CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050680	A. BUILDING _____ B. WING _____	02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHBAY VACAVALLEY HOSPITAL	1000 NUT TREE ROAD, VACAVILLE, CA 95687 SOLANO COUNTY

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	The following reflects the findings of the California Department of Public Health during an Entity Reported Incident visit. Entity Reported Incident number(s):#CA00140307. Inspection is limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the California Department of Public Health: [redacted] T22 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. Based on clinical record review and staff interview, the hospital failed to ensure that staff implemented the written policy and procedure titled "Prevention and Management of Falls," when Patient 2 was left unattended and fell off a bedside commode, and re-fracturing his left hip. This failure resulted in Patient 2 requiring a second surgery to repair the re-fractured left hip. THE FOLLOWING EVENT CONSTITUTED AN IMMEDIATE JEOPARDY (IJ), WHICH PUT THE HEALTH AND SAFETY OF PATIENT 2 AT RISK WHEN STAFF FAILED TO IMPLEMENT THE HOSPITAL'S WRITTEN POLICY AND PROCEDURE TITLED "PREVENTION AND		**CORRECTIVE ACTIONS:** 1. The staff involved in this situation were counseled regarding the importance of reviewing and following the patient's plan of care. — 2/15/08 2. Re-educated nursing staff and PT staff on use of SBARQ communication during transfer of care to another provider. — 2/18/08 3. Name and Spectra-Link phone number of RN or Lead RN phone number written on patient's white board each shift to facilitate notification of nursing staff without leaving patient's room. Name of CNA written on white board. — 2/22/08 4. "Fall Prevention Tips – Call, Don't Fall" education program for all patients was developed by the Clinical Practice Manager. — 4/4-11/08 5. All nursing staff educated on the new patient education program through a Webex inservice as part of the Annual Nursing Skills Fair. — 5/27-30/08 6. "Fall Prevention Tips – Call, Don't Fall" education handout added to the Patient Admission Packet. — 5/27/08 7. "Lessons Learned" document developed and submitted to all Directors for review with staff to explain the outcomes of this — 2/29/08	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Sugiyama | TITLE: President | (X6) DATE: 12/23/08

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	Continued From page 1 MANAGEMENT OF FALLS." PATIENT 2 WAS LEFT UNATTENDED ON A COMMODE AND SUSTAINED A FALL, WHICH RESULTED IN A RE-FRACTURE OF HIS LEFT HIP, REQUIRING A SECOND SURGERY TO REPAIR THE HIP. THIS FAILURE PLACED THE PATIENT AT RISK FOR COMPLICATIONS FROM A SECOND SURGICAL PROCEDURE TO REPAIR THE HIP. Findings: On 2/14/08 at 3 p.m., a review of Patient 2's record with administrative staff revealed documentation that Patient 2 was admitted on 12/22/07 with the diagnosis of a left hip fracture. On admission, Patient 2 was assessed as being at a high risk for falls (Morse Fall Risk). Documentation revealed that there was a green dot on the outside of the patient's room, signifying that the patient was a fall risk. A bed alarm had been placed on the patient's bed, and the patient was in a room close to the nurse's station. On 2/14/08 at 3:30 p.m., Administrative Staff B stated during an interview, that Patient 2 should not have been left alone in the room, considering that Patient 2 had chronic cognitive impairment and that the medical record documented that the patient was weak, had decreased mobility, and a gait/balance deficit. Administrative Staff B stated that there was no alarm used while patients' are out of bed using a bedside commode. During Interview on 2/14/08 at 3:45 p.m., Administrative Staff A stated that on 1/3/08 at		event and the actions taken. 8. Currently trialing hourly rounding on the Medical – Surgical Units to determine if this action will improve patient outcomes. 9. Begin open dialogue about collaborative patient care between nursing and rehabilitation staff. Director, Rehabilitation Services to attend January Lead RN Meetings at both facilities. **ONGOING MONITOR(S):** 1. Name of the patient's RN written on the white board in the patient's room. 2. Spectra-Link # of RN listed on white board in patient room. 3. C.N.A. name listed on white board in patient room. 4. Complete 10 observations for each shift in each clinical area. 5. Audit all shifts until 100% compliance achieved and sustained for at least 4 months. 6. Re-evaluate action plan monthly as part of audit review to insure timely correction of any barriers to improvement. 7. Audit data to be reviewed monthly by PI/Nursing Committee, Performance Improvement/Patient Safety Council, and the Quality Committee.	9/8/2008 1/8/09 1/15/09

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	Continued From page 2 approximately 12:10 p.m., two (2) Physical Therapists' (PTs) had finished walking Patient 2 in the hallway. Patient 2 returned to his room and asked to use the bedside commode before returning to bed. The patient was assisted to the bedside commode by the PTs. One (1) PT left the room. The other PT stayed to pull the privacy curtains and then left the room, leaving Patient 2 alone on the bedside commode. Staff at the nurse's station heard a loud crash that came from Patient 2's room. Staff found the patient lying on the floor on his left side in a fetal position. Patient 2 was taken to the Imaging Department for an X-ray of his left hip at 3 p.m. The X-ray report dated 1/3/08 at 3:31 p.m., confirmed that there was a left cortical fracture, proximal femoral metaphysic (hip fracture). The surgeon needed to order components to do a long stem press-fit of the left hip, which delayed surgery. Patient 2 was taken back to surgery on 1/11/08 for the repair of his re-fractured left hip, once the ordered components arrived and the patient was cleared by anesthesia as being stable for surgery. On 3/25/08 at 3:45 p.m., the Physical Therapist (PT C) stated that she was aware that the patient was a high risk for falls. The patient had been doing well in following instructions regarding hip precautions, balance, and safety precautions. PT C stated that when the patient had returned to his room, he asked to use the bathroom. The patient used the bedside commode. PT C stated that she had placed the walker directly in front of the patient with the call light on the walker. PT C stated that		**RESPONSIBLE PARTIES:** Director, ICU/TCU Director, Rehabilitation Services Director, Performance Improvement/Patient Safety Clinical Practice Manager, Adult Services	

Event ID:D4YO11 12/4/2008 4:00:24PM

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	Continued From page 3 she walked directly to the nurse's station and spoke with the patient's nurse. PT C stated to the nurse, "he is a risk," which means, "immediate attention is needed." PT C stated she then left the unit. PT C stated that it was less than a minute from the time she left the patient that the patient fell off the bedside commode. PT C stated that all staff are aware of the Fall Risk implementation, green dot on the outside of the patients' room, bed-alarm, and being close to the nurse's station. On 3/27/08 at 9 a.m., a review of the Plan of Care for Patient 2 dated 12/22/07, revealed that the Individualized Interventions included: Remain close to the patient when toileting. On 3/27/08 at 10 a.m., Administrative Staff B stated that Patient 2 should not have been left alone in the room while sitting on the bedside commode. The Plan of Care was not implemented as it should have been. The allied healthcare professional (physical therapist) should have stayed with the patient until another staff member arrived. The policy and procedure titled "Prevention and Management of Falls," dated 6/05, indicated that when patients' are assessed as a High Risk for Falls, there must be a plan of care developed to meet the patients' individualized needs. Staff are to ensure that patients' have a safe environment.			

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