Resubmitted 3/5/14

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
	050108	A. BUILDING _____ B. WING _____	06/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTER GENERAL HOSPITAL	2801 L St, Sacramento, CA 95816-5815 SACRAMENTO COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00362428, CA00349058 - Substantiated Representing the Department of Public Health: Surveyor ID # 29328 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 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. Health and Safety Code 1279.1 (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law. Health and Safety Code 1279.1 (b) for purposes of this section, "adverse event" includes any of the following:		*Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction has been prepared and/or executed solely because it is required by federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Derek Quain | TITLE: Director, IQS | (X6) DATE: 2-19-14

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s): 1 thru 2

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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	(5) Environmental events, including the following: (D) A patient death of serious disability associated with a fall while being cared for in a health facility. The adverse event was detected on 3/24/13. The facility reported the adverse event to the Department on 3/29/13. The adverse event was reported to the patient's family on 3/24/13. 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. The CDPH verified that the facility reported the adverse to the Department no later than five business days after the adverse event was detected. Title 22 DIV5 CH1 ART3 - 70213 Nursing Service Policies and Procedures (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.. Title 22 DIV5 CH1 ART3 - 70215 Planning and Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d).		**Immediate Actions:** 1. After careful review of this event and consistent with our Human Resources policies, the RN involved in the care of this patient was terminated. 2. A trial for Tab Alarms was initiated in the Emergency Department. This resulted in adoption of TAB alarms for patients meeting criteria . 3. The Patient Care Standard on the Fall prevention and Management was updated. This information and education on Fall Risk assessment and interventions were provided to 100% of the staff. This included : • Posey Lap belt education to staff • Morse Fall Risk Scale Education to staff • Process for accessing fall risk assessment tool in T-Systems 4. The process of handoff from EMS was reviewed and updated. This process was reviewed at the County-wide Emergency Management meeting 5. All ED staff were required to complete a competency assessment for Posey roll belt restraints.	3/28/13 4/30/13 4/30/13-6/30/13 5/30/13 5/2013

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	050108	A. BUILDING _____ B. WING _____	08/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTER GENERAL HOSPITAL	2891 L St, Sacramento, CA 95816-5615 SACRAMENTO COUNTY

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	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. The above requirements were not met as evidenced by: Based on staff interview, record review, and facility document review, the facility failed to perform an assessment on Patient 1 after his first fall in the emergency department (ED) and failed to implement safety precautions in the ED in accordance with hospital patient care standards. This failure resulted in a second fall 10 minutes later resulting in a laceration to the back of Patient 1's head. Subsequent head scan showed skull fractures, along with a large amount of bleeding in the brain that compressed vital brain structures. Patient 1 died on [redacted]13, with subdural hematoma as the immediate cause of death. Patient 1 was brought in by ambulance to the ED on [redacted]3 at 12:33 a.m. Review of the ED Screening Sheet of Patient 1 dated [redacted]13 at 12:33 a.m. revealed Patient 1's chief complaint was "unable to walk due to intoxication - found lying on concrete by neighbor." The Glasgow Coma Scale (GCS-a scale to describe the level of consciousness, measuring the eye opening, verbal response and motor response) of Patient 1 was 15, meaning his eye opening was spontaneous (4), he was oriented (5), and he obeyed commands (6). The Gait section in the sheet asked whether the		**Additional actions:** 1. Piloted safety belts in the Emergency Department — Oct., Nov., Dec., 2013 2. Safety Belts will be applied to ED patients on a gurney upon admission — 1/24/2014 3. Safety Belt education of staff — 2/2014 **Monitor for compliance:** — 5/12/13 – ongoing 1. Initial monitoring included 40 charts weekly. — 12/2013 2. Following intensive monitoring, 20 charts will be audited weekly for 3 months. — 3/2013 3. EMS handoff monitoring 4 charts weekly for 2 months. — 7/2013 4. Failure to achieve acceptable documentation requirements will result in re-education. Continued failure will result in actions consistent with our Human Resources policy **Person responsible:** Nurse Director, Emergency Services	

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	patient was "In wheelchair, steady, not observed, or with cane/crutches." There was no documentation entry on the Gait section of the sheet. Review of Patient 1's printed Prehospital Care Report Summary from the Sacramento Fire Department dated [redacted]13 at 12:27 a.m. indicated "(Patient 1), 67 year old, male, laying on sidewalk in front of his house . . . patient not cooperative with assessment per cab driver who dropped patient off in front of his house, patient stepped out of cab and fell to ground and would not or could not stand up, patient was assisted to feet but was not able to or refused to support his own weight or walk. patient denies head/neck/back pain." During an interview with Registered Nurse (RN) 1 on 5/20/13 at 7:20 a.m., she confirmed she signed the Prehospital Care Report Summary, under the section Signature Image: Receiving RN, at 12:32 a.m. via the computer screen presented to her by the paramedics, but did not read the report until the hard copy arrived at 2:55 a.m. The Report reflected, "per cab driver who dropped the patient off in front of his house, patient stepped out of the cab and fell to ground and would not or could not stand." Review of staff documentation on the form titled Clinical Report - Nurses for Patient 1 dated [redacted]2 indicated: Patient 1 was seen by RN 1 (triage nurse) at 12:37 a.m. and was triaged (an abbreviated screening assessment to determine whether a life threatening condition requires immediate lifesaving medical interventions and is		**ADDENDUM: 3/3/2014:** **Additional actions:** 100% of the RN staff in the Emergency Department will be re-educated on the Patient Assessment Process. Included is: 1. Initial assessment 2. Assessment for change in patient's condition. 3. Ongoing assessment The education will be done via staff meetings, eLearning and will also be posted for required reading. **Monitor for compliance:** 10 audits a month for 3 months will occur. The audits will focus on timeliness of the initial assessment and the appropriateness of the assessment for the chief complaint. Audit results will be shared with the staff. Target is 100% compliance. Failure to meet the target by individual staff will result in progressive actions consistent with our Human Resources policy. **Person responsible:** Nurse Director, Emergency Services	3/31/2014 3/31/2014

Janet Train Duncta IQS 3-4-14

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SUTTER GENERAL HOSPITAL	5901 L St, Sacramento, CA 95819-3615 SACRAMENTO COUNTY

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	not a complete nursing or safety assessment by nursing). Triage level was assessed at acuity of Level 3 in the Emergency Severity Index (ESI). ESI is a five-level tool for use in ED triage area to rate patient acuity from Level 1 - Resuscitative; Level 2 - Emergent; Level 3 - Urgent; Level 4 - Less than Urgent; and Level 5 - Routine. ESI 3 indicated no life threatening condition was identified on arrival to the ED. The ambulance EMT 1 (emergency medical technician) was interviewed on 12/13/13 at 4:30 p.m. and stated that there were no remarkable injuries noted during his physical assessment of Patient 1. Under the Nursing Progress Notes section, RN 2 documented at 1:24 a.m. "1 a.m. late entry unwitnessed fall from bed, assisted patient to crawl back to bed with 2 nurses and direction. patient mumbles but follow directions slowly, instructed not to leave bed and given call light, security notified by (name of staff member) to watch patient as he is etoh (intoxicated) and has fallen." There was no documentation that RN 2 or any other ED RN assessed the patient's condition immediately after this fall. There was no documentation of vital signs, GCS or pain level immediately after this fall. There was no documentation that the ED physician was immediately notified of this fall. There was no documentation that RN 2 or any staff stayed with Patient 1 until the security guard arrived to watch the patient.			

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	RN 2 documented the following at 1:30 a.m.: "1:10 a.m. late entry-nurse was in next room starting IV, heard a loud thump, found patient on his back, non-responding, back of head bleeding, assistance obtained patient with cervical collar and back boarded and 3 people assist to lift to put back in bed. nasal trumpet inserted and oxygen applied, patient does not respond to noxious stimuli or sternal rub Dr. (physician name) notified and moved to room 3." Physician Clinical Report for Patient 1 in ED on [redacted]13 indicated that an ED physician performed a medical screening exam at 1:12 a.m. The ED physician noted at "1:12 a.m., Patient fell out of bed prior to exam and passed out. He was trying to leave the ED and fell. Prior to his fall, patient was reportedly awake with slurred speech and yelling. He is currently with diminished responsiveness. cervical-collar has been placed. ordered a stat CT (scan) head. blood was noted on his posterior head after his fall." Review of Patient 1's CT Scan (imaging test, type of x-ray) of his head dated [redacted]13 at 2:01 a.m., revealed acute large cerebral subdural hemorrhage, right frontal convexity subarachnoid hemorrhage (curved shaped bleeding into the space between two membranes that cover the brain), subarachnoid hemorrhage filling the pre-peduncular cistern (space, cavity in the mid-brain section near the brain stem that controls vital life functions). The CT scan report further identified, moderate to severe leftward midline shift of 2.1 cm and uncal herniation			

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	(part of the temporal lobe of the brain being moved by the bleeding to press on other brain tissues). Right temporal calvarial (skull bone) fracture and a right parietal scalp hematoma (collection of blood on the right side of the head). RN 1 documented a late entry at 2:28 a.m. in the Clinical Report-Nurses under social history that "after reviewing the written run sheet (Prehospital Care Report Summary, PCR) from medics the cab driver called them after patient had stepped out of the cab and "fell to the ground, and would not or could not stand up." RN 1 was interviewed on 5/20/13 at 7:20 a.m. RN 1 stated that they did not get the Prehospital Care Report Summary (PCR) until 2:23 a.m. EMT 1 was interviewed on 12/13/13 at 4:30 p.m. and stated that it is his practice to leave the printed PCR at the hospital before he leaves. He stated that he either hands the PCR to the nurse assigned to the patient or puts the PCR in the file box for the patient's room. The printed PCR would have been ready and left at the hospital by 00:45 a.m. Critical Care Consultant Report of Patient 1 dated [redacted]13 at 2:55 a.m. showed Patient 1 "with an acute subdural hematoma, now with evidence of brain death. Because of his poor neurologic status, no surgery is indicated. He should be placed in the ICU overnight then withdrawn from ventilatory support following declaration of brain death. The patient has currently undergone both respiratory and neurologic failures."			

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	The ED Manager was interviewed on 5/20/13 at 8:00 a.m. She shared RN 2's personnel file which showed RN 2 was terminated involuntarily on [redacted]13 for "failing to do an initial assessment on Patient 1 nor was anything documented after first fall, it was noted by a witness that Patient 1 complained of head pain and RN 2 stated "I am sure it does hurt," witness saw RN 2 left the room and Patient 1 was unattended, witness statement supports Patient 1 was left unsupervised." Under Corrective Action Notes, "RN 2 did not complete the mandatory fall assessment and did not notify MD of first fall. Failure to provide safety precautions after first fall resulted with another fall." RN 1 was interviewed on 5/20/13 at 7:20 a.m. She confirmed that there was no fall risk assessment done on Patient 1 upon admit or after his first fall. She also stated RN 2, who was assigned to Patient 1, did not do her initial nursing assessment on Patient 1. Patient 1's Doctor's Discharge Diagnosis dated [redacted]13 had Traumatic Closed Head Injury as principal diagnosis; Subdural Hemorrhage and Cerebral Edema as secondary diagnoses and Closed Head Injury as cause of death. Facility's Internal report dated [redacted]3 presented "the decision to leave the patient unattended by the assigned RN (RN 2) following the first fall in the ED with no assessment, was not in the best interest of the patient."			

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	Review of Patient 1's Certificate of Death issued [redacted]13 indicated "Subdural Hematoma... and Cerebral Edema" under cause of death. The facility's Patient Care Standard entitled, Fall Prevention and Management, dated 3/2012, included the following staff responsibilities for assessment: 1. All patients will be evaluated for fall risk. 2. The RN will perform a fall assessment based on data collected by the RN with input from other members of the health care team at the following intervals: -on patient admission -every shift -whenever a change in patient condition occurs -upon receiving patient from another unit -post-fall event. The facility's failure to assess the patient following his first fall in the emergency department and ensure implementation of fall safety precautions is a deficient practice that caused, or was 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. 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 1280.1(c).			