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California Department of Public Health

OCT 11 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA110000000040	A. BUILDING _____ B. WING _____	C 10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETALUMA VALLEY HOSPITAL	400 N MCDOWELL BLVD PETALUMA, CA 94954

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E 000	Initial Comments The following reflects the findings of the CALIFORNIA DEPARTMENT OF PUBLIC HEALTH during a INCIDENT/COMPLAINT visit. Incident Numbers: CA00203469 and CA00203471. Inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted], HFEN.	E 000		
E 271	T22 DIV5 CH1 ART3-70213(d) Nursing Service Policies and Procedures. (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff. This Statute is not met as evidenced by: Complaint: CA00203469 Based on document review, policy and procedure review, and staff interview, the hospital failed to ensure that the nursing staff implemented the written policy and procedure titled "Standards of Nursing Care for the Mechanically Ventilated Patient." This failure contributed to Patient 2 developing an unstageable pressure ulcer inside of the left upper lip. Findings: Review of Patient 2's medical record on 9/30/09	E 271	**Response to Tag E271** Corrective Action Completion Date: 10-1-2010. Monitoring: 10-1-10 through 1-1-11. Responsible Party: Director of Inpatient Nursing. **Corrective Action Plan:** 1. All Critical Care Nurses received a mandatory policy review on the "Standards of Nursing Care for the Mechanically Ventilated Patient." Completed 10/28/09. 2. All Critical Care Nurses were educated regarding the necessary components for assessment and the required documentation needed for the mechanically ventilated patient. Staff was instructed that this needs to consist of an assessment / documentation of the patient's lips, oral cavity, and tongue for pressure ulcers. Completed 10/28/2009.	10/28/09 10/28/09

Licensing and Certification Division

Kim Lucas R.N. TITLE Quality Risk Coordinator (X6) DATE 10-8-10
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 3JA211 If continuation sheet 1 of 13

10/11/10 435pm left message with Kim Lucas RN QRC
POC accepted Blondell Powell RN

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E 271	Continued From page 1 at 1:30 pm, revealed that the patient presented to the Emergency Department (ED) on 9/12/09 at 1854 (6:54 pm) with shortness of breath that had started the night before and pleuritic (inflammation of the membrane that surrounds and protects the lungs) chest pain. The patient was intubated at 2116 (9:16 pm) (the insertion of an Endotracheal tube (ETT) through the mouth into a patient's lungs to help them breathe) in the ED due to the deterioration of her respiratory status. The ETT was held in place with a Dale Stabilock Endotracheal Tube Holder as follows: An adhesive base is placed directly above the patient's lip. A neckband is positioned around the neck and over the lip, which helps to hold in the ETT and prevents an accidental extubation (removal). The manufacturer's recommendation is to reposition the ETT often to help prevent injury to the lips and underlying tissues due to unrelieved pressure. The patient was stabilized and transferred to the Intensive Care Unit (ICU) at 2225 (10:25 pm). On 9/24/09, the patient was taken to surgery for a tracheotomy (a surgical procedure on the neck to open a direct airway through an incision in the trachea [the windpipe]) placement. At that time, the ETT was removed from the patient's mouth. Patient 2 had developed a pressure ulcer on the inside of her left upper lip while having an ETT in place during her hospitalization. During an interview with the Wound Care Nurse on 9/30/09 at 3:30 pm, he stated that he had done an assessment of the patient's mouth and lips on 9/25/09 at 11 am (The ETT had been removed on 9/24/09) when he identified a Stage II pressure ulcer (A partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled	E 271	3. Multidisciplinary team reviewed the policy and procedure titled "Standards of Nursing Care for the Mechanically Ventilated Patient" It was determined that no policy change is required; policy meets minimum standards of patient care. Completion on 10/27/2009. 4. New Registered Nurses are required to complete a 6 month orientation. A. A competency skills checklist is a required component of the orientation. B. All new registered nurses are mandated to complete the ECCO (Essentials of Critical Care Orientation) standard as part of their orientation. 5. All registry and travel registered nurses are not assigned ventilator patients until they have completed the nursing competency checklist and reviewed the policies and procedures. **Monitoring:** 1. Chart audits will be conducted for nursing documentation regarding patient assessment of lips, oral cavity and tongue for pressure ulcers of the mechanically ventilated patient. A sample of 10	10/27/09

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E 271	Continued From page 2 blister) on the inside of the left upper lip, measuring 0.25 centimeters (cm) x 0.25 cm x 0.2 cm. Review of the progress note dated 9/28/09 at 11 am, revealed documentation that the pressure ulcer had been assessed as being unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed). The Wound Care Nurse stated that the hospital had adopted and follows the National Pressure Ulcer Advisory Panel position on staging pressure ulcers. During an interview with the Nurse Manager of the Intensive Care Unit (ICU) on 9/30/09, she stated that the nursing staff is to do an assessment of the mouths of all ventilated patients' every four (4) hours and more often as needed. Review of the Nursing Assessment Flowsheets dated 9/23/09 through 9/28/09, lacked documented evidence that the nursing staff had consistently assessed the entire inside of Patient 2's mouth every four (4) hours. On 10/1/09 at 7:55 am, during an interview RN G stated that she had taken care of Patient 2 while in the ICU. RN G stated that the patient's lips were swollen. RN G stated that patient's tooth on the left side was not even with the rest of her teeth. The tooth sat forward. RN G stated that it was difficult to check the inside of the upper lip due to the ETT placement. RN G stated that she had assisted a Respiratory Therapist (RT) in repositioning the ETT; however, she did not take the opportunity to assess the inside of the upper lip. RN G stated that she usually does not use a flashlight to do a complete assessment of the patient mouths.	E 271	medical records of ventilated patients will be audited effective 10-1-10 through 1-1-11. 2. Monthly audits will be completed for 3 consecutive months until 100% compliance is obtained. 3. After 100% compliance is met, a chart audit will be conducted semi annually.	

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E 271	Continued From page 3 The policy and procedure titled "Standards of Nursing Care for the Mechanically Ventilated Patient," dated 8/22/06, reviewed on 9/30/09, indicated that the nursing staff is to check the lips, oral cavity, and tongue for pressure areas every four (4) hours when providing oral care, and more often as needed. If any pressure areas are noted, RT should then, be asked to reposition the tube (ETT).	E 271		
E 347	T22 DIV5 CH1 ART3-70223(b)(2) Surgical Service General Requirements (b) A committee of the medical staff shall be assigned responsibility for: (2) Development, maintenance and implementation of written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. This Statute is not met as evidenced by: Complaint: CA00203471 Based on record review, policy and procedure review, and staff interview, the hospital failed to ensure that the Surgical Service nursing staff implemented the policy and procedure titled "Count Policy (Sponge, Sharps, and Instruments)," resulting in a surgical laparotomy pad (lap sponge) being retained in Patient 9's abdominal cavity following surgery on 1/10/08. Patient 9 had to undergo an additional surgical procedure on 10/1/09 (approximately a year and 9 months later) to remove the surgical lap sponge, placing the patient at increased risk for complications due to the additional surgery and	E 347	Tag E347 Corrective Action Completion Date: 10-1-10 Monitoring: Effective: 10-1-10 through 1-1-11. Responsible Party: Director of Perioperative Services Corrective Action Plan: 1. "Count Policy Sponge, Sharps, and Instruments "reviewed and revised to state that x-rays are completed prior to closing for every laparoscopic procedure that requires an open conversion. Action completion date was 2-1-10. — 2-1-10 2. The Perioperative Services Director attended the webinar "Nothing Left Behind." on 6-1-2010. The hospital implemented the recommendation from Nothing Left Behind to have standardized count boards and a procedure for counting. — 6-1-10 3. A standardized count board was adapted on 9-13-10 as a recommendation from the "Nothing Left Behind" webinar. The count boards are located in every surgical — 9-13-10	

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E 347	Continued From page 4 anesthesia. THE VIOLATION OF LICENSING REQUIREMENTS CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WITHIN THE MEANING OF HEALTH AND SAFETY CODE SECTION 1280.1 IN THAT IT CAUSED, OR WAS LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT, WHEN MEDICAL AND NURSING STAFF FAILED TO IDENTIFY THAT A FOREIGN OBJECT (SURGICAL SPONGE OR LAP TAPE) HAD BEEN RETAINED IN A PATIENT AFTER SURGERY. THIS VIOLATION PLACED THE PATIENT AT INCREASED RISK FOR COMPLICATIONS AND DEATH FROM THE RETAINED SURGICAL SPONGE. Findings: Review of Patient 9 ' s record on 9/30/09 at 4:30 pm, indicated that the patient presented to the Emergency Department (ED) on 9/28/09 with a complaint of severe abdominal pain that had started two weeks ago. Patient 9 indicated that he had nausea and vomiting after eating solid food. Patient 9 indicated that passing of gas had decreased. While in the ED, the patient had a Computed Tomography Scan (CT) [An x-ray procedure that uses a computer to produce a detailed picture or cross section of the body. Useful in evaluating soft tissue organs]. The CT showed a foreign body in the abdomen. The report indicated that there was evidence of a relatively high-grade small bowel obstruction that was noted with multiple dilated small bowel loops and air-fluid levels. There is radiopaque material in the anterior aspect of the right mid-abdomen, which has an appearance suggestive of surgical sponge. Apparent surgical sponge versus other	E 347	room and serve to prevent foreign body retention. Surgical counts are accounted for on the board in addition to documentation in the medical record. 4. All Perioperative Services staff were mandated to complete a competency which included viewing a video by the Association of Operating Room Nurses titled "Surgical Counts Don't Make a Case of It". This was completed on 9-21-10. This competency reinforced proper counting procedure and documentation. 5. All staff are required to use the clear sponge count bags for open abdominal procedures. This was a revision to our surgical count policy effective 2 -1-10. 6. New registered and travel nurses are required to complete hospital orientation within 90 days of hire. a. A Surgical Skills competency checklist is required within 90 days of hire. b. All clinical skills are proctored and supervised prior to functioning independently.	9-21-10 2-1-10

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E 347	Continued From page 5 type of radiopaque foreign body was seen in the anterior aspect of the right mid abdomen. Patient 9 was stabilized and admitted to the hospital for surgery for an acute abdomen. Patient 9 was taken to surgery on 10/1/09 and had an exploratory laparotomy, lysis of adhesions, small bowel resection times two, enterostomy, and removal of foreign body with enterorrhaphy. Review of Patient 9 ' s record on 10/1/09, indicated that Patient 9 had been admitted to the hospital on 1/9/08, for an elective sigmoid colon resection secondary to recurrent acute diverticulitis on 1/10/08. Review of the Operating Room report dated 1/10/08, on 10/1/09, indicated that the first sponge closing count was documented as being correct and the final sponge count was documented as being correct. Documentation indicated that the surgeon was notified of the final count results. Documentation indicated that the patient was free from signs and symptoms of injury caused by extraneous objects. Review of the Progress note dated 1/14/08 at 1 pm, on 10/1/09, indicated that Patient 9 was concerned about his abdomen being distended. The physician's order dated 1/14/08 at 1605 (4:05 pm), indicated that physician had ordered a complete abdominal series x-ray to rule out obstruction. A second physician's order dated 1/14/08 at 1700 (5 pm) indicated that the above order for the abdominal series was canceled. Review of the discharge summary dated 1/16/08, on 10/1/09, indicated that the patient had developed a postoperative ileus (A condition in which there is an absence of muscular	E 347	7. Registry staff are not utilized as staffing needs are filled internally and long term needs through travel nurses. **Monitoring:** 1. There have been no further incidents of foreign body retention since this occurrence. 2. Random visualization audit of 5 laparoscopic surgical cases per month to ensure that count process is correct and an x-ray is completed prior to closure. The effective date for audit is 10-1-10 through 1-1-11. 3. Monthly chart audits will be completed for 3 consecutive months until 100% compliance is obtained. 4. After 100% compliance is met an audit will be conducted semiannually.	

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E 347	Continued From page 6 contractions of the intestine which normally move the food through the system). The patient was started on parenteral nutrition supplement (Feeding a person intravenously [IV], bypassing the usual process of eating and digestion) and then advanced to a clear liquid diet (Jell-O, tea, broth, apple juice, cranberry juice, water, etc) on the fifth postoperative day. The patient was gradually advanced to a regular diet (Composed of all types of foods, is well balanced and capable of maintaining a state of good nutrition). The physician indicated that the ileus had resolved on 1/17/08. Patient 9 was discharged from the hospital on 1/18/08 in satisfactory condition. On 10/1/09 at 11:40 a.m., RN A stated during an interview that she was the circulating nurse during Patient 9's surgery procedure (A circulating nurse is responsible for patient safety during the surgical procedure. The circulating nurse coordinates care of the patient with the surgeon, scrub nurse/technician, and anesthesia provider. The circulating nurse also provides assistance to the surgical team throughout the surgical procedure). RN A stated that the x-ray detectable laparotomy sponge (Also referred to as a lap sponge or pad), is a 100 percent (%) cotton cloth, with a special weave and texture, designed for surgery and are banded (secured) together in quantities of five (5) lap pads per bundle. The bundle of the lap pads are unbanded (unsecured) and laid out on the back table. RN A stated that two (2) staff counts the lap pads together. The count is then documented on a board to ensure that there are only five (5) lap pads per bundle. The tally (count) is listed on the board. There is a middle count prior to the closure of the incision. The used lap pads are counted in fives (5). RN A stated that the scrub	E 347		

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E 347	Continued From page 7 technician also counts the lap pads as they are being put into a plastic bag. The technician will say aloud, "I see five." In this surgical procedure four (4) to five (5) bundles of five (5) lap pads each, were used. RN A stated that she is sure that the process was followed. On 10/1/09 at 10 am, Scrub Technician B (ST B) (Scrub nurse/technician supports the surgeon by passing instruments during the operation while also maintaining patient safety) stated during an interview that the lap pads are counted preoperatively by the scrub technician and the circulating nurse prior to the patient's arrival in the Operating Room (OR) suite. ST B stated that two (2) bundles of the large lap pads (Five (5) per bundle -18 inches x 18 inches, x-ray detectable) were opened and counted and the count was written on the white board. Other bundles were opened as needed. ST B stated that she places the used lap pads in a kick bucket (Stainless Steel, non-corrosive, easy to clean and maintain, and has exceptional durability, which can be moved (kicked) around the OR as needed). ST B stated that this particular case was very bloody and the lap pads could have stuck together and this was not caught. It is easy to loose a lap pad when there is a lot of blood. It is up to the circulating nurse and the scrub technician to make sure that the count is correct before the patient leaves the OR suite. On 10/1/09 at 1:15 pm, the surgeon (The same surgeon that performed the first surgery on 1/10/08 (approximately a year and 9 months earlier) stated during an interview that during the first surgery, he had used the large lap sponges to retract the bowel, so that the area he was working on was kept clear. The surgeon stated that it looked like the sponge that was left in the	E 347		

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E 347	Continued From page 8	E 347		

patient, had walled itself off and then made a fistula (A fistula is an abnormal connection or passageway between two epithelium-lined organs or vessels) opening into the small bowel. The surgeon corroborated that a large lap sponges was left in the patient during the 1/10/08 surgery. The surgeon stated that he could not really explain how it happened, except that one of the lap sponges used to retract the bowel was hidden ...even though the sponge count was documented as being correct.

Review of the policy and procedure titled "Count Policy (Sponge, Sharps, and Instruments)," dated 6/08, on 10/1/09, indicated that sponge, sharp, and instrument counts are performed to account for all items and to lessen the potential for injury to the patient as a result of a retained foreign body. Complete and accurate counts promote optimal perioperative patient outcomes, support high quality patient care, and demonstrate commitment to patient safety. All items inserted into a wound, and not intended to be left in the wound after closure, will be noted on the count board or instrument count sheets. All counts are performed audibly with the scrub technician and a circulator concurrently viewing each item as it is counted. Sponge counts will be performed as follows:

1. Before the procedure to establish a baseline.

2. Before closure of a cavity within a cavity.

3. Before wound closure begins, at skin closure or end of procedure.

4. At the time of permanent relief of either the scrub person or the circulating nurse (although direct visualization of all items may not be

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E 347	Continued From page 9 possible).	E 347		
E1783	T22 DIV5 CH1 ART6-70617(a) Respiratory Care Service General Requirements (a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. This Statute is not met as evidenced by: Complaint: CA00203469 Based on document review, policy and procedure review, and staff interview, the hospital failed to ensure that the respiratory staff implemented the written policy and procedure titled "Artificial Airways." This failure contributed to Patient 2 developing an unstageable pressure ulcer inside of her left upper lip. Findings: Review of Patient 2's medical record on 9/30/09 at 1:30 pm, revealed that the patient presented to the Emergency Department (ED) on 9/12/09 at 1854 (6:54 pm) with shortness of breath that had started the night before and pleuritic (inflammation of the membrane that surrounds and protects the lungs) chest pain. The patient was intubated at 2116 (9:16 pm) (the insertion of an Endotracheal tube (ETT) through the mouth into a patient's lungs to help them breathe) in the ED due to the deterioration of her respiratory status. The ETT was held in place with a Dale	E1783	**Response to Tag E1783** Corrective Action Completion Date: 10-1-10. Monitoring: 10-1-10 through 1-1-11 Responsible Party: Cardiopulmonary Manager Corrective Action Plan: 1. The Dale ET tube holder was replaced with the Hollister ET tube holder on November 1, 2009. The Hollister ET holder design allows easy frequent repositioning of the ET tube by Respiratory Therapist (RT) or nursing. 2. Respiratory Therapists are required to reposition the ET tube by 1-2 cm with each ventilator check when using an adjustable ET tube stabilizer. 3. Policy review and revision completed to RT policy 3-1701 "Artificial Airways." The following components were revised: a. Respiratory therapists are required to move the ET tube 1-2 cm with each ventilator check, when using an adjustable ET tube stabilizer. b. Respiratory therapists are required to document ET tube position change on the ventilator flow sheet. c. Nasal and oral tubes that are taped are required to be re-taped every day.	11-1-2009

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E1783	Continued From page 10 Stabilock Endotracheal Tube Holder as follows: An adhesive base is placed directly above the patient's lip. A neckband is positioned around the neck and over the lip, which helps to hold in the ETT and prevents an accidental extubation (removal). The manufacturer's recommendation is to reposition the ETT often to help prevent injury to the lips and underlying tissues due to unrelieved pressure. Review of the Respiratory Therapist (RT) Care Ventilation Flowsheets dated 9/12/09 through 9/26/09, on 9/30/09, revealed that the respiratory staff had not followed the policy and procedure. The Manager of the Cardiopulmonary Services stated during an interview on 9/30/09 at 1:30 pm, that the staff had not documented the ETT position (Right, Middle, and Left) every 24 hours on the Flowsheets on the following dates: 9/12/09 - evening shift (PM 3 pm - 11:30 pm). 9/13/09 - night shift (Noc 11 pm - 7 am), day shift (Day 7 am - 3 pm), or PM shift. 9/14/09 - Noc shift and PM shift 9/15/09 - Day shift 9/16/09 - Day shift 9/17/09 - Noc shift and Day shift 9/18/09 - Noc shift Pm shift 9/19/09 - Noc shift 9/20/09 - Noc shift, Day shift, and PM shift. 9/21/09- Day shift and PM shift 9/22/09 - Noc shift 9/23/09 - Noc shift and PM shift 9/24/09 - Noc shift. The Manager of the Cardiopulmonary Services corroborated the above findings. The Manager of the Cardiopulmonary Services stated during an interview on 9/30/09 at 1:30 pm,	E1783	4. Respiratory staff were educated regarding the above documented policy revisions on October 13, 2009. 10-13-09 5. Respiratory staff were required to sign off on an education memo on 10-13-2009. This discussed the importance of documentation, the consequences of not documenting and the importance of visible inspection of the patient's mouth for signs of skin breakdown. 10-13-09 6. Respiratory staff also completed a competency on October 14, 2009 regarding the new Hollister ET holder usage and frequency of tube repositioning by 1-2 cm with each ventilator check. 10-14-09 7. All new respiratory therapists, travelers, and registry staff are required to attend an orientation class and complete a skills orientation checklist prior to functioning independently. **Monitoring:** 1. Chart audits will be conducted for respiratory documentation of ET tube repositioning with ventilator checks. A sample of 10 medical records will be audited effective 10-1-10 through 1-1-11. 2. Monthly chart audits will be completed for 3 consecutive months until 100% compliance is obtained. 3. After 100% compliance is met, a chart audit will be conducted semi annually.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA110000000040	A. BUILDING _____ B. WING _____	C 10/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E1783	Continued From page 11 that the RT staff had not followed the policy and procedure in repositioning and retaping of the ETT, which should be done every 24 hours. 9/12/09 - Documentation indicated that the placement of the ETT was at 2116 (9:16 pm). 9/13/09 - The ETT should have been repositioned before 2100 (9 pm). The record lacked documented evidence that the ETT was reposition with the 24 hours. 9/14/09 - The ETT was repositioned at 9 am. The documentation revealed that it was 34 hours from 9/12/09. 9/15/09 - The ETT repositioning was greater than 24 hours. The medical record lacked documented times when the ETT was repositioned. 9/16/09 - The ETT repositioning was 26 hours. The Manager of the Cardiopulmonary Services, corroborated the above findings. Concurrent review of the RT Care Ventilation Flowsheets dated 9/12/09 through 9/26/09, lacked documented evidence that the RT staff checked the skin condition of the patient's lips. The Manager of the Cardiopulmonary Services corroborated the above findings. Review of the policy and procedure titled "Artificial Airways," dated 10/12/05, on 9/30/09, indicated that the when a patient had an oral tube (ETT) the position should be changed every 24 hours. The ETT should be retaped every 24 hours. The frequency can vary depending on the patient's skin condition. Changes should be	E1783		

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E1783	Continued From page 12 documented in the nurse's notes and on the RT Flowsheet. Reason for not retaping every 24 hours should also be documented.	E1783		