CALIFORNIA HEALTH AND HUMAN SERVICES . .GENCY
DEPARTMENT OF PUBLIC HEALTH

(X2)/Late 6/29/09.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050167	A. BUILDING _____ B. WING _____	07/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN JOAQUIN GENERAL HOSPITAL	500 W. HOSPITAL ROAD, FRENCH CAMP, CA 95231 SAN JOAQUIN COUNTY

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	The following reflects the findings of the California Department of Public Health during a visit to investigate Complaint #CA00136701. Representing the California Department of Public Health: [redacted] HFEN #1934 Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. 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 RULE: is not met as evidenced by: Based on interview and document review, the facility nursing staff failed to implement the facility's Policy and Procedure (P&P) for falls and the Fall Risk Program correctly which resulted in Patient A sustaining a fall with subsequent head injury and death. On admission, Patient A's fall assessment did not include the additional 4 points associated with past history of falls, resulting in a lower Fall Risk Score of 4 instead of an 8. Patient A did not receive slip resistant socks per the facility's fall precautions and was allowed to use her bedside commode without staff assistance resulting in her fall. The facility's failures resulted in harm to Patient A, constituting an Immediate Jeopardy (IJ). The IJ was called on 6/26/09 at 10:05 a.m. with the hospital's		T22 DIV 5 CH1 ART3-70213(a) Nursing Service Policies and Procedures Corrective Actions: 1. Standardization of color-coded arm bands: On January 2, 2008, San Joaquin General Hospital changed the color of the armbands for fall precautions from red to yellow, reflecting a state-wide initiative to standardize color-coded armbands in hospitals. The Administrative policy "Identification Bands" was revised, and education packets were distributed and completed by RNs, LVNs, RCPs, LCSWs, MSWs, NAs, HUCs and technicians working in the inpatient units and in the departments of Surgery, Emergency, Cardiology, Radiology, Float Pool, Respiratory Therapy, and Dialysis. In addition, staff members in Pharmacy, Rehabilitation Services, Social Services, Clinical Dietetics, Admitting and Registration, and	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Hospital Director — (X6) DATE: 7/31/09

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	Continued From page 1 administrative and risk management staff . On 6/29/09 the facility presented written acceptable plan of correction that included revisions to P&Ps and staff training. The IJ was lifted on 7/9/08 at 2:45 p.m. with the administrative and risk management staff present after the facility presented and implemented the plan of correction, confirmed during an on-site visit. Findings: A review of Patient A's clinical record was conducted on 9/5/08 at 11:15 a.m. Patient A presented to the emergency department (ED) with complaints of falling at home and being too weak to get up from the floor, for approximately 36 hours. Patient A was able to call out to a neighbor who assisted her and called the ambulance. Patient A was admitted to the hospital on [redacted]07 with diagnoses that included dehydration and generalized weakness. A review of the, "PHYSICIAN ORDERS", (dated [redacted]07), showed under, "Special Precautions-Fall Precautions", "Yes" was circled. The, "Critical Care Flowsheet (dated [redacted]07) indicated that Patient A arrived to the unit at approximately 12:30 a.m. Documentation showed that Patient A was given a, Falls Assessment Scale Score" of 4. Documentation showed that assessment for falls included, "1. Clinical status=1, 2. Mental status=0, 3.		Standards and Compliance were given the education newsletter titled "Color-coded Alert Bands for Patient Safety." The change in armband colors was discussed at the Environment of Care/Patient Safety Committee meetings in November 2007, December 2007, and January 2008 with the expectation that attendees would discuss the topic at their department meetings. New employees are educated regarding the arm bands during orientation. Completed January 2008 and Ongoing. Persons Responsible: The Chief Nursing Officer and Department Managers are responsible for ensuring employees are aware of the meaning of color-coded arm bands. 2. Hourly Rounding: In April of 2008 the Nursing Division started the process of Hourly Rounding. This process has been proven to increase patient safety by reducing falls and preventing pressure ulcers. There are eight key behaviors required when rounding, but the two most important for patient safety and the reduction of falls are 3) Address the 3 P's of pain, potty, and position, and 7) Explain when you or others will return. New staff members are given training on the eight key behaviors during clinical orientation. After performing the hourly rounding, the nurse logs the visit on a log sheet. The log sheets are reviewed daily by the charge nurses to ensure compliance. Deviations	1/2008

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	Continued From page 2 Continence=1, 4. Mobility=0, 5. Age=2, 6. Sex=0, adding up to 4. The area directly under these criteria read, "Past history of falls-automatic 4". 4 or more, or at nurse's discretion, implement care plan". Patient A's fall assessment did not include the additional computation of her fall at home prior to her admission (which would have been a total score of 8). A review of the [redacted]07 (untimed) form, "Occupational Therapy Acute Evaluation" showed that Patient A fell at home and needed moderate assistance with toilet/commode transfers, hygiene and bed mobility. The, "Critical Care Flowsheet (dated [redacted]07) showed that Patient A was given an increased , Falls Assessment Scale" of 5, with an increase in, "Mobility, b. Walks slowly, holds furniture". Documentation (untimed) showed that assessment for falls included, "1. Clinical status-1, 2. Mental status-0, 3. Continence-1, 4. Mobility-1, 5. Age-2, 6. Sex-0. The scale did not reflect the additional, "Past history of falls-automatic 4". Nursing documentation at 2000 (8:00 p.m.) read, "Pt (patient) able to get up and use bedside commode independently voiding and stooling". Another entry at 2320 (11:20 p.m.) read, "Found pt on floor after hearing loud crash. Attempted to get up to BSC (bed side commode) without using call light. Bilateral heel protectors on, no skid proof socks. Helped back to bed". Removed heel protectors and put skid proof socks" (on). Further documentation showed that Patient A was up many times that night to the BSC with moderate assistance. Patient		from expected compliance are addressed with the nurse by the charge nurse or by the department manager. Ongoing. Persons Responsible: The Chief Nursing Officer and the Deputy Directors of Nursing are responsible to ensure the eight elements of Hourly Rounding are being followed consistently. 3. Revision of the Nursing Department policy titled Falls – Inpatient: In June 2008, Nursing Administration approved a new/revised Nursing Clinical Falls Policy. This revised policy included improvement in the risk assessment and prevention measures. The interventions are based on a tiered-level of risk. The new policy also identified specific post-fall management interventions to perform that standardized the post-fall response and assessment. A self-study module with a post-test was provided to 100% of the nursing staff. Objectives of the module are to identify factors that contribute to falls (enabling staff to intervene at that level to decrease the influence of those factors), to explain the use of the new assessment tool, to evaluate proper use of the tool, and to identify appropriate interventions for prevention. The new policy and procedure and education module were the subject of individual unit staff meetings. Falls risk assessment and interventions are part of the annual review of nurse competencies and have	

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	Continued From page 3 A was seen by the in-house physician and monitored. On [redacted]07, Patient A was found to be lethargic (deficient in alertness or activity) and a scan of her head revealed a subdural bleed (A collection of blood on the surface of the brain). Patient A was transferred to the ICU, underwent surgery to remove the blood from her brain. Patient A's [redacted]/07 (untimed) fall scale was 3. On [redacted]07 Patient A's fall scale were all zero's except for, "3. Continence-1 (Patient A had a foley catheter in), documentation showed Patient A was non responsive to verbal stimulus. On [redacted]07 the scale showed, "1. Clinical status=2, 2. Mental status=2, 3. Continence=1, 4. Mobility=0, 5. Age=2, 6. Sex=0, adding up to 7, but did not include the additional 4 for the previous falls and a, "Rehab Care Plan: High Risk For Injury" was initiated. On [redacted]07 the entire fall scale was left blank. Patient A expired on [redacted]07 at 1515 hours. Per the, "Death Summary, Cause of death was cardiopulmonary arrest status post subdural hematoma status post accidental fall. On 9/5/08 at 2:10 p.m., an interview was conducted with the Director of Standards and Compliance, (DSC). The DSC stated that once the physician marks a yes in the fall precautions the patient is to automatically be scored higher on the fall scale,		been included in the 2009 Nursing Skills Fair held July 24th, 27th, and 28th, 2009. New employees are educated on the policy and procedures during their clinical orientation. Completed June 2008 and Ongoing. The Chief Nursing Officer is responsible for ensuring the effectiveness of the hospital's fall assessment and prevention program. 5. Performance Improvement Project – Fall Reduction Program: A performance improvement project focusing on reducing falls was started in the Medical/Surgical areas in May of 2008. The frequency of falls including the severity of any injury is reported monthly and quarterly in Department meetings, the Environment of Care/ Patient Safety Committee, and the Hospital-wide Performance Improvement Committee. On a quarterly basis the patient-fall data is reported to the Medical Executive Committee and the Joint Conference Committee. Individual falls are investigated to determine prevention strategies. Reducing falls and harm from falls continues to be one of the annual goals of the Environment of Care/ Patient Safety Committee. Ongoing. The Deputy Director of Standards and Compliance and the Chief Nursing Officer are responsible for monitoring the performance improvement project and the falls data.	6/2008

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	Continued From page 4 receive a fall-specific colored armband, have anti-skid slippers placed on them. The DSC stated that there was no area on the record to document when these things are implemented. The DSC stated that Patient A did not get the non-skid slippers until after her fall in the hospital. Upon review of the fall scale section in the nurses' notes, the DSC stated that there should always be some kind of supportive evidence when a fall scale is changed and could find no documentation of this in Patient A's chart. The DSC stated that, overall, the nursing staff were not computing the fall assessment scales the same way. A review of the facility P&P titled, "Falls-Patient" (effective date 8/05) under, "Procedure: 1. The physician will write "Fall Precautions" on the admission orders when patients have been identified as a fall risk. 2. The nurse will complete a falls assessment and score and document on the Nursing Admission Assessment sheet upon admission. Most common factors attributing to falls include age (older than 65), higher acuity patients, medications (sedatives, antipsychotics), unsteady gait. 5. On the nursing flow sheet, nursing will document a fall score based on the fall criteria, at least every 24 hours. Shift variations from nurse assessments will be documented on the flow sheet/nursing notes and appropriate actions will be taken to ensure patient safety".			

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