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
	CA070000149	A. BUILDING _____ B. WING _____	C 04/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANTA CLARA VALLEY MEDICAL CENTER	751 SOUTH BASCOM AVENUE SAN JOSE, CA 95128

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incident on 4/14/09, 4/20/09, and 4/21/09. For Entity Reported Incident CA00184152 regarding Death-General, a State deficiency was identified (see California Code of Regulations, Title 22, Section 70215(b)). Inspection was limited to the specific entity reported incident and does not represent the findings of a full inspection of the hospital. Representing the California Department of Public Health: [redacted]	E 000	CALIFORNIA DEPARTMENT OF PUBLIC HEALTH MAY 27 2009 L & C DIVISION SAN JOSE	
E 294	T22 DIV5 CH1 ART3-70215(b) Planning and Implementing Patient Care (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. This Statute is not met as evidenced by: Based on interview, record and document review, the hospital failed to provide an accurate triage assessment and a timely medical screening examination for one patient (1) in the emergency department (ED) which resulted in an immediate jeopardy situation. Findings: Patient 1 arrived in the ED with a family member on 4/6/09 at 1:42 p.m. per referral from a physician in an urgent care clinic. The Nursing	E 294	On 4/07/09 the nurse manager (NM) counseled the registered nurse (RN) focusing on the importance of a detailed review of all documents that accompany the patient upon arrival to the Emergency Department (ED) and synthesizing the information within the patient's triage assessment. If there are	

Licensing and Certification Division

Lindy Johnson, RN (for M Skehan) — Chief Nursing Officer (for Exec Dir) — 5-21-09

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

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E 294	Continued From page 1 Triage record dated 4/6/09 at 1:40 p.m. indicated the patient's chief complaint was dizziness and fatigue for four days. Registered nurse A (RN A) who performed the triage assessment documented the following: the patient had postural hypotension (drop in blood pressure upon standing), denies any serious illness, and had no risk factors for falls. Upon admission on 4/6/09 at 1:52 p.m. the patient's blood pressure was 107/57, his heart rate was 114 (normal range is 60 to 70 beats per minute) and respirations were 29 (normal range is 15 to 20 resting). The records from the urgent care center dated 4/6/09 at 11:15 a.m., where the patient was previously seen, indicated the following: the patient had been dizzy for four days when he stood. He complained of fatigue and blurred vision. He had an episode of dizziness the previous day with a fall and shortness of breath afterwards. The patient was diagnosed with severe anemia by the urgent care physician. The patient's lab work done at the clinic indicated his hemoglobin (the protein molecules in red blood cells) was 6.1. The normal range for men is 13.8 to 17.2 gm/dl (grams per deciliter). The record indicated upon arrival at the urgent care clinic the patient's heart rate was 126, his blood pressure was 74/56, and his respirations were 26. The record indicated the patient was referred to the above hospital's ED for further evaluation and treatment. Abnormal hemoglobin results was documented twice in the record that was sent with the patient to the hospital's ED. The "Health Encyclopedia of Health and Diseases" documented hemoglobin levels below 13.5 gm/dl of hemoglobin in men indicates anemia. A cause of low hemoglobin levels	E 294	any questions or concerns noted in the paperwork and/or the assessment, the triage RN must review with the designated physician (MD) and, when necessary, contact the referring clinic or MD. Based on the information that he nurse gathered off the referring clinics paperwork and his assessment, the patient was assigned a triage level of 3. Medical screening exams (MSE) occur when the patient is seen by the MD; the patient left prior to being seen and did not receive a MSE. During 1:1 interactions and staff meetings, the Staff Developers (SD) and NM reinforced the importance of the accuracy of the triage assessment and the need to bring any questions to the MD if there are questions and concerns. This includes when a patient presents to the ED triage area with paperwork from an ontlying clinic, to thoroughly evaluate that paperwork and bring any significant findings to the attention of the ED physician Althongh the patient had serial vital signs by an Emergency Room Technician (ERT) an ongoing nursing assessmenr of the patient did not occur. The ERT was counseled on the necessity to report any values outside the designated paramcters to the triage RN and/or MD. On 4/30/09 the NM distributed and reviewed the list of vital	

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E 294	Continued From page 2 included bleeding. On 4/15/09 at 9 a.m. RN A stated the patient gave him the clinical record from the urgent care center. He stated he reviewed the record during the triage assessment. On 4/15/09 at 9:20 a.m. the triage nurse stated he "assumed" the line drawn under the hemoglobin results was a line drawn through the results indicating the values documented were incorrect. He stated he did not further clarify the above hemoglobin results with the physician at the clinic and was not aware of other documentation found in the patient's records indicating the patient's hemoglobin was 6.1 gm/dl. He stated the patient did not appear in acute distress and was able to ambulate to the triage area and then to the waiting room, so he triaged the patient as a Level 3. The Hospital policy and procedures, "Triage Process" indicated the following: "The goal of triage is to rapidly assess and identify life, sight, or limb threatening emergencies...Triage is not a medical screening examination. Triage is intended to determine the order in which patients will be seen, not whether the patient has an emergency medical condition." The policy further indicated "Any patient who is in need of immediate care for sight, limb, or life threatening emergencies shall be classified as Triage level 1 or 2, and escorted immediately to an appropriate bed in the treatment area...All non emergent patients will be categorized as Level 3, 4, or 5. The policy further indicated a Level 3 is "potentially serious but not life threatening at present." On 4/15/09 at 9:30 a.m., RN A stated if he had been aware the patient's hemoglobin was 6.1 he	E 294	sign parameters to nursing staff and when it is required to notify the RN/MD. This includes when the ERT obtains vital signs on a patient that are out of range that those values are reported to the nurse for re-evaluation and assessment. A root cause analysis was completed on 4/9/09. On 4/29/09, this event was reviewed in the Emergency Performance Improvement Committee (EPIC). Additional action items include: 1) During peak hours (as determined by patient volume and acuity) a lobby nurse and intake physician are added to the waiting area. Their goals are to rapidly assess level 2 and 3 patients waiting to be seen. They will also initiate proper treatments and lab/DI studies. This was implemented on 4/13/09 , 2) ED policy, A-6634-066, was created to elarify the roles and responsihilities of the triage RN, the lobby RN and the lobby ERT 3) A process was formalized to include if/when a patient informs a non-licensed staff that he/she is leaving without being seen, then the staff will notify the triage RN to assess the patient. The triage RN will explain the potential consequences of not being seen by a physician, communieate this to the designating physician, and assist with identifying an appropriate location for the physician to begin seeing the patient.	

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E 294	Continued From page 3 would have assessed him as a level 2 acuity which would have changed the priority for the patient to immediately be medically screened by the physician when the next room was available. As a level 3 acuity the patient had to wait until the urgent cases had been seen. On 4/15/09 at 9:30 a.m. the nurse manager of the ED stated the number of patients seen in the ED on 4/6/09 was around 400 so the wait time for nonurgent patients on that day was longer than the desired 3 to 4 hours. The record indicated the patient's heart rate had increased to 119 at 8:26 p.m. The nurse note indicated at 8:26 p.m. when the above vital signs were taken, a family member asked how much longer Patient 1 had to wait to be seen. She said she did not have time to wait any longer. The nurse documented the patient and family member were seen walking toward the waiting room rest room. The record lacked documentation a physician was informed of the patient's increase his heart rate or that he wished to leave the hospital. The patient was in the ED waiting room for approximately seven hours with a medical emergency condition without a medical screening examination by a physician, which could cause or likely cause death. On 4/6/09 at 11:31 p.m. the physician documented the patient was found in the lobby unconscious and a code blue (cardiopulmonary resuscitation) was started. The record indicated the code was started at 8:40 p.m. on 4/6/09 and stopped at 9:40 p.m. The resuscitation was unsuccessful and the patient expired. The hospital failed to provide a comprehensive and accurate assessment which prevented the	E 294	The NM or her designee and the ED Medical Director or his designee will monitor a minimum of sixty medical records per month for accuracy of assessment to level designation (level I, II or III), vital signs and notification of RN/MD if outside the determined parameters, timeliness of MSE and documentation. Monitoring will occur for a minimum of 3 months and continue until benchmark is reached. Results will be reviewed at EPIC, the Executive Nursing Committee and reported up to the Steering Committee for Improvement of Organization Performance. Action Plans will be developed by the committees or nurse manager as needed.	

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E 294	Continued From page 4 patient from having an immediate medical screening examination and treatment by a physician which caused, or most likely resulted in the patient's death.	E 294		