarterly); and • Board of Directors (quarterly as part of Quality Assurance program).	

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	Review of Cardiology "Physician Progress Notes" dated 9/28/15 at 2000 (8 p.m.) indicated, "...SIP [status post] cardiopulmonary arrest [the heart stops beating] unwitnessed & off monitor..." Review of the American Heart Association (AHA) Scientific Statement, "Practice Standards for Electrocardiographic Monitoring in Hospital Settings," dated June 2004 indicated, "...the AHA advocates that each facility establish protocols to govern the roles and responsibilities at all staff levels regarding cardiac monitoring...". The facility's failure: 1) to develop, implement, and maintain a policy for placing telemetry patients on the central monitor, and related failure: 2) to ensure Patient 1 was reconnected to the central telemetry monitor after being transported off the unit to have an MRI performed, coded on the unit, and subsequently, having all care withdrawn by Patient I's family, 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 Health and Safety Code section 1280.1 (c). 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).		INTENTIONALLY BLANK	