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 ________	08/04/2016

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: CA00472561 - Substantiated Representing the Department of Public Health: Surveyor ID # 2178, 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 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		Policies and Procedure for patient care were developed and implemented by the Nursing Service, to include planning and delivery of care. Registered Nurses will be responsible for the assessment and documentation of patients to determine initial needs, and effectiveness of care interventions. Reassessment will be completed and documented according to the Maternal Child Service guidelines and when: • A significant change in patients condition • A change in level of care • An untoward event that places the patient at risk • Abnormal findings I. In review of ACOG/AWHONN guidelines related to Post Partum Hemorrhage, a code H (Code Hemorrhage) team and risk assessment was initiated with multidisciplinary team involvement (4/30/2016). Involvement, to include: • Labor and Delivery Department • Mother Baby Department • House Supervisor • Transitional nurses • Respiratory Services • Laboratory, Blood Bank • Radiology • ICU Charge Nurse • Emergency Room Physician • OB Anesthesiologist • OB/Attending OB MD.	8/30/2016 8/30/2016

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mario Saverio RN	CNO	08/10/2017

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.

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	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 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 Professions Code Section 2725(b)(4). Such assessments shall be		The policy and procedure was written, education plan was designed to ensure readiness, early recognition, response and best possible outcome (in accordance with CMQCC guidelines/toolkit). (4/30/2016) II. The Plan will include: Hemorrhage risk assessment of the L&D patient will be done collaboratively with MD and RN, on every admitted patient with a Risk Factor assigned, according to the CMQCC guidelines, and recorded on the patient board and documented in the patient's record for shared information and effective communication process with the team. Patients with a higher hemorrhage risk assessment will be communicated further to the attending OB, OB anesthesiologist, House Supervisor, Director of Maternal Child Health Services, Blood Bank and Laboratory to ensure readiness.	8/30/2016

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	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. (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. (d) Information related to the patient's initial assessment and reassessments, nursing diagnosis, plan, intervention, evaluation, and patient advocacy shall be permanently recorded in the patient's medical record. Business and Professions Code Section 2725(b)(4) (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. The above regulations were NOT MET as evidenced by:		A Code H (Code hemorrhage) will be called for any OB patients that have cumulative QBL: • Vaginal bleed QBl > 500 ml with continued abnormal bleeding including recovery) • C-Section QBL > 1,000 ml and continue abnormal bleeding (including recovery)or vital signs > 15% change from admission baseline or B/P < 85/45 or O2 Sat < 95% or increased bleeding. The Code H (Code Hemorrhage) team roles and responsibilities are also delineated to assure assessments, planning, interventions, patient advocacy, evaluations are ongoing for the L&D patient.	8/30/2016

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	Based on interview, medical record review, and hospital document review, the hospital failed to provide medical care to the patient as per the hospital's policies and procedures (P&Ps) and hospital licensing standards, including but not limited to, ensuring the nursing staff advocated for Patient 1's well-being and provided the necessary care to Patient 1 when RN 1 (Registered Nurse), the primary nurse for Patient 1 in the operating room (OR) for a C-section (cesarean section is a surgical delivery of an infant through an incision in the mother's abdomen and uterus) and in the OB/PACU (Obstetric/Post Anesthesia Care Unit), failed to provide complete ongoing assessments and interventions for the patient as per the hospital's obstetric P&Ps as evidenced by: * RN 1 failed to accurately monitor Patient 1's excessive vaginal bleeding during the postpartum period using the quantification method (weighing bloody saturated pads and blood clots in order to measure the actual amount of blood loss after the birth of the baby) as directed by the hospital's P&P. Instead, RN 1 estimated the blood loss by observing the amount of blood staining on the perineal pads during the three hours and 25 minutes the patient was in the OB/PACU. *RN 1 did not report the total amount of the estimated blood loss of 3550 ml (milliliter) or 3.35 liters (during the C-section and recovery period) to the physician until Patient 1 was		Multidisciplinary team members are to respond to bedside with roles assigned to included: •Resource review/allocation •Notification of departments, eg. Pharmacy, Lab, or, etc. to prepare and mobilize actions • Care of baby • Hemodynamic monitoring of patient • Blood products/lab work • Anticipate other blood products, pharmacological needs, radiology, operating room services and ICU readiness • IV and Infusion roles • Assist anesthesia • Airway maintenance • Timely documentation by scribes • Control environment • Assure timeliness of care • Assure timely ongoing calculation of cumulative QBL, f fundal assessment • Ongoing MD notification of: •Adequate Intake and Output • Assessment of changes • Signs of deterioration • Abnormal lab results • CQBL Code H (Code Hemorrhage) members will be active in the management of the hemorrhaging patient until stability has been determined.	8/30/2016

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	transported to the OR for an emergency hysterectomy (surgical removal of the uterus). * RN 1 failed to notify the physician when there was a change in Patient 1's condition. RN 2 (Charge Nurse) notified the physician of the patient's laboratory results during her recovery; however, the physician was not made aware of Patient 1's elevated heart rate, ranging from 100 to 112 bpm (beat per minute; normal heart rate: 60 to 100 bpm); uterine tone alternating from being boggy (soft due to absence or lack of muscle tone) to firm, with continuous vaginal bleeding; and decreased urine output to allow for the physician to give further orders for treatment and/or evaluation of the patient to address the abnormalities and prevent further deterioration of the patient's condition. * RN 1 failed to ensure Patient 1's vital signs and assessments were documented in the patient's EHR (Electronic Health Record) while the patient was in the OB/PACU and as soon as possible after the occurrence. The patient's vital signs and all assessments while in the OB/PACU were entered into the EHR as late entries, several hours after the patient was transferred to the OR. * RN 1 failed to activate the Rapid Response Team (a team of health care providers that responds to hospitalized patients with early signs of clinical deterioration on non-intensive care units to prevent respiratory or cardiac arrest) and/or notify the anesthesiologist on the		III Education of Policy and Procedures: •Labor and Delivery nursing staff, Mother Baby nursing staff were educated to massive post Partum hemorrhage policy and procedure incuding utilization of rapid response team, completed with Skills Day review and signed off. •OB Physician education of Massive Post Partum Hemorrhage policy and procedures. •Educated Mother Baby Unit and Labor and Delivery nurses to the revised QBL and documentation that includes ongoing totaling in the intake and output charting. Education was done through staff meetings and daily huddle. •OB physicians' education video of AWHONN QBL cumulative quantitation presented at OB Medical Staff Committee. •Labor and Delivery, Mother Baby nursing staffing Educated to conversion of estimated blood loss to cumulative quantitative blood loss for all vaginal, c-section deliveries and recovery and any post partum hemorrhage by video, demonstration and Skills Day sign off. • Labor and Delivery, Mother Baby nursing staff education to conducting and communicating a hemorrhage risk assessment by staff meetings, huddles.	8/30/2016

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OB unit of Patient 1's declining condition as directed by the hospital's P&P, Maternal Child Health Services titled Assessment-Reassessment.

The cumulative effect of the hospital's deficient practices resulted in the hospital's failure to provide appropriate interventions for Patient 1 to prevent a significant change in condition following the C-section.

As a result, Patient 1 developed a severe postpartum uterine hemorrhage (loss of blood) secondary to uterine atony (loss of tone in the uterine musculature). Patient 1 was taken to the OR for exploratory laparotomy (a surgical operation where the abdomen is opened and the abdominal organs examined for injury or disease) and hysterectomy. Patient 1's medical status continued to rapidly deteriorate as the severe loss of blood lead to DIC (disseminated intravascular coagulation, a life-threatening condition that prevents a person's blood from clotting normally. It may cause excessive clotting [thrombosis] or bleeding [hemorrhage] throughout the body and lead to shock, organ failure, and death).

Subsequently, the patient developed multi-system organ failure and expired on 1/8/16 at 2010 hours (three days after the C-section), despite the full code response.

Findings:

- •Planned Grand Rounds MD/Staff education for massive post partum and hemorrhage evaluation and management. (5/5/16)
- •CNO, Director of Maternal Child Services, Director of ICU and ER, Director of Med/Surg, Tele, Risk Manager, and Director of Education attendance of American Red Cross recommendation for massive transfusion; a protocol for bleeding and non-bleeding patients. (5/23/16)
- •Code H (hemorrhage) education was completed to multiple departments as follows:
  - •Labor and Delivery, Mother Baby nursing staff with education to new code policy and procedure roles responsibilities with, sign-off or education.
  - •House Supervisors educated to new code, roles, responsibilities and acknowledgement with sign off.
  - •PBX/Admitting - new code introduction.
  - •OR & Recovery Room were educated by director of Education as to the Code Hemorrhage Policy and Procedure.

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	On 1/11/16, the Department received a report from the hospital regarding Patient 1's maternal death after a C-section on 1/5/16. On 3/30/16, an unannounced visit was conducted at the hospital. Review of the hospital's P&P for the Maternal Child Health Services titled Assessment - Reassessment, under OB/PACU, section 1.1, reviewed 10/15 showed "the RN will assess the post-operative patients within five minutes of arrival to the OB/PACU and at regular intervals as condition warrants to prevent and manage sudden acute changes in condition. Assessments will be documented on the Peri-Anesthesia Care Unit Flowsheet, a part of the medical record, and include the vital signs [blood pressure [BP], temperature, pulse, and respirations]; airway status, breathing, and circulation; wound status, skin integrity, and color; numerical Aldrete score (a score to gauge a patient's responsiveness, breathing, color, circulation, and activity); level of consciousness/neurological status; and drainage tube for patency and color noted (if present). Cardiac monitor will be placed on all PACU patients." Section 2.0, Reassessment, "The patient will be reassessed by the RN by checking the vital signs after the first five minutes three times, then every 15 minutes until discharged by Anesthesiology by or discharge criteria." Review of the hospital's P&P for the Maternal		Continued... •Respiratory Therapy department was education to their role in the code and response. •Blood Bank/Laboratory was educated to both lab draws and transfusion needs of a Code H patient including response times, immediate release, transport massive transfusion blood management. •Radiology department was educated to their roles/responsibilities of Code H (hemorrhage) response. •ICU Charge nurses were educated of their roles and responsibilities in the Code H. •House-wide written education was provided to assure knowledge of the Code H (hemorrhage). •Annual OB Skills/Competence Including: •AWHONN QBL Calculation Including weights, cumulative and quantitative, MD notification in cumulative vs estimated blood loss. •Post Partum hemorrhage review and mock code •High Risk Medication •SBAR / Hand Off communication •Designed a plan for regularly Code H drills and mock codes for six months on both shifts.	8/30/2016

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	Child Health Services titled Recovery Guidelines Post Delivery reviewed 10/15 showed the following, under Procedure: * 1.0 "Within 15 minutes of the delivery of the placenta end of the third stage of labor after delivery of the infant), the labor and delivery nurse checks vital signs, fundal [top of the uterus] location, lochia [the vaginal discharge after giving birth containing blood, mucus, and uterine tissue], and perineum; and records all information on the Postpartum Flow Sheet." * 2.0 "Check vital signs, fundus, and lochia every 15 minutes and record on the flow sheet for one (1) hour or until the patient is stable; every 30 minutes times two (2) hours, and routinely thereafter if stable." * 5.0 "If the patient has excessive bleeding or numerous clots notify the physician immediately." NOTE: All persons in this facility affected by this policy are expected to adhere to the practices as outlined in this policy. Review of the hospital's P&P titled Chain of Command, Physician Response to Patient Needs revised 4/14, section 3.0 under Policy, states "[i]n situations requiring acute medical care and the presence of a physician, it will be the responsibility of the RN caring for the patient to contact the treating physician immediately and report the condition of the		Continued... •Drills will be reviewed through a de-briefing, looking for strengths and opportunities for improvement, and shared with staff. •Competency on post delivery recovery and care including fundal assessment, vaginal care, assessment and reassessment for L&D and MBU Staff. •L&D and OB Staff educated on use of chain of command and patient advocacy and physician communication by Skills Day, staff meetings and huddles. •Plan for completion of AWHONN Post Partum Hemorrhage on line module, mandatory for all L&D and Mother Baby staff.	

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	patient. If unable to elicit timely and appropriate physician response, the RN or employee ...shall implement the chain of command." Review of the P&P for the Maternal Child Health Services titled Hemorrhage Obstetric Massive last reviewed on 10/15 showed the purpose of the policy is to aid in the medical and nursing management of the patient experiencing, or at increased risk of obstetric hemorrhage. Obstetric hemorrhage is a frequent cause of maternal morbidity and mortality. All obstetrical patients are at some risk, but some are at significantly increased risk for postpartum hemorrhage. The P&P has four stages to address obstetric hemorrhages, which are described below: * Stage 0: Care should be used to not underestimate blood loss...1. The patient receives routine OB postpartum care including the quantification of blood loss during the antepartum, intrapartum, recovery, and postpartum periods. Weigh blood and blood clots. Use scale... * Stage 1: When maternal blood exceeds the expected for routine cesarean delivery. Isolated uterine atony usually will respond to fundal massage [uterine massage is a technique used to reduce bleeding of the uterus after childbirth] and uterotonic agent [medication used to induce contraction or greater tonicity of the uterus]. Failure of uterine response suggests the possibility of another		V Process Improvements •Initiated routine type and screen on All L&D admissions. •Revision of hemorrhage risk assessment to meets CMQCC standards •Revised contents of post partum hemorrhage cart. •Revised ordering process of blood products to be more timely and use of immediate release and massive transfusion policy. •Designed a post partum pharmaceutical hemorrhage kit with ease of access •Acquired in house platelets apheresis for emergent use from American Red Cross •Recovery period for delivered L&D patients was expanded to ensure adequate observation for possible hemorrhage during recovery phase until OB anesthesiologist discharges patient. •Cumulative quantitative blood loss documentation revised. That includes cumulative Electronic Health Record (EHR) documentation with ongoing totaling in the intake and output charting. •Developed order set for effective Code H management. •Scheduling of procedures (c-section, inductions, etc.) revised to include risk factors of patients. •Improved access and team communication for recovery.	8/30/2016

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	diagnosis such as retained products of conception [placenta and/or fetal tissue in the uterus] or vaginal trauma or cervical trauma. Under the section for Nursing Care, the policy showed the licensed professional should check the vital signs every five minutes; apply uterine massage; weigh the blood and the blood clots (1 gm [gram] = 1 ml [milliliter]). Use a scale, do not estimate [quantification of blood loss is an objective method used to evaluate excessive bleeding, weigh all blood-soaked materials and clots to determine cumulative volume]; and call the physician if not present with the Situation, Background, Assessment, and Recommendation (SBAR is a technique used for standardized communication in healthcare, sharing patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy) report including blood loss amount and color. If fundal massage and single dose of an uterotonic agent are not effective the status of the patient needs to be converted to Stage 2. * Stage 2: Obtain Assistance: A. MD presence in house required, B. Activate Rapid Response, C. Request Anesthesiologist on call for in-house assistance and possible surgery, D. Obstetric Hemorrhage box to be brought to patient room and obtain light source, E. Notify in house nursing supervisor. Under the section for Patient Assessment, the		V. Monitoring e H (Code Hemorrhage) drills and mock codes using simulated scenario will be ongoing, reviewed, and reviewed through a debriefing looking for strengths and opportunities for improvement and shared with staff. •Code H (Code Hemorrhage) debriefing Findings will be regularly reported, for six months, to Maternal Child nursing staff , in staff meetings and huddles, Performance Improvement, OB/Peds, Medical Executive Committee and Governing Board. •Monthly chart reviews to review use of QBL vs EBL, cumulative calculations, assessments, reassessments, timely documentation, and MD notification by nursing staff. •Monthly monitoring of staff use of Risk Assessment in the L& D patient By nursing staff. •Review of charts for all hemorrhage Patients will be ongoing thru Medical Staff. Monitoring and Data will be reported to the Performance Improvement Committee, Quality Council, OB/Gyn/Peds Committee and Medical Executive Committee. Responsible Parties for Plan of Correction Are: Director of Maternal Child Services, Chief Nursing Officer Performance Improvement Director.	8/30/2016 8/30/2016

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	policy showed to assess the patient's fluid volume, oxygen carrying capacity, and coagulation system through frequent and appropriate assessment monitoring and laboratory tests. Section III, Patient Interventions: the policy showed to start second intravenous line, monitor for signs of hypovolemia [urinary output less than 30 ml per hour for 2 hours], monitor mental status, administer oxygen via mask, and continue monitoring of the oxygen saturation level (a measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry). Highlighted in a box at the bottom of stage 2 of the policy showed it is important to stop and reassess the patient's estimated blood loss (EBL) and vital signs. If the EBL is greater than 1500 ml, coagulopathy (condition in which the blood's ability to coagulate becomes impaired) is suspected, or vital signs are abnormal, the patient should be moved to Stage 3 (Significant Persistent Maternal Hemorrhage) and move the patient to the operating room or the Intensive Care Unit (ICU). On 3/30/16, review of Patient 1's medical record was initiated. The nursing admission records showed Patient 1 presented to the hospital on 1/5/16 at 0507 hours. The patient was admitted to the hospital and was prepared for a repeat C-section. The nursing admission records showed the patient had no acute distress or			

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any known health risks.

Review of Patient 1's Perioperative Vital Signs Assessments dated 1/5/16 starting at 0700 hours, showed Patient 1's baseline vital signs on arrival to the hospital were as follows: the heart rate of 80 bpm and BP of 149/83 mmHg (millimeters of mercury; normal BP: 120/80 mmHg).

Review of MD 1's (the primary surgeon) Operative Note dated 1/5/16, showed the infant was delivered without complications at 0827 hours. The placenta was significantly attached to the lower uterine segment. The placenta was removed intact; however, there was significant uterine atony and it was resolved with Methergine and Hemabate (medications used to contract the uterus). The uterus was manually expressed, clots cleared, and the sterile dressing was placed at the incision site. MD 1 documented Patient 1 sustained an 800 ml of blood loss during the procedure, and no blood was replaced at that time. The nurses were instructed to perform uterine massage and closely follow the patient's clinical status in the recovery room.

Review of RN 1's Nursing Documentation dated 1/5/16, showed the following:

At 0910 hours (while the patient was still in the OR), documentation showed MD 1 "just left. Uterus boggy/bleeding. Contracting with massage." This indicates the uterus required

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manual massage to stay contracted.

At 0915 hours, upon the patient's arrival to the OB/PACU, documentation showed the patient's uterus was firm and positioned at the umbilicus midline (normal position after birth) with a moderate amount of lochia (vaginal discharge) with clots, 25-50 ml.

At 0920 hours, documentation showed the patient's BP was 112/70 mmHg, pulse rate was 91 bpm, and respiration rate was 18 breaths per minute. The patient was alert and verbal.

At 0937 hours, documentation showed the patient's lower abdominal dressing was stained with approximately two inches of fresh blood; the area was marked and would be observed continually. RN 2 (Charge Nurse) was also at the patient's bedside.

At 0945 hours, documentation showed Patient 1's uterus was boggy and positioned above the umbilicus with heavy lochia, more than 50 ml EBL.

At 0950 hours, documentation showed Patient 1's uterus was boggy and positioned at two fingers above the umbilicus, the uterus was massaged with a large amount of blood draining, and the uterus was firm after a massage.

On 1/5/16 at 0943 hours, MD 1 ordered a complete blood count (CBC) test STAT

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(immediate response) for Patient 1. At 0945 hours, MD 1 ordered a STAT DIC (disseminated intravascular coagulation) panel. DIC is a serious, life-threatening condition in which the proteins in the blood involved in blood clotting become overactive. Blood clots form in small blood vessels throughout the body. At 1000 hours, the blood specimens were collected.

Review of the Laboratory Report dated 1/5/16, showed the results for the DIC panel and CBC tests were received at 1024 hours by RN 2, and showed the following:

* The PT with INR tests results showed the high PT value of 12.7 seconds (normal range: 9.5-11.1 seconds) and INR of 1.3 (normal range: 0.8-1.2), indicating the patient's blood was not clotting normally.

* The D-Dimer tests [part of the DIC panel and used to help rule out the presence of an inappropriate blood clot] results showed the high value of 27.07 (normal range: 0.19 - 0.5 mg/L) (positive predictor for DIC or a thromboembolic [formation in a blood vessel of a clot that breaks loose and is carried by the blood stream to plug another vessel] event).

* The CBC result showed the patient's hematocrit (the ratio of the volume of red blood cells to the total volume of blood) was low at 18.9% (normal hematocrit range: 36 to 48%; low level of hematocrit indicates a loss of blood due to the blood failing to clot and continuing to

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bleed) and hemoglobin (protein molecule in the red blood cells that carries oxygen) was low at 6.2 g (gram)/dl (deciliter) (normal hemoglobin range: 12 to 16 g/dl; low level of hemoglobin indicates anemia from the loss of blood).

Review of the Nursing Documentation dated 1/5/16, showed at 1048 hours, RN 2 notified MD 1 of the DIC panel and CBC results, 24 minutes after RN 2 received the results. RN 2 documented she received the orders from the physician to transfuse Patient 1 with two units of packed red blood cells and transfer the patient to the postpartum unit when stable.

Review of Patient 1's obstetric recovery room Vital Signs Assessments form dated 1/5/16, as late entries, showed documentation that the patient's vital signs were obtained every 5 minutes from 0920 to 1245 hours, in the OB/PACU. The documentation showed the following:

* From 0920 to 1020 hours, the systolic BP (the highest pressure when the heart beats and pushes the blood round the body) ranged from 105 to 127 mmHg and diastolic BP (the lowest pressure when the heart relaxes between beats) ranged between 70 to 96 mmHg. For the same period, the patient's heart rate ranged between 78 to 99 bpm.

* From 1040 to 1125 hours, Patient 1's systolic BP ranged from 107 to 131 and diastolic BP was between 96 to 71 mmHg. For the same

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	period, the heart rate ranged from 97 to 112 bpm. The above vital signs for Patient 1, obtained in the OB/PACU, were entered into the EHR as late entries all at the same time at 1432 hours, from three to five hours after the vital signs were obtained, and over 1.5 hours after the patient was transferred to the OR for an emergent hysterectomy at 1255 hours. The vital signs were not accessible by other staff until 1432 hours, several hours after the vital signs were taken by the OB/PACU staff. However, there was no documentation found in the EHR to show RN 1 had assessed and documented the patient's body temperature, skin color, and appearance of the mucous membranes to determine if the patient had adequate tissue perfusion during her stay in the OB/PACU as per the hospital's P&P. There was no documentation to show the physician was notified of Patient 1's fluctuation of BPs and elevated heart rates during her stay in the OB/PACU. Review of the Nursing Documentation dated 1/5/16, showed at 1100 hours (while the patient was in the OB/PACU), RN 1 documented Patient 1's uterus was boggy and the patient was bleeding with uterine massage. Cytotec (medication used to contract the uterus) 1000 mcg (microgram) was administered rectally. Review of Patient 1's Intake and Output record			2017 AUG 14 PM 12:51

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	in the OB/PACU dated 1/5/16 from 1059 to 1159 hours, showed urinary output was not monitored and recorded hourly (a sign of decreased blood volume is urinary output that is less than 30 ml/hour) as per the P&P. In addition, there was no documentation to show the blood loss and oral or intravenous fluid intake were assessed and recorded. Review of the Nursing Documentation dated 1/5/16, showed at 1235 hours, RN 1 documented the patient's bleeding was measured through observation and estimated at the following amounts: 10 perineal pads with some blood saturated; eight chucks (absorbent disposable pads), two of them with blood saturated; and three blue operating towels, one of them with blood saturated. There was no documented evidence the blood loss was measured through the quantification method as per the P&P. Further review of the medical record failed to show documented evidence RN 1 had obtained assistance from the Rapid Response Team as per the hospital's P&P when the medication and uterine massage were ineffective as indicated by the patient's continued bleeding. Review of the Nursing Documentation dated 1/5/16, showed MD 1 was notified of Patient 1's continuous blood loss at 1235 hours (three and a half hours after admission to the OB/PACU). At that time RN 1 documented the patient's vital signs were "stable." RN 1 documented MD 1			2017 AUG 14 PM 12: 57

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	was on his way to evaluate the patient's status and ordered four more units of the packed red blood cells for possible hysterectomy. Review of the Nursing Documentation dated 1/5/16, showed at 1240 hours, Patient 1's blood loss for the three and a half hour stay in the OB/PACU was measured for the first time. The quantitative blood loss was documented as 2750 ml. At 1245 hours, RN 1 documented MD 1 was at the patient's bedside discussing a hysterectomy. At 1255 hours, the patient was transferred to the OR. Review of the C-section Recovery form dated 1/5/16, showed the documentation by RN 1 for the patient's fundus, lochia, and perineum assessments in the OB/PACU on 1/5/16 at 0925, 0930, 0940, 0945, 0950, 1000, 1005, 1015, 1030, 1045, 1100, 1110, 1120, 1130, 1140, 1150, 1200, 1210, 1220, 1230, 1240, and 1255 hours, were entered into the EHR as a late entry at 1518 hours, two and a half to six hours after the assessments were performed. No documentation was entered into the medical record prior to 1518 hours. On 3/30/16 at 1300 hours, RN 2 (Charge Nurse) was interviewed. RN 2 stated she reported the results of the CBC and DIC panel laboratory tests to MD 1 on 1/5/16 around 1048 hours. MD 1 stated to transfuse two units of the packed red blood cells. When RN 2 was asked what other information she had communicated to MD 1 at that time, she stated, "That was it"			

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	since she had not seen the patient. When asked if RN 1 had informed MD 1 of Patient 1's bleeding, or any changes in the patient's vital signs, consistency of the uterus, or urinary output, RN 2 stated she knew the patient's vital signs were normal. RN 2 stated she could not recall the other information about the patient's status. RN 2 stated at some point, RN 1 communicated with MD 1 that the patient was continuously bleeding. RN 2 was asked to explain RN 1's late entry documentation of Patient 1's vital signs and assessments. RN 2 stated all information was entered in the computer and no paper flowsheet was used. When asked how the nurses remembered the exact information for hours later on, RN 2 had no answer. When asked how the patient's blood loss would be estimated, RN 2 stated the nurses did not give a quantitative estimate. The nurses would tell the physicians that the patient's bleeding was "large, medium, or scant amount, with or without blood clots." RN 2 stated the OB emergency hemorrhage protocol for Patient 1 was started on 1/5/16 at 1250 hours. When RN 2 was asked why the Rapid Response Team was not called to assess the patient, RN 2 stated she did not have an answer for that. On 3/30/16 at 1400 hours, the Director of Medical, Surgical & Telemetry unit was			

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	interviewed. The Director confirmed according to the hospital's P&P for Obstetric Hemorrhage, Stage 1 was when the maternal blood loss exceeded the expected blood loss routine for a C-section delivery. The Director stated the RNs should weigh the bloody pads and blood clots in order to obtain the quantitative results. During an interview with MD 3 (Anesthesiologist) on 3/30/16 at 1400 hours, he stated he was available in the labor and delivery unit during Patient 1's stay in the OB/PACU on 1/5/16. MD 3 stated when he transferred the patient to the OB/PACU, the patient was stable. MD 3 stated he was not notified of Patient 1's emergency until 1130 hours; at that time, he helped the nurses to start the second IV line to administer the blood transfusion. On 3/30/16 at 1430 hours, MD 2 (OB assistant surgeon) was interviewed. MD 2 stated during the surgery there was more bleeding than usual, but it was controlled. MD 2 stated Patient 1 bled 800 ml. MD 2 stated when the patient bled more than 1500 ml, the investigation should be done to find out the source of the bleeding. MD 2 stated he was not notified of the changes in Patient 1's condition. MD 2 stated if the nurse did not feel comfortable with anything, she should notify the physician. During an interview with MD 1 (the primary OB surgeon) on 4/14/16 at 1300 hours, he stated Patient 1 bled more than usual during the			2017 AUG 14 PM 12: 5

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	surgery due to uterine atony, which was resolved. MD 1 stated the Charge Nurse (RN 2) informed him of the CBC results on 1/5/16 around 1030 hours. MD 1 gave the orders to initiate the blood transfusions. MD 1 stated at approximately 1230 hours, RN 2 asked him to see the patient and he arrived at 1245 hours. At that time, Patient 1 had pallor (extreme paleness), was severely anemic (a condition in which the blood doesn't have enough healthy red blood cells), and was resting on her side. MD 1 stated the patient's uterus was dramatically expanded with lots of clots inside. MD 1 stated he was never made aware of the patient's total blood loss prior to that time. MD 1 stated the nurse told him the patient was "oozing blood." RN 1 reported the blood loss of 2700 ml as he was transferring the patient to the OR for the hysterectomy. MD 1 stated he "was shocked" at the large blood loss; he would have liked to have known the EBL sooner. When MD 1 was asked his expectations of the nurses caring for Patient 1, MD 1 stated the nurses should evaluate the patient and call him right away for any significant changes in the vital signs, such as a change of 15 to 20 % from the baseline and a drop in the BP, urine output, and oxygen saturation levels. MD 1 further stated after Patient 1's hysterectomy, the hematologist was consulted to assist with the DIC and blood products management. However, Patient 1 became increasingly hypotensive (low BP) and the patient's abdomen was expanded. On 1/6/16,			

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	the abdominal wound was surgically reopened. On 1/8/16, Patient 1 continued to do poorly secondary to severe hemorrhagic shock and DIC. He stated the patient had a multi organ failure, went to pulseless activity despite the code response, and expired. The above findings were confirmed on 3/30 and 4/14/16, at the time of the medical record review and during the interviews with the Chief Nursing Officer & Director of Maternal Child Health, Director of Medical Surgical & Telemetry unit, Risk Manager, Chief of Medical Staff, MDs 1, 2, and 3. During an interview with RN 1 on 6/2/16 at 1400 hours, she stated prior to transferring Patient 1 from the OR to the OB/PACU, she notified MD 1 of Patient 1 having a gush of blood and clots when massaging the uterus. MD 1 ordered the laboratory tests and medications to contract the uterus and then left the hospital at 0910 hours. Patient 1 was transferred to the PACU at 0915 hours. RN 1 stated once in the OB/PACU, Patient 1 was cyanotic (blue/purple discoloration of the skin). RN 1 was concerned and called the Charge Nurse to request additional nursing support. RN 1 requested the Charge Nurse to call and inform MD 1 of Patient 1's bleeding. RN 1 stated the Charge Nurse called MD 1 with the laboratory results and MD 1 ordered to start the blood transfusion. RN 1 stated it was not the hospital's practice to weigh perineal pads to estimate blood loss; however, RN 1 stated she weighed all the blood soaked			2017 AUG 14 PM 12: 52

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pads at the end and notified the physician of the patient's low urine output when MD 1 arrived at 1245 hours. RN 1 stated she did not notify the physician about the changes of the patient's vital signs.

During the interview, RN 1 stated she was overwhelmed caring for Patient 1 as she was changing the patient's vaginal pads, cleaning the patient, checking the vital signs every five minutes, as well as assessing the patient's uterus every 15 minutes, without help. RN 1 stated she did not document any of the assessments and vital signs in the EHR while caring for Patient 1 and she did not use a paper flowsheet. RN 1 stated she "estimated" and documented the information in the patient's EHR later.

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).

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