California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000002	A. BUILDING ______ B. WING ______	08/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALIFORNIA HOSPITAL MEDICAL CENTER LA	1401 SOUTH GRAND AVENUE LOS ANGELES, CA 90015

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E 000	Initial Comments The following reflects the findings of the Department of Public Health during an investigation of an entity reported incident. Entity Reported Incident Intake Number: CA00233103 Representing the Department of Public Health: Sheilah Creus, RN, HFEN The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. 1280.1 (c) Health and Safety Code Section 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 likely to cause, serious injury or death to the patient.	E 000	HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION 2012 JAN 12 PM 3:31 RECEIVED	
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on review of Patient 1's clinical record, review of the facility documents, and interviews with facility staff, the facility failed to implement their policies and procedures on initiating cardiopulmonary resuscitation (a lifesaving	E 264	E 264 Nursing Service Policies and Procedure Written policies and procedures related to Cardiopulmonary resuscitation have been implemented to ensure that hospital personnel call a Code Blue on any patient or visitor found to have no pulse and/or no respirations unless the patient has been designated as a 'DNR'.	

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procedure) and promptly calling a "Code Blue" for a patient who was not breathing. Patient 1 was identified in the CT scanning room with circulation problems, with no visible chest movement and was not breathing. The patient was covered and transported back to the emergency room, placed in a bed and then resuscitation measures were initiated and were unsuccessful.

Findings:

On August 17, 2010, an unannounced visit was made to the facility to investigate a facility reported incident regarding a patient death due to a possible failure to monitor the patient, failure to report the patient's critical condition and failure to resuscitate.

The medical record for Patient 1 was reviewed on August 17, 2010. The Admission Face Sheet indicated Patient 1 was admitted to the facility on [redacted] 2010, as a trauma patient from an assault.

The electronic medical record indicated Patient 1 arrived in the emergency department at 6:11 p.m. on [redacted] 2010, by ambulance, with diagnoses that included Traumatic Injury, Multiple Sites, and Alcohol Intoxication.

A review of the Physician's Orders dated [redacted] 2010, at 6:27 p.m., indicated orders for Computerized Tomography (an x-ray procedure that combines many x-ray images with the aid of a computer to generate cross-sectional views and three-dimensional images of the internal organs and structures of the body) (CT) scan of the pelvis, abdomen and chest with contrast, and CT of the head and face without contrast. There was an order for continuous cardiac monitoring and

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On [redacted] 2010, after learning of the event, the employee was suspended pending an investigation which was undertaken immediately. On [redacted] 2010, hospital administration and physicians met with the family of the patient and disclosed the event the details of the event. On [redacted] 2010, the California Department of Public Health was notified of the event and our Root Cause Analysis was conducted. The incident was referred to Peer Review for their review and actions.

On [redacted] 2010, all monitors in the ED were sequestered and sent to biomedical engineering for evaluation.

New policies were immediately implemented that require a physician assessment of a sedated patient before that patient can be moved out of the Emergency Department for testing. A policy change was implemented which required that all significant changes in the GCS be reported to the physician immediately.

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pulse oximeter readings, and to keep oxygen saturations greater than 95%. (Measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry. Normal reading is 95 to 100 %).

The Trauma Patient History and Physical report dated [redacted] 2010, at 7 p.m., indicated Patient 1 was able to state his name and what happened to him. The diagnosis was "assaulted with head trauma and facial trauma with abrasions." The report also indicated Patient 1's heart rate was 105 per minute, the blood pressure was 116/86, the oxygen saturation was at 96% on room air (no supplemental oxygen needed~21%, supplemental oxygen begins at 22% to 100% maximum), and the Glasgow Coma Scale (GCS) was 14.

The Glasgow Coma Scale (GCS) is a scale used as an objective way to initially assess and reassess the level of consciousness of a patient. It is used on all acute medical and trauma patients. (http://en.wikipedia.org/wiki/Glasgow_coma_scale) The consciousness level is classified based on how a patient would respond when eye opening and verbal/motor responses are being checked. Patients with mild head injury have a GCS score of 13 to 15, moderate head injury has a GCS score of 9 to 12 and severe head injury has a GCS score of 8 or less.

According to the Trauma/Resuscitation Flowsheet dated [redacted] 2010, at 6:11 p.m., Patient 1's GCS was 14 which indicated he opened his eyes spontaneously, obeyed commands, and was confused. At 6:22 p.m., Patient 1 was combative, uncooperative and attempting to strike at staff. Patient 1 was given

On June 28th 2010, the employee was terminated.

In July of 2010, new monitors arrived for transporting patient.

During the months of June July and August of 2010, the Hospital President personally held town hall meetings to present the details of the event to all hospital employees in order to reinforce our policies and impress upon them that they all have a responsibility for the wellbeing of every patient, not just the Registered Nurse. This was followed by our mandatory "Speak-Up-Speak-Out" campaign that was designed to empower all hospital employees to pay attention to their surroundings, bring problems to the attention of their supervisors and intervene when they come upon anyone in distress.

We are continually monitoring and tracking Code Blue events at the hospital each month. Each Unit Director is responsible for their staff's compliance with the policies. We have implemented a "Code Help" program so patients and their families can seek immediate assistance if their caregiver is not in their room.

9/2010

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E 264	Continued From page 3 Ativan (an anti-anxiety medication) at 6:25 p.m. and at 6:30 p.m. At 6:47 p.m., Patient 1 "remained altered and combative, medicated per order." Patient 1 was given Haldol (an anti-psychotic) at 6:47 p.m. At 7 p.m., Patient 1 "remains altered-reason unable to transport at to CT at this time. Dr. XX aware. Airway patent, breathing even/unlabored." Patient 1's GCS was documented as 14 at 7 p.m. The trauma/Resuscitation Flowsheet dated [redacted] 2010 at 7:27 p.m. (prior to transport for a CT scan), indicated Patient 1's heart rate was 130 per minute; the blood pressure was 157/88; the respiration rate was 20 per minute, his oxygen saturation was 95%, and his GCS was 7. The GCS of 7 was defined in the Trauma/Resuscitation Flowsheet as the patient's eyes opened to painful stimuli, he withdrew from pain (as his motor response), and Patient 1 was confused (verbal response). At 7:30 p.m., it was recorded on the Trauma/Resuscitation Flowsheet that Patient 1 was receiving oxygen at 15 liters per minute (lpm). The Trauma/Resuscitation Flowsheet dated [redacted] 2010, revealed that at 7:30 p.m., the patient was "transported to CT via gurney on cardiac monitor with pulse ox (pulse oximeter- monitors oxygen saturation) /bp (blood pressure) cuff." Another entry on the Trauma/Resuscitation Flowsheet dated [redacted] 2010, at 7:30 p.m., by Employee A, disclosed "Pt. (patient) sedated, GCS 7, arousable to pain, on cardiac monitor with pulse ox/by cuff, O2 (oxygen) 15 lpm via a NRM (non-rebreather mask-a device used to deliver high oxygen concentrations to the patient that is worn over the nose and mouth.), on 4-pt (point) restraint." According to the facility document,	E 264		

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E 264	Continued From page 4 "Trendable M-8," the patient's oxygen saturation at 7:27 p.m. was 88 %. According to the facility's "summary of facts," while Patient 1 was sedated, with GCS of 7, arousable to pain, on cardiac monitor with pulse oximeter, blood pressure cuff, oxygen at 15 lpm via a non-rebreather mask, Patient 1 was transported to the CT scanning room at 7:30 p.m. with the above vital signs. The CT of the head was completed at 7:44 p.m., the chest was done at 7:52 p.m., and the abdomen/pelvis was completed at 7:54 p.m. At 7:56 p.m., Patient 1 was taken out of the CT scanning room, with the staff stopping the gurney for several seconds to check if the patient was breathing. According to the facility's summary of facts, there was no visible chest rising and no resuscitation efforts were started. The staff "covered the patient up" and continued to bring Patient 1 back to the Emergency Department room, passing the physician sitting at the desk with no indication to the physician that anything was wrong with the patient. At 7:57 p.m., Patient 1 was taken back to his bed in the Emergency Department. At 7:58 p.m., the physician was called to the patient's bed and an EKG was performed (first documentation of an ECG since returning from CT scanning room). The Resuscitation Record dated [redacted] 2010, disclosed that Patient 1's pulses were impalpable and the patient was in asystole (absent heart beat) at 7:58 p.m. CPR was initiated, rescue medications were given, Patient 1 was intubated (inserted a tube into the larynx so that oxygen can be supplied to the lungs) at 8 p.m., and a defibrillator was used twice. At 8:12 p.m., the CPR was terminated and the patient was pronounced dead by the physician.	E 264		

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A review of the Radiology Report for CT Abdomen and Pelvis with Contrast dated [redacted] 2010, revealed "Reflux of contrast is noted down the IVC (Inferior Vena Cava - a large vein which returns blood to the heart from the lower part of the body.) No evidence for contrast flow into the heart. Stasis of contrast within the venous structures worrisome for cardiac arrest."

During an interview on August 26, 2010, at 3:28 p.m., Employee B, a Radiology Technician, explained that in a normal circulatory system, you can see the contrast going in the aortic vessel to the heart, however with Patient 1, the contrast went up the inferior vena cava and backflows. "I told the nurse and the tech - something was wrong with this patient, he has no circulation. They put the patient on the bed." Employee B stated a "code blue "(CPR policy and procedure) was not called in the scanning room, despite the fact that he thought the patient had bad injuries and had a circulation problem. Employee B stated he never saw the patient move while in the CT scanning room.

Employee C, an Emergency Medical technician, was interviewed on August 30, 2010, at 8:26 a.m. Employee C stated that during the transport, Patient 1 was sedated with medications and "was very still." During the scan, Patient 1 "did not move at all." After Patient 1 and the monitor were positioned in the scanning bed, Employee C stated that he and Employee A went to the waiting room of the CT room where Employee A charted on his patient notes. Employee C stated that after the scan was done, "We got the patient, placed him on the gurney and as we were coming out the door, I looked at the patient. I said, this patient may not be breathing" to Employee A and

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Employee A replied, "Let's just take him to his room." Employee C stated a code blue was not called in the hallway after Employee A was notified Patient 1 was not breathing. Employee C stated he does not recall if Employee A notified the physician as they walked past the Nursing Station that Patient 1 needed CPR.

The facility policy and procedure titled, "Cardiopulmonary Resuscitation Procedures" dated September 2009, indicated "Hospital personnel shall initiate cardiopulmonary resuscitation and shall call a "Code Blue" on any adult found in the facility to have no pulse and/or no respiration unless an Advance Directive for health care or other appropriate document dictates otherwise."

A document titled, "Notice of Termination" dated June 28, 2010 indicated Employee A was terminated due to failure to monitor and observe the patient's physical condition, signs and symptoms in order to provide proper nursing care and treatment."

The facility's failure to implement their policies and procedures to ensure CPR was administered to Patient 1 when the Registered Nurse (Employee A) was informed the patient was not breathing is a deficiency that has 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.