P.O.C. Egm 11/8/11
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HEALTH FACILITIES
INSPECTION DIVISION
ADMINISTRATION

2011 NOV -4 PM 3:40

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FORM APPROVED
OMB NO. 0938-0391

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
	CA930000072	A. BUILDING _____ B. WING _____	07/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAISER FOUNDATION HOSPITAL - LOS ANGELES	4867 SUNSET BLVD LOS ANGELES, CA 90027

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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 Event. Entity Reported Incident Number: CA00233429. Representing the Department of Public Health: Edgar Solis, RN, HFEN. The inspection was limited to the specific adverse 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 a patient.	E 264	In response to the event that occurred on [redacted]10, the following corrective actions were taken by Nursing Management and Hospital Administration: • An immediate post event investigation was conducted by the Chief Nurse Executive (CNE), the Nursing Director and the Medical Surgical Nurse Manager. • A Situation Management Team (SMT) was held on 6/21/10. The SMT was attended by the Chief Executive Officer, Area Medical Director, Chief Nurse Executive, Nursing Director, Nurse Manager, the Patient Safety Director, the Assistant Administration for Patient Safety and Quality and the treating physicians. • An email communication was issued by the Area Medical Director on 6/22/10 to advise all hospital physicians that the placement of patients with femoral central venous catheters on the medical surgical units was no longer permitted. (Attachment A)	6/22/10
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 interview and record review, the facility failed to implement its policy and procedure by failing to ensure Patient 1's cardiac monitor was being viewed by staff at all times. Patient 1's cardiac (heart) rhythm on the cardiac monitor screen was blank for 10 minutes and the monitor was not being watched continuously by staff which delayed in staff intervention. Patient 1, who	E 264	• An immediate ban restricting the placement of patients on cardiac monitors, confused or disoriented patients, patients on restraints and patients with infectious disease processes on 4 West was implemented on 6/21/10. These restrictions were communicated to the Nurse Staffing Office, the Bed Control Coordinators, the 4 West Nurse Manager and staff on 6/24/10 by the CNE. • An email communication was issued by the Assistant Area Medical Director for Hospital Operations and the Chief Nurse Executive on 6/25/10 to all hospital physicians addressing the regulatory requirements for physician documentation for patients in restraints (Attachment B). • A full investigation was conducted by the Patient Safety Department with full participation of the CNE, the Nursing Director, the Nurse Manager, the involved nursing staff, the treating physicians and hospital administration from 7/9/10 to 8/4/10.	6/21/10 6/25/10 8/4/10

Licensing and Certification Division

B Hellmuth RN
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Accreditation Director

(X6) DATE: 11/2/11

California Department of Public Health

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E 264	Continued From page 1 had a loose wrist restraint, pulled her left femoral hemodialysis catheter (the catheter is a tube inserted into the vein at the groin area for venous access to remove blood from the body, cleanse and return to the body), bled from her femoral vein, and expired within hours. According to the Certificate of Death, the immediate cause was exsanguination (losing blood) with displaced femoral intravenous line. Findings: The Department received a facility letter dated June 23, 2010 which indicated that on [redacted] 2010 Patient 1 "was discovered by staff at approximately 1 p.m." "pulseless and non-responsive." According to the letter, a hemodialysis catheter that had been in her left femoral vein was displaced and found on the bed beside the patient. Patient 1 was pronounced dead at 1:25 p.m. On July 12, 2010, an unannounced visit was made to investigate an entity reported incident regarding quality of care. On July 12, 2010, a review of Patient 1's History and Physical assessment dated [redacted] 2010, indicated the patient was admitted to the facility with the diagnoses of congestive heart failure (weakened heart), atrial fibrillation (abnormal heart rhythm), and dementia. The patient was admitted to the telemetry unit where the patient's heart rate and rhythm are to be continually monitored by a cardiac monitor. A review of a Procedure Note dated [redacted] 2010, indicated a hemodialysis catheter was placed into Patient 1's left femoral (groin area) vein for hemodialysis treatment. The	E 264	The action plan from that investigation is reflected in Attachments C through G. • The 4 West Relief Charge Nurses were retrained on how to sign on to the Vocera/ Emergin electronic notification system on 8/25/10 (Attachment C). • The revised 4 West staffing guidelines and admission criteria were formally presented to the Bed Utilization Coordinators and Administrative Managers by the Medical Surgical Nursing Director on 9/17/10. • The 4 West staffing levels/mix were formally approved by the Medical Surgical Nurse Management Team and the nursing union on 11/1/10 (Attachment D). • The 4 West Structural Standards were formally revised on 10/12/10 to include the admission restrictions on patients with cardiac monitors, confused or disoriented patients, patients with infectious disease processes and patients on restraints (Attachment E). • Mandatory staff retraining on requirements for restraint monitoring and documentation was conducted for the 4 West nurses from 6/22/10 to 8/10/10 by the Clinical Nurse Specialist and the Nurse Educators. 87% (55/83) nurses were retrained in this time frame. This training continued on a 1:1 basis for nurses who were on vacation or leave of absence until 2/5/11 when 100% of the 4 West nurses (55/55) were retrained on these requirements. (Attachment F) • Mandatory education was conducted for the 4 West nurses, the Nephrologists, and the Family Medicine physicians from 9/1/10 to 9/30/10 on the hospital escalation policy and the process for communicating patient care concerns to a higher authority (Attachment G). • A formal nurse competency validation process was implemented on 6/30/11 for the 4 West nurses on the requirements for central telemetry station coverage and the Vocera/ Emergin electronic alarm notification system sign on and activation.	8/25/10 9/17/10 11/1/10 10/12/10 2/5/11 9/30/11

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E 264	Continued From page 2 hemodialysis catheter was sutured to the patient's body. A review of a Registered Nurse Multi-Discipline Progress Note dated [redacted] 2010, indicated Patient 1 "began to pick at her R [right] arm dressing and at her femoral port [hemodialysis catheter]. A restraint order was obtained and [the patient] was placed in bilateral wrist restraints." A review of " Request for Restraints Order " dated [redacted] 2010 at 4 p.m., indicated to place Patient 1 in restraints due to the patient's attempts to interfere with medical devices (i.e. hemodialysis catheter). A review of a written statement given by RN 1, the registered nurse assigned to Patient 1, indicated that on [redacted] 2010, before her shift was over, RN 1 and RN 2 spent approximately 20 minutes or more conducting a narcotic count in the medication room. At about 12:40 p.m., after completing the narcotic count, RN 1 noticed Patient 1's cardiac monitor was off and found the patient in a pool of blood. Patient 1 had "pulled out her [hemo]dialysis catheter from the left groin." RN 1 then called a code blue (code called when a patient is in respiratory or cardiac arrest). RN 1 also indicated she was carrying a "Vocera" alarm receiver (communication system that syncs the cardiac monitor with a receiver carried by staff), however the receiver did not alarm when Patient 1's cardiac monitor was blank. During an interview with RN 3 on July 12, 2010 at 1 p.m., RN 3 stated RN 2 was responsible to log the staff into a Vocera alarm receiver; however, RN 2 was not educated on how to use it. A review of an undated written statement	E 264	Competency was validated on 100% of the staff nurses, Clinical Nurse Coordinators, Relief Charge Nurses, Monitor Techs, and the Ward Clerks by the Clinical Nurse Specialists and Nurse Educators from 6/30/11 to 10/6/11. See attached Competency Assessment Form (Attachment H). • The Monitor Tech Role & Responsibilities Policy # 5010 (Attachment I) and the Wireless Communication Policy # 3137 (Attachment J) were revised in 09/11 and are in the process of final approval. Approval will be completed by 11/14/11 and the policy revisions will be fully implemented and any additional staff training on the revisions will be completed by 12/1/11. • An audit has been implemented in the Medical Surgical units, one audit per shift per day for 30 days. The audits are being conducted by the Nurse Manager, the Clinical Nurse Coordinator, or the Relief Charge Nurse. A sample audit tool is attached (Attachment K). Remediation for any identified non compliance will be provided on the spot. The audit results will be monitored weekly by the CNE, Nursing Directors, and Patient Safety Department.	10/6/10 12/1/11 12/1/11

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provided by RN 2, indicated that she was the charge nurse the morning of [redacted]2010. RN 2 stated that at 12 p.m. there was no nurse available to relieve RN 1 from her assignment. RN 2 indicated that she had to be both the charge nurse and monitor technician and she thought the "staffing [was] very unsafe." According to the written statement, at 12:30 p.m. RN 2 and RN 1 were counting narcotics in the medication room for 20 to 25 minutes. At approximately 1 p.m., RN 2 and RN 1 came out from the medication room and found the cardiac monitor was blank, they went into Patient 1's room, they found blood on the floor and the femoral hemodialysis catheter was pulled out. The patient was non-responsive and pulseless. According to an interview on July 12, 2010 at 4 p.m., RN 2 stated Patient 1's restraint was loose when she was found bleeding from her groin on the day of the incident.

A review of a Code Blue Note written by a physician and dated [redacted]2010, indicated that he responded to a code blue for Patient 1 and upon arrival to the patient's bedside, there was blood on the floor and the femoral hemodialysis catheter was "pulled out." Patient 1 was pulseless and not responsive. Cardiopulmonary resuscitation (CPR) was indicated but was stopped due to the patient's status being "do not resuscitate." Patient 1 was pronounced dead at 1:25 p.m. on [redacted]2010. According to the physician note, "it appeared [the] patient may have exsanguinated by pulling out her femoral dialysis catheter."

A review of an electrocardiogram Strip Report indicated that on [redacted]2010 from approximately 12:36 p.m. to 12:46 p.m., Patient 1's heart rhythm was undetectable. Patient 1's cardiac monitor did not detect a heart beat for

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approximately 10 minutes.

A review of a Death Summary dated June 24, 2011 and written by another physician, disclosed the patient was pronounced dead on [redacted] 2011 and it appeared the patient exsanguinated by pulling out her femoral hemodialysis catheter. The Certificate of Death indicated the immediate cause of death was " exsanguination " (losing blood) with "displaced femoral intravenous line."

A review of the facility's policy and procedure titled "Cardiac/Telemetry Monitoring" dated March 2009, stipulated that the charge nurse/relief nurse would function as the monitor "watcher" during their shift and would ensure that there was always someone to perform the monitor "watcher" function at the nursing station.

The facility's failure to implement its policy and procedure by ensuring that there was always a staff member who functioned as a cardiac monitor
"watcher" and the failure to respond to a cardiac monitor alarm resulted in a delay in recognition that Patient 1's heart beat was stopped due to bleeding from the femoral vein secondary to the displaced femoral dialysis catheter. The facility's failure to implement its policy on cardiac monitoring, is a deficiency that has caused, or is likely to cause, serious injury or death to a patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1