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
	050076	A. BUILDING _____ B. WING _____	07/22/2016

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Kaiser Foundation Hospital - San Francisco	**2425 Geary Blvd, San Francisco, CA 94115-3358 SAN FRANCISCO COUNTY**

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00493807, CA00484762 - Substantiated Representing the Department of Public Health: Surveyor ID # 26616, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.3(g): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. The State regulations violated were: Title 22 - 70213(b), 70215(d) 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. Abbreviations and Acronyms used: Code Blue - a medical emergency in which a team of medical personnel work to revive an individual in		The administration, staff and physicians of Kaiser Foundation Hospital San Francisco (KFH-SF) take our responsibility for safe quality care for our patients very seriously and provide the following response to the issues identified in the Statement of Deficiencies. Documents demonstrating these actions are available for review. CA DEPT OF PUBLIC HEALTH JAN – 6 2017 LICENSING SAN FRANCISCO	

Event ID: J0DX11 12/23/2016 11:28:42AM

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

Hospital Administrator January 6, 2017

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 13

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.

POC Accepted. Jie Wang Acting HFES. 1/11/17.

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	cardiac arrest. CPR or Cardiopulmonary Resuscitation; Using rescue breathing and chest compressions to help a person whose breathing and heartbeat have stopped. Defibrillation - is a treatment for life-threatening abnormal heart rhythm by delivering a therapeutic dose of electrical currents to the heart with a device called a defibrillator. Hemodialysis - a treatment using a machine and a filter (artificial kidney) to remove waste products and extra fluids from the body which the damaged kidneys can not excrete. Obstructive sleep apnea - repetitive episodes of shallow or paused breathing during sleep, despite the effort to breathe, and is usually associated with a reduction in oxygen in the blood. Respiratory failure - respiratory system fails in one or both of its gas exchange functions: oxygenation and carbon dioxide elimination. Hypercapnic respiratory failure also known as carbon dioxide retention. Carbon dioxide is a gaseous product of the body's metabolism and is normally expelled when the patient breathes out. Tracheostomy (trach) - a surgical procedure to create an opening through the neck into the trachea (windpipe).		See below starting on page 5	

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	Tracheostomy cap - covers the opening of the trach tube and blocks air from entering the tube. This forces the patient to breathe in and out through their nose and mouth. This is often the last step before the trach is removed (decannulation). If the trach can be capped for a long enough time without any problems, it is probably safe to be removed. Tracheostomy tube - a tracheostomy tube is a piece of curved tube inserted into a tracheostomy opening to provide airway and to remove secretions from the lungs.Trach tube can be cuffed or cuffless and fenestrated (with holes) or unfenestrated (without holes). Tracheostomy tube cuff - is a piece of balloon attached at the end of the trach tube which can be inflated (filled with air) and deflated (air is released). The purpose of the inflated cuff is to keep the tracheostomy tube in place and prevent aspiration of secretions. When the cuff is inflated, it will prevent air from moving through the vocal cord and stop the patient from making sounds or speech. When the cuff is deflated, the air is able to move around the trach and through the vocal cords, enabling the patient to be able to make sounds and speak. Pilot balloon - a small plastic balloon with a valve seal attached to the trach tube. The trach cuff is inflated and deflated via this balloon and the status of the trach cuff inflation can also be determined by the inflation status of the pilot balloon. The trach cuff itself sits deep within the trachea, it is impossible to see the status directly. However, if		See below starting on page 5	

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	the pilot balloon is inflated, this is an indication the trach cuff is inflated as well, and the same goes if the pilot balloon is flat, or deflated, this is an indication the trach cuff is deflated. Minimal Leak Test or MLT - this is done by deflating the cuff, then slowly begin re-injecting air with a syringe while listening with a stethoscope to the side of the patient ' s neck near the trach tube. Inject air into the pilot line until you can no longer hear air going past the cuff. This means the patient ' s airway is sealed and the patient is breathing thru the tracheostomy tube. Fenestrated tracheostomy - fenestrations are holes on the posterior part of the tube above the cuff. The holes allow the patient less effort to breathe and talk when using a speaking valve. Speaking valve - a one-way valve that attaches to the end of a trach tube. It is designed to open when the patient breathes in and close when the patient breathes out. When the valve closes, it forces air up into the airway and across the vocal cords allowing for sound and speech. The patient will breathe in through the trachea and exhale out through the nose and mouth. If a speaking valve is being used with a cuffed tracheostomy tube (unfenestrated or fenestrated with inner cannula), the cuff MUST BE DEFLATED before placement of the device. Placing a speaking valve on a patient who has an inflated cuff can result in DEATH because this will only allow the patient to inhale air and will not be able to exhale the air since the airway is obstructed with the inflated cuff.		See below starting on page 5	

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	T22 DIV5 CH1 ART3-70213(b) Nursing Service Policies and Procedures. (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. T22 DIV5 CH1 ART3-70215(d) Planning and Implementing Patient Care (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. This RULE: is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Follow the speaking valve manufacturer's directions for use, when Registered Nurse (RN) 1 placed a speaking valve on Patient 1's unfenestrated tracheostomy tube without deflating the tracheostomy cuff in order for the patient to breathe in and breathe out. Patient 1 was found unresponsive, not breathing, pulseless and died on 4/12/16 due to hypercapnic respiratory failure. 2. Develop a tracheostomy policy and procedure for the Respiratory Care Services, which incorporate the speaking valve manufacturer's directions for use		**Failure #1 and Related Findings** Immediate and Systemic Actions: The practice of placing speaking valves onto patients' tracheostomies is solely performed by Respiratory Therapists (RT) at KFH-SF. To ensure that all adult medical surgical and critical care RNs and RTs follow correct process at all times, and in order to prevent reoccurrence, the	

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	which include to use the speaking valve only with cuffless or fenestrated (cuffed or cuffless) tracheostomy tube. 3. Ensure medical records were complete and accurate, when RN 1 did not document Patient 1's nursing assessment and evaluation after she placed the speaking valve on 4/12/16. The Respiratory Therapist (RT) 1 did not document Patient 1's respiratory assessment, patient condition, errors with speaking valve placement and interventions done when she (RT 1) found the patient was unresponsive and pulseless on 4/12/16. Findings: Review of the clinical record indicated Patient 1 was admitted to the facility on 2/2/16 with diagnoses including acute on chronic hypercapnic respiratory failure, adult obstructive sleep apnea and end-stage renal disease on hemodialysis. Patient 1 had a tracheostomy on 2/24/15. Review of 4/8/16 physician's order, indicated, "Speaking valve. Leave cuff down (deflated) as tolerated." Review of the 4/11/16 physician Progress Note, indicated, "Adult Obstructive Sleep Apnea ...Tolerating speaking valve. Failed capping trial 4/7 (hypoxia {low level of oxygen in the blood}, tachypnea {abnormal rapid breathing}, tachycardic {abnormal rapid heart rate}) .... Altered Mental Status - improving, following commands, nods head appropriately."		following immediate actions and systemic changes have been implemented: - KFH-SF changed the speaking valve product used during the incident to a new product in order to have better compliance with manufacturer's product recommendations for use. The package of the new product, that is utilized by RT staff for all patients with speaking valves, includes bright purple visual warning signs for easy identification and clear visual reminder of correct practice. - The Kaiser Permanente "Just Culture" algorithm based on James Reason's Just Culture Model was applied in reviewing this case. Follow up with involved staff was completed in accordance with Human Resource Policies and Procedures. - Immediate education providing reinforcement to Managers, RTs, adult medical surgical RNs and Patient Care Technicians (PCTs) that only RTs are allowed to place speaking valves was provided to all staff in 7 South and 7 Center units via ongoing daily huddle messages.	4/13/16 4/13/16 4/29/16

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	During record review and concurrent interview, the Tracheostomy Care Flowsheet dated 4/12/16 at 4:09 AM, indicated, the section for Speaking Valve indicated "NO", meaning RT 2 removed the speaking valve. The section Trach Cuff Inflated indicated "NO", meaning RT 2 deflated the trach cuff. The section Cuff Pressure indicated "MLT", meaning RT 2 inflated the cuff and checked that Patient 1's tracheostomy had no leak around the trachea. On 7/25/16 at 8:00 AM, RT 2 verified her documentation for section "Trach Cuff Inflated" should be "YES" because she did the MLT and the only way to do the MLT was to inflate the cuff. RT 2 verified on 4/12/16 at 4:09 AM, she left Patient 1 with the trach cuff inflated. Review of Patient 1's Vital Signs Flowsheet indicated, on 4/12/16 at 8:13 AM, RN 1 did set of vital signs (temperature 97.4 F, respiration 20, oxygen saturation 98%, pulse and blood pressure 124/56). This was the last entry in the Vital Signs Flowsheet. Review of the 4/12/16 Code Blue Record indicated, the code was called at 8:57 AM. The initial evaluation of Patient 1 indicated he was not conscious, no respirations, no pulse and no heart rhythm. CPR was given and Patient 1 was given 3 defibrillation and medications to help restore heart rhythm and breathing. Review of the 4/12/16 physician's Death Note indicated, "Called by nurses to pronounce patient (Patient 1). No spontaneous movement. No		- RNs in 7 South and 7 Center units submitted signed attestations confirming understanding that speaking valves can only be placed by RTs at KFH-SF. - All newly hired adult medical surgical and critical care RNs receive education and submit signed attestations confirming understanding that speaking valves can only be placed by RTs at KFH-SF. - All RTs have completed a newly created training module called "Care of a patient with tracheostomy and speaking valve". Manufacturer's directions for use were incorporated into module content. o All newly hired RTs complete this training module. - Respiratory Care Department policy "Tracheostomy Care" SF-PCS-21-03 was reviewed and found to lack a clear statement limiting the practice of placing the speaking valves to RTs only at KFH-SF. The policy was revised to correct this deficiency and to make clear the expectation for following manufacturer's instructions for use of the speaking valve. The policy	4/29/16 4/29/16 ongoing 4/30/16 4/30/16 ongoing 5/06/16

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	respirations. No heart sounds or pulse. Death pronounced at 0930 (9:30 AM) 4/12/16." Review of the 4/12/16 Death Certificate indicated the immediate cause of death was "Acute Respiratory Failure." During an interview on 7/14/16 at 11:00 AM, the Respiratory Therapy Manager (RTM) stated he knew what happened to Patient 1 when RT 1 reported to him on the morning of 4/12/16. RTM stated RT 1 went to Patient 1's room on 4/12/16 at approximately 8:45 AM to assess Patient 1. RTM stated when RT 1 found Patient 1, the patient was flaccid, the speaking valve was on the trach tube and the trach cuff had not been deflated. RTM stated RT 1 told him, "Oh my God, I know what happened. The cuff had not been deflated. "RTM stated if the trach cuff was not deflated while the speaking valve was on, air can go in the trachea (breathe in) but air could not be exhaled (breathe out) easily. RTM stated RTs were the "only" staff allowed to place the speaking valve because of the inherent concerns and potential danger of the speaking valve. When asked if that was specified on the Tracheostomy Care policy, RTM stated, the old policy did not distinguish between RN and RT, who could place the speaking valve. During an interview on 7/14/16 a 12:00 PM, RN 2 stated on 4/12/16, he responded to a Code Blue for Patient 1. RN 2 stated when he arrived in Patient 1's room, RT 1 was in the room and bagging (giving respirations with the use of resuscitation bag) Patient 1. RN 2 stated he helped with the CPR by		change was approved by the Medical Executive Committee (MEC) on 5/06/16. - Education completed by 7 South and 7 Center RNs was incorporated into the Annual RN Skills Days for all adult medical surgical RNs in the hospital during April and May 2016. - All adult medical surgical and critical care RNs submitted signed attestations confirming understanding that speaking valves can only be placed by RTs at KFH-SF. - All RTs have read the revised policy and were educated on policy changes. This intervention was documented with signed attestations. - A competency checklist for RT tracheostomy care and speaking valve placement was developed and used to validate competency of all RTs. The checklist will be used for new hire orientation and annual competency validation going forward. o All newly hired RTs complete this competency assessment. - Physician education was provided by the Head and Neck Surgery (HNS) Chief and included review of manufacturer's directions for	5/31/16 6/16/16 7/13/16 7/13/16 7/13/16 ongoing 7/31/16

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	giving Patient 1 chest compressions. RN 2 stated during the Code, he heard RT 1 comment that the speaking valve was on and the trach cuff was not deflated. RN 2 stated per facility's practice, only RT was allowed to place the speaking valve. During an interview on 7/14/16 at 1:35 PM, RN 3 stated on 4/12/16, she heard someone yelling for help so she went to Patient 1's room. RN 3 stated she checked the code status of Patient 1 and when she found out he was a full code (for resuscitation or CPR), they called Code Blue and started chest compressions. When asked if she had placed a speaking valve on Patient 1, RN 3 stated, it was not the facility ' s practice to put the speaking valve because it was RT's responsibility. During an interview on 7/20/16 at 11:16 AM, RT 1 stated on the morning of 4/12/16 at approximately 8:45 AM, she went to assess and to do trach care of Patient 1. RT 1 stated she tried to wake up Patient 1 and shook him but Patient 1 was not responding. RT 1 stated she looked at the trach to suction him and she saw the speaking valve was on, however, the trach cuff was inflated. RT 1 stated she verified the trach cuff was inflated by looking at the balloon (pilot balloon) that was pretty inflated. RT 1 stated she removed the speaking valve and started bagging Patient 1 and called Code Blue. RT 1 stated she did not know who put the speaking valve but the person who put it should deflate the trach cuff. When asked if Patient 1 was capable of putting the speaking valve by himself, RT 1 stated, "Patient 1 had no capacity to put the speaking valve." When asked how important the trach cuff		use. Education emphasized the importance of confirming that the tracheostomy tube is cuffless or cuffed-fenestrated at the time when the initial order for speaking valve is placed. - Weekly "Tracheostomy Rounds" were implemented by the HNS department in collaboration with Respiratory Care to assess each patient for appropriate tracheostomy product selection. The Tracheostomy care plan is updated and documented in the medical record during rounds. Person responsible for monitoring: Chief Nurse Executive Monitoring plan: - Beginning on 4/13/16 and for a period of 3 months, the department manager or designee randomly interviewed 7 South/7 Center RNs to confirm understanding that only RTs place speaking valves. Compliance of 100% was documented. Results will be reported to the MEC on 1/11/17. - Beginning on 4/13/2016 and for a period of 4 months, the RT manager or designee reviewed medical records of all patients with speaking valves and verified that the appropriate equipment was in	7/31/16 1/11/17 9/14/16

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	was deflated when the speaking valve was on, RT 1 stated, "It was vitally important because the patient could breathe in but could not breathe out." RT 1 stated it had been the facility's practice to allow only RTs to put speaking valve on a patient, however, there was no policy that specify only RT can put the speaking valve. RT 1 verified she did not document on the electronic health record her observation of Patient 1 that cuff was inflated and the patient was unresponsive before she called a code on 4/12/16. During an interview on 7/20/16 at 11:38 AM, RN 1 stated she took Patient 1's vital signs at around 8:00 AM on 4/12/16. RN 1 stated while she was doing her assessment, Patient 1 gestured to her to get the speaking valve. RN 1 stated she asked Patient 1, "Do you want your speaking valve?", and Patient 1 nodded. RN 1 stated she took the speaking valve from a container on top of the bedside table and put the speaking valve on Patient 1's trach tube. RN 1 stated, "After I placed the speaking valve, Patient 1 tried to speak but could not speak." RN 1 stated she told Patient 1, "I will ask RT because the speaking valve doesn't seem to be working." RN 1 stated she was going to call RT after she assessed Patient 1. When asked why she did not remove the speaking valve after she saw Patient 1 could not speak, RN 1 stated she made a poor judgment of not removing the speaking valve right away and call the RT. When asked if there were any signs that Patient 1 was going to pass out or any signs of respiratory distress after she put on the speaking valve, RN 1 stated she stayed in the room for approximately 15 minutes		use and placed by RT per policy and in accordance with manufacturer's directions for use. Compliance of 100% was documented. Final results were reported at MEC on 9/14/16. **Failure #2 and Related Findings** Immediate and Systemic Actions: - Respiratory Care Department policy "Tracheostomy Care" SF-PCS-21-03 was revised to make clear the expectation for following manufacturer's instructions for use of the speaking valve. The policy change was approved by MEC on 5/06/16. - All RTs, adult medical surgical and critical care RNs were educated on policy changes. This intervention was documented with signed attestations. Person responsible for monitoring: Chief Nurse Executive Monitoring plan: Beginning on 4/13/2016 and for a period of 4 months, the RT manager or designee provided daily review of all patients with tracheostomies for identification of any patients with speaking valves. If such patients were identified, the manager or	5/06/16 7/13/16 9/14/16

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	after she placed the speaking valve but did not see any signs of respiratory distress or any detrimental effect of the speaking valve. RN 1 was asked if she had documentation of Patient 1's observation after placement of the speaking valve, RN 1 stated she did not document in the electronic health record. When asked if she had put on the speaking valve on Patient 1 before, RN 1 stated, "No." When asked if she knew the cuff should be deflated when the speaking valve was on so the patient could breathe in and breathe out, RN 1 stated, "I wasn't aware about the cuff." During an interview on 7/20/16 at 2:25 PM, RTM stated Patient 1's tracheostomy tube was unfenestrated (no holes) cuffed tube. RTM was referred to the manufacturer's DFU that speaking valve should only be used with "cuffless or fenestrated" trach tube. RTM stated the respiratory care team was unaware of the manufacturer's indications for use. RTM stated the facility had been using the product for a long time and had been historically safe because it was engraved in the RTs practice to deflate the cuff. RTM further explained that fenestrated or non-fenestrated trach tube was safe to be use as long as the cuff was deflated. RTM stated the fenestration was for the patient's benefit that lesser effort would be exerted by the patient while using the speaking valve. During an interview on 7/20/16 at 3:40 PM, Physician 1 stated Patient 1 was admitted with hypercapnic respiratory failure and although patient had infections, Patient 1 was not clinically septic and was breathing on his own. Physician 1 stated		designee reviewed patient care record and verified that the appropriate equipment was in use and placed per policy. Audit results showed that performance exceeded the established threshold. Final results were reported at MEC on 9/14/16. **Failure #3 and Related Findings** Immediate and Systemic Actions: - All adult medical surgical RNs and all RTs are routinely reminded of importance of accurate and timely documentation via huddle messages distributed to all Adult Services departments. Huddle messages distributed during the week of 1/4/2017 included a reminder to all staff that documentation in the electronic medical record of all patient assessments and interventions is required by hospital policy ("Basic Unit Care for Medical-Surgical patients", SF-PCS-11-73, Section 6). - To assure ongoing compliance with documentation requirements in nursing units, department managers or their designees review a sample of charts each week for accuracy of documentation. Nursing documentation, including assessments and response to	1/14/17

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Kaiser Foundation Hospital - San Francisco	2425 Geary Blvd, San Francisco, CA 94115-3358 SAN FRANCISCO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	she wrote the Death Note and wrote the cause of death was hypercapnic respiratory failure. Physician 1 stated the use of the speaking valve without deflating the cuff seemed to be the cause of the acute on chronic respiratory failure (acute deterioration of respiratory functions in patients with chronic respiratory problems). Review of the Shiley Speaking Valve Manufacturer's Directions for Use (DFU), indicated, "Indications for Use - The Shiley Speaking Valve is intended for use only with a cuffless of fenestrated (either cuffed or cuffless) tracheostomy tube having a 15 mm (millimeter) connector to provide means of phonation (speech sounds) for alert, awake tracheotomized patients who can breathe spontaneously without assisted mechanical ventilation .... WARNINGS 1. The tracheostomy tube cuff must be completely deflated before placing the Shiley speaking valve. Patient will be unable to breathe if cuff is not fully deflated ... 8. Each time the Shiley speaking valve is attached to the tracheostomy tube, the patient should be closely observed by trained caregiver for a period of time to ensure adequate ventilation. Review of the facility's Tracheostomy Care policy and procedure by the Respiratory Care Department, revised on 9/14, indicated, "1.0 Policy Statement Tracheostomy care will be done at least once a shift by Respiratory Care Practitioners (RCP) and RN's in a consistent systemic manner. Both RCP's and RN's will contribute to the patient's individualized plan of care and address the patient 's emotional and educational needs related to the		interventions, is reviewed utilizing a checklist for electronic medical record review. If documentation is found inaccurate, immediate feedback is provided to staff. In an effort to facilitate accurate and timely documentation of patient care during and after a Code Blue, a structured template for comprehensive code blue documentation was developed. This documentation will appear as a "Code Blue note" in the electronic medical record. The trial of the template has been completed. Education will continue until all appropriate staff and physicians are reached. Full implementation of the template will occur by 1/31/17. Persons responsible for monitoring: Chief Nurse Executive Code Blue Committee Co-Chairs Monitoring plan: - To confirm ongoing compliance with documentation requirements, the Director of Adult Services provided monthly review of chart audit results. Over 400 electronic medical records were reviewed between the time of the incident and 12/31/16. Audit results showed that performance consistently exceeded the	12/2/16 1/31/17 1/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050076	A. BUILDING _____ B. WING _____	07/22/2016

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Kaiser Foundation Hospital - San Francisco	**2425 Geary Blvd, San Francisco, CA 94115-3358 SAN FRANCISCO COUNTY**

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	tracheostomy ... 6.0 Procedure for Use of A Tracheostomy Plug:... 6.5 If the patient has a cuffed tracheostomy tube, the cuff must be deflated before the plug is inserted ... 6.7 Watch patient carefully for respiratory distress, choking, cyanosis, or change in vital signs and respiratory rate." The Tracheostomy policy did not specify tracheostomy plug include speaking valve, and did not reflect the speaking valve manufacturer's directions for use which include to use the speaking valve only with cuffless or fenestrated (cuffed or cuffless) tracheostomy tube. 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).		established threshold. These results will be reported to MEC on 1/11/2017. - To confirm staff compliance with code blue note documentation requirements, beginning on 2/01/2017, the Code Blue committee co-chair or designee will review a random sample of Code Blue events for the presence of a complete Code Blue note. Audits will continue until sustainable compliance is achieved. Results will be reported to MEC.	2/01/17 ongoing