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FORM APPROVED

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 09/22/2011

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 a complaint conducted from 08/09/11 to 09/22/11. For Complaint CA00280742 regarding Quality of Care/Treatment, a State deficiency was identified (see California Code of Regulations, Title 22, Section 70215(b)). Inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the hospital. Representing the California Department of Public Health was 28767, Health Facilities Evaluator Nurse. Health and Safety Code1280.1 (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 the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY	E 000		
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:	E 294		

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
FEB 2 2012
L & C DIVISION
SAN JOSE

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 2/1/12

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E 294	Continued From page 1 Based on observation, interview, and record review, nursing failed to assess one sampled patient (1) when his cardiac (heart) monitor stopped displaying his cardiac rhythms. The failure to respond to the emergency situation delayed emergency treatment. The patient was not assessed for approximately nine minutes. When the nurse did assess Patient 1, she found him lying on the floor, unresponsive, and disconnected from the cardiac monitor. The hospital emergency (code) team gave the patient cardiopulmonary resuscitation and placed him on life support. Cardiopulmonary resuscitation is only likely to be effective if commenced within six minutes after blood flow (heart beat) stops because permanent brain cell damage occurs. Patient 1's post emergency condition included severe anoxic (lack of oxygen) brain injury. Due to the patient's lack of brain function and poor prognosis, he was removed from life support systems, resulting in his death. Nursing's failure to timely assess the patient's cardiac status resulted in delayed emergency care which caused, or is likely to have caused, serious injury or death for the patient. Findings: On 8/9/11, Patient 1's medical record was reviewed. The Discharge Summary dated [redacted]/11 indicated Patient 1 was an active, alert and oriented, 83 year old who had a brief loss of consciousness at home, and fell on [redacted]/11. He was transported to the emergency department (ED) and a computed tomography (CT) scan (an X-ray procedure that combines many X-ray images with the aid of the computer to generate cross-sectional views) report demonstrated he suffered a left subarachnoid hemorrhage (bleeding into the brain) due to the fall. Patient 1 was admitted to the Trauma Intensive	E 294	 Monitoring of patient was discontinued for nine minutes without follow-up by a RN. The monitor technician called for the nurse, but the existing policy and process describing the timeframes for follow-up and assurance of a RN assessment were not clearly spelled out for the telemetry area. Action Taken: On the shift following the patient fall, the monitor technician and those subsequently performing as monitor technicians, including RNs acting as monitor technicians, were mandated to implement a new process: When a patient is off the monitor, the monitor technician is required to	7.20.11 by Director, Critical Care and Nurse Manager TCNU

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E 294	Continued From page 2 Care Unit on [redacted]/11 for close observation. According to the Discharge Summary dated [redacted]/11, over the next two days the patient's neurological status remained stable. Review of the [redacted]/11 at 2:30 p.m. physician order indicated the patient was transferred to the Transitional Care Neurosurgery Unit (TCNU) Stepdown for Q2 (every two hour) neurological checks (nursing assessment of a patient's neurological [brain function] status) and "telemetry monitoring [cardiac monitoring] except for tests." The physician order dated [redacted]/11 documented Patient 1 was a full code (perform cardiopulmonary resuscitation, if needed). During an interview with Patient 1's telemetry primary nurse (RN 1) on 8/10/11 at 9:20 a.m., RN 1 stated at the beginning of her shift (11 p.m.), Patient 1 was oriented to self (knew who he was) and was able to follow commands. RN 1 further stated Patient 1 was a fall risk and fall precautions (nursing interventions to prevent falls) were established. RN 1 stated she walked by Patient 1's room at 1:25 a.m. and noticed he was lying in bed with his eyes closed. She proceeded to the room next door, where she was receiving a new patient. At approximately 1:36 a.m., she walked by Patient 1's room again and noticed the patient was on the floor, face down. RN 1 confirmed the telemetry box (a medical device connected to the patient which monitored Patient 1's cardiac rhythm), was on the floor, not attached to the patient. RN 1 stated she yelled for help. When they turned Patient 1 over, he was "pale and bluish". At that exact time, she heard the monitor technician (MT 1), an employee trained and assigned to observe the TCNU cardiac monitors, call into the patient's	E 294	immediately notify the nurse by overhead page or Vocera of the patient needing assessment. If the nurse does not respond immediately and the rhythm is restored on the monitor, the monitor technician is ordered to call the nurse in charge to assure someone is checking the patient. The nurse checking the patient is to notify the technician of the patient status immediately and replace the leads. Additionally, to distinguish planned removal of leads, the process for notifying the monitor technician of routine removal of patients from monitors was clarified. A policy covering all telemetry areas was revised by Nursing Management and approved by Nursing Administration, Policy "Telemetry – Cardiac Monitor Alarm Notification & Escalation Procedure", # A-6504.38.1, A6527-14.0 (see attachment). Starting 7/25/2011, all nurses and monitor techs were in serviced on the new policy. Monitoring: Compliance with the policy is audited at least weekly on each shift on TCNU. When a patient's rhythm is not displayed on the monitor, the monitor tech documents the response time of the RN and the escalation to a second RN if needed. The Nurse Manager reviews these findings weekly and counsels monitor techs and nurses if they do not meet the above standards. These results are reported to the Executive Nursing Council (ENC) Quality meeting on a quarterly basis. The Nurse Manager is responsible for the monitoring and reporting to the Director and Executive Nursing Council quarterly.	In-service and implement ation completed by 8/14/2011 Begin reporting January 2012..

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room to notify her Patient 1 was off the monitor. RN 1 responded to MT 1, and notified MT 1 Patient 1 had coded (cardiac arrest). The hospital code team arrived and performed cardiopulmonary resuscitation. RN 1 stated she did not hear the overhead page MT 1 announced the patient was off the monitor at 1:27 a.m.

According to Patient's 1 Discharge Summary dated [redacted]/11, Patient 1 suffered severe anoxic brain injury from cardiac arrest and was put on life-support. On [redacted]/11, the patient's family decided to take Patient 1 off life support due to the patient's poor prognosis. Patient 1 passed away later that day.

On 8/10/11 at 9 a.m., during an interview with MT 1, she stated Patient 1 was "off" the cardiac monitor [no cardiac activity showing on the monitor screen] for approximately nine minutes. On 8/10/11, review of Patient 1's cardiac rhythm strips (documented heart rhythms) indicated the last rhythm strip that presented cardiac activity for Patient 1 was dated [redacted]/11 at 1:27 a.m.

MT 1, who was responsible for observing the TCNU monitors at the time of the incident, was interviewed on 8/10/11 at 9 a.m. MT 1 stated that at approximately 1:27 a.m. on [redacted]/11 she noticed Patient 1's cardiac rhythm was not registering on the telemetry monitor screen. MT 1 stated she made an announcement on the overhead paging system that Patient 1 was off the monitor. MT 1 stated she made a second attempt to notify nursing that Patient 1 was off the monitor at 1:36 a.m. when she called into Patient 1's room to notify the patient's primary nurse that Patient 1 was off the cardiac monitor. MT 1 stated the nurse responded from the patient's room and told her the "patient coded" (cardiac

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E 294	Continued From page 4 arrest). When asked why there was a nine minute delay from the first announcement to the second announcement, MT 1 stated she was occupied performing other tasks and lost track of time. MT 1 described the usual steps taken to notify nursing when a patient was off the monitor. She stated first an announcement was made over the intercom. If nursing did not respond within two minutes, a second intercom announcement was made, along with a call to the primary nurse through the "Voicera System". If there was still no nurse response, another overhead page was made through the intercom system. A tour of the TCNU department was conducted on 8/9/11 at 11 a.m. The TCNU provided continuous cardiac monitoring for the patients in the unit. The continuous cardiac monitoring in TCNU was performed by a monitor technician (MT). During the tour it was noted an MT was stationed in a private room approximately 10 to 15 feet around the corner from the TCNU nurses stations. The MT was observed sitting in front of screens which displayed the cardiac rhythms for the TCNU patients. The room included a microphone system the MT could use to page staff, and a call light system which allowed the MT to make voice contact with the patients in their rooms. The MT could also contact nurses via Voicera (a personal intercom communication device carried by the nurses). Prior to his hospital admission, Patient 1 was an independent and active person. According to the discharge summary notes, Patient 1 came into the hospital for "minor trauma". The patient's cardiac rhythms were not monitored for approximately nine minutes. During that time,	E 294		

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E 294	Continued From page 5 Patient 1's emergent situation was not assessed by nursing staff, therefore delaying treatment. Patient 1 suffered severe anoxic brain injury due to a cardiopulmonary arrest of undetermined etiology (unknown cause). These actions caused, or are likely to have caused, serious injury or death for the patient and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code, Section 1280.1	E 294		