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
	050230	A. BUILDING _____ B. WING _____	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Grove Hospital and Medical Center	12601 Garden Grove Blvd, Garden Grove, CA 92843-1908 ORANGE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00392062 - Substantiated Representing the Department of Public Health: Surveyor ID # 26756, 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. Health and Safety Code 1279.1(b) For purposes of this section, "adverse event" includes the following: (4) Care management events, including the following: (c) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy. Health and Safety Code Section 1279.1 (c): The facility shall inform the patient or the party responsible for the patient of the adverse event by			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 10/14/2016

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 23

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.

10/18/16 POC accepted Surveyor 2097

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	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. Deficiencies Constituting Immediate Jeopardy: Title 22, Division 5, Chapter 1, Article 3 §70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy. Title 22, Division 5, Chapter 1, Article 3 §70215 (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professional Code, section 2725(b)(4). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (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		T22 DIV 5 CH1, ART s70215 (a) (b) I. Policy and procedure on ICU Assessments/Reassessments was reviewed and revised to include: • Focused assessment every 2 hours or more often if any signs of deteriorating change. • Blood Pressure, Pulse, • Respiration Rate and Pulse Oximetry every hour and more often is any deteriorating change. • Continuous cardiac monitoring with strips documented every 4 hours. • Intake and Output hourly. Data demonstrating changes in patient assessment related to declining condition will warrant MD notification and interventions. • Assessments of patients that have obstetrics needs will have a nurse consult by L&D or MBU for monitoring of Obstetric issues – o Fetal heart tones as applicable every shift unless otherwise ordered. o Uterine assessment post-delivery every 15 minutes for the 1st hour then ½ hour for the next hour then every 4 hours, or more often as nurse consults will be initiated by Charge	7/3/14

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	validated competency, and/or regulation. (3) The assessment, planning, implementation, and evaluation of patient education, including ongoing discharge teaching of each patient. Any assignment of specific patient education tasks to patient care personnel shall be made by the registered nurse responsible for the patient. (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. (c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's family, or other representatives, when appropriate, and staff of other disciplines involved in the care of the patient. California Business and Professional Code Section 2725 (b)(4)- observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation of appropriate reporting, referral, changes in treatment regimen are done in accordance with standardized procedures, or the initiation of emergency procedures. Title 22, Division 5, Chapter 1, Article 3 §70243 (f) The director of the clinical laboratory shall assure that: (5) A communications system to provide efficient		Nurse and documentation of assessment and interventions will be completed. • Critical Care RNs will monitor and assess their patients and notify the attending physician when changes occur. To provide criteria for the RN to use to determine when to call the physician regarding changes in the patient's condition. Critical Care RN's will monitor and assess their patients and notify the attending physician when changes occur. To provide criteria for the RN to use to determine when to call the physician regarding changes in the patient's condition. The physician will be immediately notified for the following: 1. Pulmonary 1.1 Worsening arterial blood gases 1.2 Dyspnea 1.3 Increase wheezing 1.4 Excessive bleeding around a tracheotomy stoma 1.5 Mechanically ventilated patients experiencing increasing peak pressures 1.6 Unequal breath sounds	7/3/14

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	information exchange between the laboratory and related areas of the hospital is established. Title 22, Division 5, Chapter 1, Article 3 §70263 (g)(2) Medications and treatments shall be administered as ordered. Title 22, Division 5, Chapter 1, Article 6 §70493 (a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professional and administration. Policies shall be approved by the governing body. Procedures shall include, but not limited to: (1) Admission, discharge, and transfer policies, (2) Staffing requirements, (3) Routine procedures, (4) Emergency procedures. Title 22, Division 5, Chapter 1, Article 6 §70495 (a) A physician with training in critical care medicine shall have overall responsibility for the intensive care service. The physician or his designated alternate shall be responsible for: (1) Implementation of established policies and procedures. (4) Assuring there is continuing education for the medical staff and nursing personnel. (b) A registered nurse with training and experience in intensive care nursing shall be responsible for the nursing care and nursing management of the intensive care unit when a patient is present. Based on interview and record review, the hospital failed to provide medical care to the patient as per		1.7 New onset of subcutaneous Emphysema 1.8 Refractory hypoxemia 2. Cardiac 2.1 Ventricular tachycardia 2.2 Ventricular fibrillation 2.3 Symptomatic bradycardia 2.4 2nd and 3rd degree heart block 2.5 Superventribular tachycardia 2.6 New onset of atrial fibrillation, Flutter or widening or QRS 2.7 New onset of chest pain or chest pain refractory to physician's orders 3. Vital Signs/Hemodynamci Monitoring: 3.1 Heart rate <50 or >120 3.2 SBP <90 OR >180mmHg (CABG Patient <100 or >150mmHg) 3.3 Urine output <30cc/hr x 2 hrs. 3.4 Right arterial pressure <5 or >15mmHg 3.5 Cardiac index <2L/min/m2 3.6 Oral temperature >101.5F 4. Post Surgical 4.1 More than 100cc per hour chest tube drainage 4.2 Any sudden cessation of chest tube drainage with an increasing CVP and PCWP with a decreasing blood pressure (Suspect tamponade)	7/3/14

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	the hospital's policies and procedures (P&Ps) and hospital licensing standards, including but not limited to: * The RNs caring for Patient 1 in the ICU (Intensive Care Unit, a special unit in the hospital to provide intensive care medicine) failed to monitor the patient's vital signs every 15 minutes as per the hospital's P&P related to addressing a patient with a severe postpartum hemorrhage, failed to monitor the patient's urine output hourly, and failed to notify the physician of Patient 1's deteriorating physical condition after Patient 1's arrival to the ICU with severe postpartum bleeding. The appropriate interventions were not provided to Patient 1 as per hospital's P&P and physician's orders in response to a decrease in blood pressure, pale and cold skin, and continued vaginal bleeding. * The nursing staff failed to ensure the physician's orders for laboratory tests were carried out in a timely manner to measure the patient's response to continued blood loss after the transfer to the ICU. In addition, the nursing staff failed to advocate for the patient to obtain the laboratory tests and failed to report the delay in obtaining the laboratory tests to the physician. This resulted in a delay in treatment for Patient 1. * The ICU's Charge Nurse failed to advocate for Patient 1, assuming the responsibility and leadership to ensure the nursing care was carried out in accordance with the hospital's standards and physician's orders and failed to contact an immediate Supervisor to alert of the potential or		4.3 Low HGB and Hct 4.4 Surgical dressing saturated with blood 4.5 Excessive hemovac or JP drainage 4.6 Severe pain refractory to Analgesic medications 5. Neurological 5.1 Acute metal status change / or neurological changes 5.2 Aphasia 5.3 Seizures 5.4 Motor Weakness 5.5 Dysphagia 5.6 Increased intra-cranial Pressure 6. Peripheral Vascular 6.1 Absence of pulses 6.2 Extremity becomes cool/cyanotic 6.3 Numbness and tingling in extremity 7. Gastrointestinal 7.1 Hematemesia 7.2 Melanotic stool 7.3 Excessiv diarrhea 7.4 Nausea and vomiting 7.5 refractory to anti-emetics 8. Ingegumentary 8.1 new rash 8.2 Petechiae 8.3 State II or IV dermal ulcer 8.4 Extravasation of Dopamine	

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	actual patient safety issue. * The hospital failed to ensure the ICU RNs obtained and administered blood products in a timely manner and failed to ensure the nursing staff informed the physician of a delay in administering blood products. * The hospital failed to ensure the ICU RNs received training in caring for an obstetrical patient in the ICU with a severe postpartum hemorrhage, including the hospital's P&P titled "Hemorrhage Obstetric Massive." Blood products were not administered to Patient 1 by the nursing staff as ordered by the physician or as per the hospital's P&P titled "Hemorrhage Obstetric Massive" and P&P titled "Blood/Blood Product Identification, Administration and Transfusion Reaction" to address the significant persistent hemorrhage. * The hospital failed to develop a specific P&P to address the care of a patient with a tamponade balloon catheter (a catheter placed inside the patient's uterine cavity used to control bleeding) to provide the nursing staff with the information and guidance for the safe use and care of the device. The cumulative effect of these systemic failures and deficient practices resulted in the hospital's failure to provide the appropriate interventions for Patient 1 to prevent and treat a severe persistent postpartum hemorrhage following a cesarean section (a surgical procedure used to deliver a baby through an incision in the mother's abdomen and a second incision in the mother's uterus). A Code Blue (a		9. Laboratory Critical Values 9.1 Read back values to Clinical Laboratory Scientist from whom call received, as described in Critical Values Policy 9.2 Identify critical laboratory values that need to be called to the physician. 10. Miscellaneous 10.1 Central IV line clotted while patient Is on TPN 10.2 Suspected transfusion reaction. 11. In case of the inability to reach the consulting physician, call the attending physician. 12. Inability to reach the attending or consulting physician must be reported to the Nursing Supervisor. The Nursing Supervisor will initiate the Chain of Command. 13. The nursing record will reflect all changes in patient status as well as physician notification. Physician response to notification should also be documented. Policy changes were passed through Multidisciplinary/Policy Committee on 6/24/14 and went to MEC on July 1, 2014.	7/3/14

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	hospital code used to indicate when a patient requires immediate resuscitation) was initiated on 3/10/14 at 0315 hours, three hours after Patient 1's transfer to the ICU (five hours after the cesarean section). As a result, Patient 1 died from a cardiopulmonary arrest on 3/14/14 at 2316 hours (four days after the cesarean section). The patient's severe postpartum hemorrhage led to DIC, and ultimately, caused fatal cardiopulmonary arrest. (DIC is disseminated intravascular coagulation, a life-threatening condition that prevents a person's blood from clotting normally. DIC may cause excessive clotting (thrombosis) or bleeding (hemorrhage) throughout the body and lead to shock, organ failure, and death.) These failures in combination delayed potential life saving measures to Patient 1 and caused her death. Findings: Review of the hospital's P&P titled "Assessment/Reassessment of Patients" (reviewed date 11/12) showed all patients who receive care are assessed by an RN to determine changing needs and effectiveness of care/intervention. All assessment data are utilized to determine and prioritize the care needs. Additional reassessments are done and documented if there is a significant change in the patient's condition, a change in the level of care, an untoward (unexpected adverse) event that places the patient at risk for an adverse		Education to ICU Staff of MD Notification ,Assessment/Reassessment and nurse consult will be completed on July 3, 2014. Education to OB Staff regarding nurse consult expectations/role will be completed by July 3, 2014 Any OB case in ICU will be monitored for nurse consulting for specialized data collection. ICU patient chart reviews will occur to monitor timeframes, for assessment/ reassessment. Monitoring will be report to: 1. Patient Safety 2. Performance Improvement 3. Governing Board Responsible Party/Parties: o Director of ICU o Director of OB T 22 DIV 5 CH1 ART S 70213(a) 2. A. Physician order policy Reviewed and will re-educate all licensed nursing on the policy including orders to discontinue or edit previous orders. To ensure complete	7/3/14

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	outcome, no response to treatment, and/or abnormal findings different from previous assessment. Review of the hospital's P&P titled "Hemorrhage Obstetric and Procedures" (reviewed date 5/13) showed it is important to stop and reassess the patient's estimated blood loss (EBL) and vital signs. If an EBL is over 1500 ml, coagulopathy (condition in which the blood's ability to coagulate becomes impaired) is suspected or vital signs are abnormal, the patient care guidelines should move to Stage 3 of the policy: "Significant Persistent Maternal Hemorrhage." - Stage 3: Modified Postpartum Care indicates the patient should be transferred to the ICU with management by an MD. A minimum set of vital signs should be taken at every 15 minutes for six (6) hours, then every 30 minutes for 18 hours, with continuous monitoring of the patient's oxygen saturation (concentration of oxygen in the blood, measures the percentage of hemoglobin binding sites in the bloodstream occupied by oxygen). A complete blood count (CBC) and a DIC panel are recommended at 1, 2, 4, and 6 hours. If the CBC and DIC panel are stable for three readings, may stop and recheck the labs at 24 hours (stable is defined as: Hematocrit (Hct) (a blood test to indicate the proportion of red blood cells in the blood) equal to or above 24 %, International Normalized Ratio (INR, an indicator of the blood's ability to clot) less than 1.4, and platelets (assist in clotting) over 50,000).		documentation of cancellation order, the electronic order system has been modified to include specific rationale of order changes as of 6/25/14. Education of all licensed nursing staff was completed 7/3/14. Monitoring will include house-wide review of telephone order for MD Order Management and will be reported to Patient Safety, Performance Improvement and Governing Board. Responsible Party: o Performance Improvement o Director of Nursing o Nursing Directors 3. The ICU Charge Nurse failed to follow Policy and Procedure on Critical Value Notification, suspension and final written warning was completed June 30, 2014. Monitoring of Charge Performance will be reviewed by ICU Director concurrent and ongoing. Critical result management will be monitored	

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	- An indwelling urinary catheter is in place and urine output monitored hourly for 24 hours. - If six (6) units of Packed Red Blood Cells and four (4) units of fresh frozen plasma were used and there is ongoing bleeding, consider increasing the ratio of packed red blood cells to fresh frozen plasma to 1:1. Fresh frozen plasma should be given to maintain the INR at less than 1.5. Review of the hospital's P&P titled "Chain of Command, Physician Response to Patient" needs (revised 8/11) showed in situations requiring acute medical care and the presence of a physician, it is the responsibility of the RN caring for the patient to contact the physician immediately and report the condition of the patient. Review of the hospital's P&P titled "Blood/Blood Product Identification, Administration and Transfusion Reaction" (approved 1/12) showed an RN or IV Certified LVN takes a copy of the physician's order for transfusion and a copy of the Blood Product Order Form to the lab for pick-up of the blood product. After the nurse and lab staff verifies that all identification is correct, the nurse takes blood bag to the nursing unit for transfusion to the patient. On 6/4/14, Patient 1's medical record was reviewed. Documentation showed Patient 1 arrived at the hospital on 3/9/14. The patient was alert, oriented, and in no acute distress, with no known health risks. Patient 1 was admitted in labor and was prepared for a repeat cesarean section.		monthly and reported to Patient Safety, Performance Improvement and Governing Board. Responsible Party/Parties: o Performance Improvement o Director of Nursing o Nursing Directors 4. New policy on Massive Transfusion Was developed including hypotension treatment, lab guides component replacement, possible use of multi unit infusion simultaneously. Policy was passed through MDY 6/24/14. Education of licensed nursing in ICU,OB, L&D will be provided by 7/3/14. (6/27/14 – 1st classes held with make-up class before 7/3/14 with 95% attendance.) Monitoring cases where 8-10 or greater units of RBC within 24 hours will be reported to Risk Management by Blood Bank for review. Results of monitoring will be reported to Patient Safety, Performance Improvement and Governing Board.	

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	Review of the Operative/Procedure Report dated 3/9/14, showed the cesarean section surgery progressed as planned and an infant was delivered at 2219 hours. The placenta was removed manually; there was no bleeding inside the abdomen and the abdomen was closed. Review of the physician's Progress Notes dated 3/9/14 at 2300 hours, showed MD 1 documented Patient 1 had postpartum bleeding. At this time MD 1 documented Patient 1's family member wanted the physician to try to save the patient's uterus in order for her to have more babies. Review of the Surgical Case Record dated 3/10/14 at 0203 hours, showed a late entry by RN 1 (nurse caring for Patient 1 during the surgery) for events which occurred on 3/9/14 at 2300 hours (while the patient was still in the operating room). RN 1 documented Patient 1's uterine fundus (top portion of the uterus) was palpated (nurse places two hands on the abdomen to determine the location and firmness of the uterus) at below the naval (normal position immediately after delivery) with massage (stimulation of the uterine muscle to contract to a normal position after delivery). RN 1 notified MD 1 of the patient's "heavy bleeding" (vaginal discharge). At 2305 hours, RN 1 again palpated the patient's uterine fundus and notified MD 1 of a "large amount of blood clots." At 2318 hours, RN 1 notified MD 1 that the patient's uterine fundus felt boggy (not firm due to absence or lack of muscle tone) and the patient was still bleeding with a moderate amount of blood clots. MD 1 gave		Responsible Party/Parties: o Blood Bank Supervisor o Laboratory Director 5. The ICU Charge Nurse failed to follow policy on Chain of Command and failed to demonstrate leadership role,final written warning was completed on June 27, 2014. ICU Charge Nurse signed-up and attended Charge Nurse Development Class on June 30, 2014. Charge Nurse Education Meeting for Charge and relief Charge Nurses was held on 6/30/2014. To include but no limited to o Patient Safety o Review of all policy/ procedure changes o Review of job descriptions and expectations o Chain of Command o Speak-Up for Patient (patient advocacy) o Leadership skills	

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	the orders to administer four units of packed red blood cells (PRBCs). Review of the Blood Bank Transfusion Records showed the four units of PRBCs were infused beginning at 2253 hours on 3/9/14, and finished at 0015 hours on 3/10/14. Patient 1 was moved from the operating room (OR) to the ICU at 0030 hours due to the patient's continued bleeding and the need for close observation. Review of the physician's Discharge Summary dated 3/14/14, showed during Patient 1's cesarean section, the patient had a "gush of blood" vaginally following uterine massage, and the patient had postpartum bleeding. MD 1 documented he attempted to stop the uterine bleeding by placing a Bakri Balloon (a tube with a balloon, also called a balloon tamponade catheter, inserted vaginally to provide pressure for temporary reduction of postpartum uterine bleeding). The patient was transferred to the ICU for monitoring and continued care. Review of the manufacturer's recommendations for the Balloon Tamponade Catheter showed under the section for "warnings", the application of this device should be concomitant with close monitoring for signs of worsening bleeding and/or DIC. Deteriorating or non-improving conditions may indicate the need for more aggressive treatment and/or management of uterine bleeding. Review of the Anesthesia Record dated 3/9/14, showed Patient 1 sustained a 1500 ml blood loss		o Charge Nurse documentation o Expectation of staff skills and MD notification o Nurse Consults expectations o MD notification Monitoring of Charge Nurses performance will be ongoing of expected goals and objectives as above. Responsible Party/Parties: o Director of Nursing o Nursing Directors 6. New policy on Balloon Tamponade Uterine Catheter was developed and passed through Multidisciplinary Policy Committee on June 24, 2014. Policy will include, but not limited to: a) Guidance and use of catheter, and b) Patient monitoring c) Collection Connection Education for ICU, OB and L&D Nurses was initiated with a competency on 6/25/14 with 95% attendance. Make-up class was completed before 7/3/14.	

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	over approximately a one and a half hour time frame and continued to bleed. During the time Patient 1 was in the OR, her blood pressure ranged from a baseline of 110/60 mmHg on arrival to the OR to 85/53 mmHg just prior to the transfer to the ICU (normal BP range is 100 to 140 mmHg over 60 to 90 mmHg) after receiving four units of PRBCs. Review of Patient 1's nursing documentation dated 3/10/14 at 0030 hours, showed on arrival to the ICU, Patient 1 was lethargic with an elevated heart rate of 145 beats per minute (normal heart rate: 60-100), blood pressure of 98/45 mmHg, abdomen round and distended, and a dry and intact abdominal dressing. The vaginal balloon inserted to slow the bleeding was dislodged with "a lot of dark, red bloody drainage." MD 1 replaced the balloon. Review of Patient 1's ICU Blood Pressure History form dated 3/10/14 from 0020 to 0700 hours, showed a complete set of vital signs was obtained every 30 minutes, not every 15 minutes as per the hospital's P&P. The following was documented by RN 2: - At 0130 hours, Patient 1's BP was 93/50 mmHg. - At 0200 hours, Patient 1's BP was 75/52 mmHg, heart rate 152 beats per minute, and respiratory rate was 32 respirations (normal respiratory rate: 12-20). - At 0230 hours, Patient 1's BP was 83/24 mmHg, heart rate 148 beats per minute, and a respiratory rate was 32 respirations. There was no record of a body temperature.		Monitoring of class attendance and competency will be completed. Responsible Party/Parties: o Director of OB o Director of ICU 7. Policy and Procedure on Obstetric Hemorrhage Massive was reviewed and expanded to ICU a New Post-Partum Hemorrhage Management policy. Policy includes: o Nursing Care o Patient Intervention o Nurse Consult Policy was passed through MDY on 6/24/14. Education of ICU-Post-Partum Hemorrhage was initiated 6/25/14 with 95% ICU attendance and make-up by 7/3/14. Monitoring of policy compliance will be done on cases as they arise due to low volume. Responsible Party/Parties: o Director of OB o Director of ICU	

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	There was no documentation to show the physician was notified of Patient 1's decrease in BP at 0200 hours, or the patient's persistent elevated heart rate and respiratory rate. According to Mosby's Manual of Clinical Nursing Sixth Edition, hypovolemic shock is the syndrome characterized by decrease of the blood flow of body tissues that result in a lack of oxygen to cells, caused by severe blood loss. Some symptoms include: hypotension (low blood pressure), rapid weak pulse, shallow breathing, and cold, clammy skin and decreased urine output. At some point in the progress of untreated shock, the process becomes irreversible and results in death. Review of Patient 1's Intake and Output records in the ICU dated from 3/10/14 at 0030 hours to 3/10/14 at 0600 hours, showed RN 2 documented the patient received 2520 ml of blood products with an additional 220 ml of 'other" for a total intake of 2740 ml. However, in that time period, the patient's urinary output was only 100 ml with an additional 500 ml documented as "drainage." No specific description was documented to show if the drainage was from the abdominal surgical incision or was vaginal blood loss. There was no documentation to show RN 2 monitored Patient 1's urinary output hourly. The total volume of urine output over 5.5 hours was approximately 18 ml/hour (a sign of decreased			

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	blood volume is urinary output less than 30 ml/hour). Patient 1 had a positive fluid balance (intake greater than output) of 2140 ml. There was no documentation to show the physician was notified of the decreased urine output. During an interview with the Director of Maternal Child Health Services on 6/11/14 at 1400 hours, the Director was asked if while in the ICU, Patient 1 was also assessed by an obstetric nurse, and if not, whether the ICU nurses had competencies to care for a patient with a postpartum hemorrhage. The Director stated no obstetrical nurse assessed Patient 1 while in the ICU. The Director stated the hospital had not provided any specific training to the ICU nurses to care for patients with a postpartum hemorrhage or to care for the tamponade balloon catheter. When asked to provide for review a P&P for the care of a patient with a tamponade balloon catheter, the Director stated no P&P was developed by the hospital. Review of RN 2's personnel record showed a completed ICU list of competencies; however, there was no specific competency for care of obstetric patients. During an interview with the Director of Nursing (DON) on 6/11/14 at 1500 hours, she stated the ICU nurses could consult with the hospital's obstetric nurses, and an obstetric nurse could go to the ICU to assess the patient if needed. However, further review of the hospital's P&P titled Assessment/Reassessment of Patients failed to show guidance for coordination of care between ICU			

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	and Maternal Child Health Services. Review of the Charge Nurse Job Description showed the nurse performs direct patient care within the scope of practice. The Charge Nurse monitors the patient's status, interprets the results, communicates to the physician any abnormal results, and assumes leadership and responsibility, assuring the nursing care is carried out in accordance with departmental standards and physician orders. RN 3, the ICU Charge Nurse was interviewed on 6/11/14 at 1500 hours. When asked how the ICU nurses monitored Patient 1's vaginal blood loss, RN 3 stated when Patient 1 was admitted to the ICU, the patient's vaginal blood loss was continuous and the patient's blood pressure was decreasing. RN 3 stated the vital signs were obtained for critical patients in the ICU every two hours; the assessments were completed by the RN at the beginning of the shift and every 4 hours, with a focused reassessment every two hours. RN 3 confirmed if there was a change in the patient's condition, the nurse was required to contact the physician. RN 3 stated a patient's blood loss should be monitored hourly. When asked if MD 1 was notified of Patient 1's abnormal vital signs prior to the Code Blue at 0315 hours on 3/10/14, RN 3 stated she discussed Patient 1's vital signs with RN 2 (ICU primary nurse); however, RN 2 did not ask her to call the physician. RN 3 stated MD 1 came to the hospital when notified of the Code Blue. RN 3			

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	stated she had no further communication with MD 1 that night. When asked, RN 3 stated she did not contact her immediate supervisor to alert of a potential or actual patient safety issue for Patient 1. Review of a physician's order for Patient 1 from MD 1 after arrival in the ICU dated 3/10/14 at 0047 hours, showed STAT (immediate response) orders for CBC (a blood test that measures several components and features of blood including red blood cells to diagnose anemia and infection), Comprehensive Metabolic Panel (a blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function), Prothrombin (PT, a blood test measures the time for the blood to clot) with INR, and a routine Partial Thromboplastin Time (PTT, a coagulation test). Review of Patient 1's laboratory results dated 3/10/14, did not show the STAT CBC and Partial Thromboplastin tests were performed as ordered. Review of the Order Audit Trail form dated 3/10/14 at 0215 hours, showed RN 3 cancelled MD 1's STAT physician's order; however, there was no accompanying physician's order to show an order from MD 1 to discontinue the STAT laboratory tests. Review of the nursing documentation completed by RN 2 dated 3/10/14 at 0030 hours, (recorded in the electronic record at 0852 hours, eight hours after the occurrence) showed MD 1 gave the orders to transfuse 10 units of PRBCs. RN 2 documented MD 4 (ICU physician) was consulted and gave an order to draw the STAT laboratory tests after four units of PRBCs were transfused.			

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	However, review of the physician's orders dated 3/10/14 at 0140 hours, showed an order from MD 1 to transfuse 8 units of PRBCs, not 10 units as documented by RN 2 and there was no order from MD 4 to draw the STAT laboratory tests after four units of PRBCs were transfused. Review of the Blood Bank Transfusion Records showed the four units of PRBCs ordered prior to the patient's transfer to ICU were infused beginning at 2253 hours on 3/9/14, and finished at 0015 hours on 3/10/14. Patient 1 did not receive additional PRBCs in the ICU until after the Code Blue at 0315 hours. Further review of Patient 1's physician's orders showed another order dated 3/10/14 at 0215 hours, from MD 1 for a STAT CBC, PT with INR, and routine PTT tests. Review of the Laboratory Report dated 3/10/14, showed the CBC test was not collected until 0305 hours (50 minutes later). At 0320 hours, (five minutes after Patient 1 coded in the ICU), the patient's critically low values were reported to RN 2 as a hematocrit at 13.6% (normal hematocrit range: 36 to 48) and hemoglobin 4.5 g/dL (normal hemoglobin range: 12 to 16). There was no documentation to show the PT with INR and routine PTT tests were drawn until 0440 hours, two and a half hours after reorder. Review of a Laboratory Report dated 3/10/14, showed high PT values of 19.7 seconds (normal range: 9.5-11.1 seconds) and an INR of 1.8 (normal range: 0.8-1.2),			

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	indicating the patient's blood was not clotting normally, were called to the ICU at 0525 hours. During a concurrent interview and review of Patient 1's medical record with MD 1 on 6/18/14 at 1400 hours, MD 1 confirmed he was not contacted to cancel the order for the STAT laboratory tests ordered on 3/10/14 at 0047 hours, and did not speak with RN 3 to reorder the laboratory tests at 0215 hours. When asked, MD 1 confirmed he was not notified of Patient 1's change in condition in the ICU, of the patient's low BP and low urine output prior to the Code Blue. MD 1 stated he left the hospital on 3/10/14 by 0130 hours, and was not called regarding Patient 1 until around 0315 hours when notified of Patient 1's Code Blue. Review of the Nursing Documentation completed by RN 2 dated 3/10/14 at 0315 hours (recorded in the electronic record at 0858 hours, five and a half hours after the occurrence) showed Patient 1's oxygen saturation decreased (low blood oxygen concentration) to 85% (normal: 90%) and the patient's heart beat decreased to a rate of 65 beats per minute (bpm) (normal heart range: 60-100 bpm). A Code Blue was called. The Emergency Department Physician responded to the Code Blue and the medication was administered to increase the patient's heart rate. Cardiopulmonary Resuscitation (CPR, an emergency procedure) was started and a breathing tube was inserted to assist Patient 1's breathing.			

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	RN 2 documented a central IV (intravenous line) was inserted because the peripheral IV access was difficult due to the patient's dehydration. Two units of PRBCs were given. Review of Patient 1's medical record did not show any nursing narrative notes were documented on 3/10/14 between 0030 and 0315 hours. There was no documentation found to show MD 1 or MD 4 was notified of Patient 1's decline in condition, or any communication between the nursing staff and physicians. Review of Patient 1's laboratory results for INR, an indicator of the blood's ability to form clots (increased INR levels indicates patient at risk for bleeding) showed the level was 1.1 (normal 0.8-1.2) on 3/9/14 at 2330 hours, prior to the transfer to the ICU. After the patient's Code Blue, the INR was reported as 1.8 (high) at 0440 hours, and at 0650 hours, the INR was reported as over 9.0 (critically high indicating the patient's blood was "thin" with a critical decrease in its ability to clot). The U.S. National Library of Medicine and National Institutes of Health describe fresh frozen plasma "as the fluid portion of one unit of human blood that has been centrifuged, separated, and frozen solid within 6 hours of collection". Review of the physician's orders showed the orders were written to transfuse Patient 1 with a total of 15 units of fresh frozen plasma between 3/9/14 at 2330 hours and 3/10/14 at 0537 hours.			

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	- On 3/9/14 at 2330 hours, the physician ordered to transfuse two units of fresh frozen plasma. Review of the Blood Bank record dated 3/10/14, showed Patient 1 received the first of the two units of fresh frozen plasma in the ICU at 0100 hours and the second unit at 0120 hours. - On 3/9/14 at 2345 hours, the physician ordered to transfuse two additional units of fresh frozen plasma. On 3/10/14 at 0051, 0136, and 0537 hours, the physician ordered to transfuse an additional 11 units of fresh frozen plasma. However, review of the Blood Bank record dated 3/10/14, showed no additional fresh frozen plasma was administered to Patient 1 in the ICU after 0120 hours, until 0650 hours (approximately seven hours after the order was received). No additional documentation was found in Patient 1's medical record to show the patient received the fresh frozen plasma as ordered by the physician or to show the nursing staff informed the physician of a delay in obtaining the fresh frozen plasma. Review of Patient 1's medical record showed the nursing documentation identified as an addendum to the nursing note to the electronic record dated 3/14/14, (four days after the occurrence) by RN 2 for an occurrence on 3/10/14 at 0730 hours. RN 2 documented at that time, a blood transfusion (the eighth unit) and fresh frozen plasma (the first unit of four) were still being administered to the patient. During a concurrent medical record review and			

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	Interview with the Blood Bank Supervisor on 6/18/14 at 1500 hours, the Supervisor stated the clinical staff had access to fresh frozen plasma on site; it was up to the nurse to go to the blood bank to obtain blood products; however, the Supervisor stated the nurses never called the blood bank to deliver the blood products or went to pick up the fresh frozen plasma units. The Supervisor reviewed Patient 1's Lab Final Report dated from 3/9/14 to 3/14/14, and confirmed Patient 1 received only three units of fresh frozen plasma by 3/10/14 at 0645 hours. Further review of the hospital's P&P titled "Blood/Blood Product Identification, Administration and Transfusion Reaction" (approved 1/12) showed a procedure for nursing staff to pick up blood and blood products from the Clinical Laboratory Service, but did not show a procedure for delivery of blood products by lab staff to the nursing units. During an interview with MD 1 on 6/18/14 at 1400 hours, he stated he was not aware Patient 1 did not receive the number of fresh frozen plasma units as ordered. MD 1 stated the administration of plasma was a high priority and should be done as soon as available. MD 1 stated he expected the ICU RNs would follow the hospital's P&P for postpartum hemorrhage when transfusing fresh frozen plasma. MD 1 stated Patient 1 did not have a history of bleeding. MD 1 stated Patient 1 had postpartum bleeding while still in the OR. Pharmacological management of the bleeding was tried, but patient did not respond.			

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	During an interview with MD 2 on 6/4/14 at 1400 hours, he confirmed while the patient was in the OR, MD 1 was updated regarding Patient 1's abnormal vital signs, the estimated blood loss of 1500 ml, and that a blood transfusion was initiated. MD 2 stated he remained with Patient 1 until she was transferred to the ICU. Review of a Physician Consultation report dated 3/10/14 at 0800 hours, by the Hematologist (a physician who specializes in diagnosing and treating diseases of the blood and of blood-forming organs) five hours after the Code Blue, showed following Patient 1's cesarean section the patient continued to have massive vaginal bleeding. The physician's report documented the patient's coagulopathy (a condition in which the blood's ability to clot is impaired), thrombocytopenia (condition in which the body does not produce enough platelets and patients may bleed excessively) and anemia (occurs when your blood doesn't carry enough oxygen to the rest of your body). The physician concluded these conditions were secondary to her severe post-partum hemorrhage, and also explained the ongoing bleeding. Review of MD 1's Physician's Progress notes dated 3/10/14 (untimed), showed Patient 1 was still oozing bloody drainage from around the balloon. The physician documented the patient was taken to radiology for an embolization (a minimally invasive treatment that occludes, or blocks, one or more blood vessels); however, the patient had another			

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	Code Blue prior to the procedure. A total abdominal hysterectomy was done on 3/10/14 at 1015 hours. Postoperatively Patient 1 required more blood transfusions. On 3/10/14 at 1800 hours, MD 1 documented the patient's abdomen became distended and the abdominal wound was surgically reopened. On 3/11/14, Patient 1's bowel was found not viable and another exploratory laparotomy surgery (a surgical incision into the abdominal cavity, for diagnosis) was done. Patient 1 died on 3/14/14 at 2316 hours. Review of the death certificate, showed DIC led to a cardiopulmonary arrest (cessation of heartbeat and breathing). Postpartum hemorrhage was listed as a significant contributing cause of the DIC. The above findings were confirmed at the time of medical record review during interviews with the Chief Nursing Officer, Director of Nursing, Director of Process Improvement, Director of Medical Staff, Director of ICU, and the Director of Maternal Child Health. 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).			