CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050305	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2013
NAME OF PROVIDER OR SUPPLIER: Alta Bates Summit Medical Center-Alta Bates Campus	STREET ADDRESS, CITY, STATE, ZIP CODE: 2450 Ashby Ave, Berkeley, CA 94705-2067 ALAMEDA COUNTY		

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	The following reflects the findings of the Department of Public Health during an inspection visit:			
	Complaint Intake Number: CA00373507 - Substantiated			
	Representing the Department of Public Health: Surveyor ID# 16538, HFEN			
	The inspection was limited to the specific facility 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 the patient.			
	Title 22: 70213(d) Nursing Service Policies and Procedures			
	Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical staff.			
	Based on interview and record review, the hospital failed to ensure nursing staff followed patient care policies and procedures for "Swallow Screen by Nursing, Bedside" and failed to follow physician orders to obtain a			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annie Rosario 3/14/14 TITLE: Chief Nursing Executive (X6) DATE: 3/14/14

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Accepted [signature] 3/17/14

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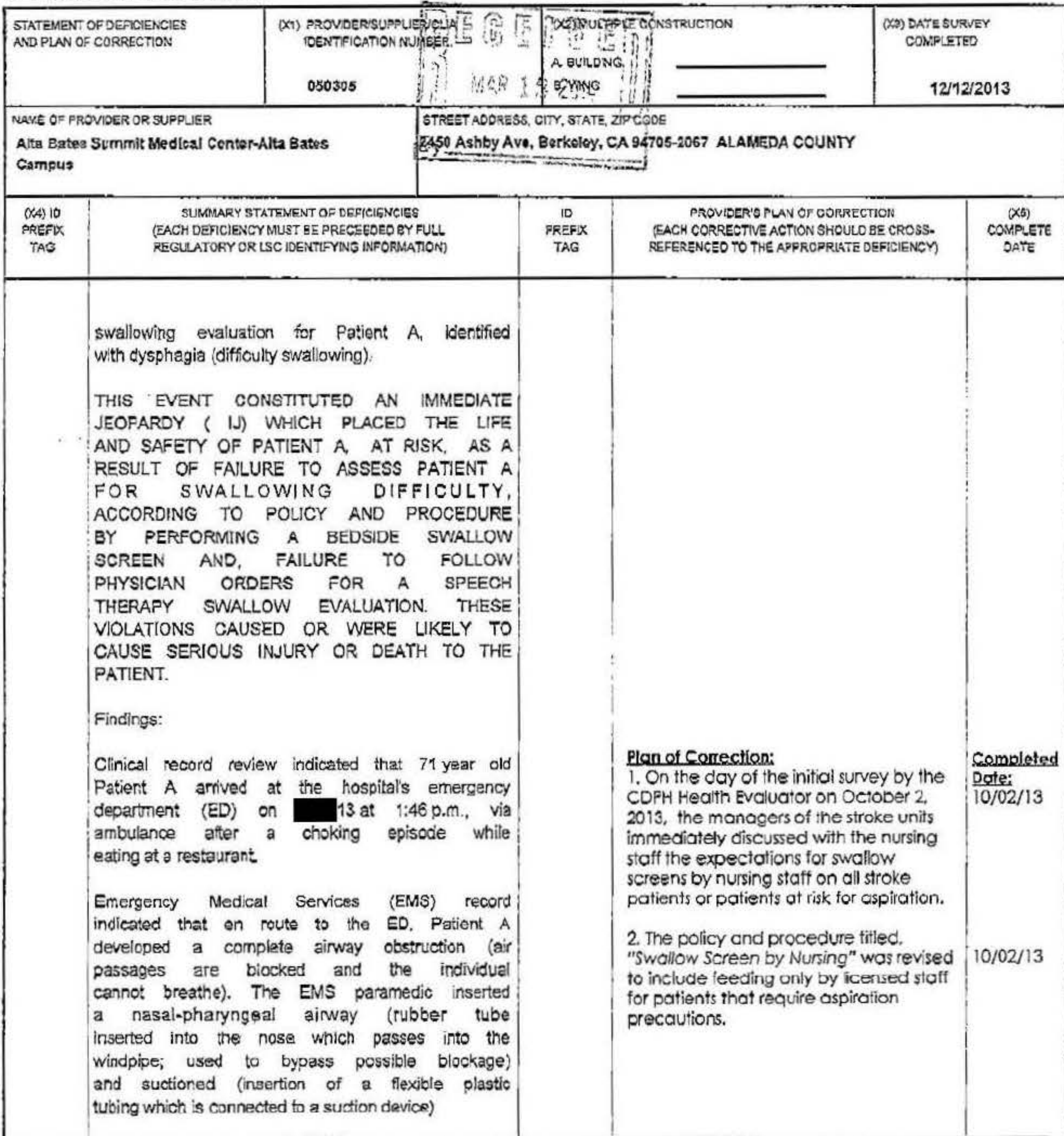

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swallowing evaluation for Patient A, identified with dysphagia (difficulty swallowing).

THIS EVENT CONSTITUTED AN IMMEDIATE JEOPARDY (IJ) WHICH PLACED THE LIFE AND SAFETY OF PATIENT A, AT RISK, AS A RESULT OF FAILURE TO ASSESS PATIENT A FOR SWALLOWING DIFFICULTY, ACCORDING TO POLICY AND PROCEDURE BY PERFORMING A BEDSIDE SWALLOW SCREEN AND, FAILURE TO FOLLOW PHYSICIAN ORDERS FOR A SPEECH THERAPY SWALLOW EVALUATION. THESE VIOLATIONS CAUSED OR WERE LIKELY TO CAUSE SERIOUS INJURY OR DEATH TO THE PATIENT.

Findings:

Clinical record review indicated that 71 year old Patient A arrived at the hospital's emergency department (ED) on [redacted] 13 at 1:46 p.m., via ambulance after a choking episode while eating at a restaurant.

Emergency Medical Services (EMS) record indicated that en route to the ED, Patient A developed a complete airway obstruction (air passages are blocked and the individual cannot breathe). The EMS paramedic inserted a nasal-pharyngeal airway (rubber tube inserted into the nose which passes into the windpipe; used to bypass possible blockage) and suctioned (insertion of a flexible plastic tubing which is connected to a suction device)

Plan of Correction:

1. On the day of the initial survey by the CDPH Health Evaluator on October 2, 2013, the managers of the stroke units immediately discussed with the nursing staff the expectations for swallow screens by nursing staff on all stroke patients or patients at risk for aspiration. — **Completed Date:** 10/02/13

2. The policy and procedure titled, *"Swallow Screen by Nursing"* was revised to include feeding only by licensed staff for patients that require aspiration precautions. — 10/02/13

Accepted 3/17/14

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in an attempt to clear Patient A's airway.

After continued suctioning by the paramedic, a large amount of mucus and food was removed. Patient A's condition was documented as "color improved" and level of respiratory (breathing) distress was documented as "decreased."

Review of the ED physician's physical examination of Patient A indicated that he continued with breathing difficulty and presented with a low oxygen saturation level of 46%,(hypoxia: low level of oxygen circulating in the blood; normal range 95%-100%), and had a history of a prior stroke which resulted in a right sided weakness of his body.

The ED physician admitted Patient A to the medical-surgical Stroke Unit for continued management of diagnoses of choking, hypoxia, and possible aspiration (the taking of a foreign object, for example food, into the lungs). The ED physician's admission orders were as follows:

a. NPO (nothing by mouth) except medications.

b. Bed rest and oxygen at 2 liters per minute and to monitor oxygen saturation (measurement of oxygen in patient's body) continuously.

c. Call hospitalist for further orders.

Review of the Hospitalist physician's

3. The nursing staff in Med/Surg, Critical Care, ED and Acute Rehab were required to read and sign a Self Instructional Module (SIM) regarding the revised policy and procedure including the swallow screening criteria in the electronic health record. This will now be an annual competency for nursing staff in the above referenced departments. Nurses on leave of absence will be required to complete prior to returning to work. — 10/17/13

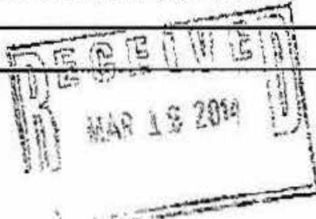
Monitoring Plan:

1. 100% of the nursing staff in Med/Surg, Critical Care, ED and Acute Rehab read the revised policy and procedure including the swallow screening criteria in the electronic health record. — Daily

2. Chart audits on all stroke patients with aspiration precautions were conducted for compliance with the medical center policy and procedure for swallow screen prior to first oral intake until 100% compliance is reached and maintained for four consecutive weeks. — Weekly x4 weeks

3. Random chart audits will then be conducted on all stroke patients and patients with aspiration precautions to assure that compliance is maintained. Any deviation will result in coaching and counseling of the nursing staff. — Monthly

4. As part of the ongoing education and performance improvement, results of the audits will be presented to the staff for review and discussion using a variety of communication modalities. — Monthly



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	(Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients) evaluation and assessment of Patient A on [redacted]13 at 7:40 p.m. indicated the following documentation: 1. Aspiration (event and presumed aspiration pneumonitis [inflammation of lung tissue]). The patient (Patient A) is being admitted due to his continued need for supplemental oxygen and hypoxia. He (Patient A) has been placed on Clindamycin (antibiotic medication); we will continue this. 2. Hypoxia secondary to above. Supplemental oxygen will be weaned as needed. 3. Questionable dysphagia (difficulty swallowing), resulting in aspiration event. We will ask for a speech and swallow therapy evaluation. 4. Anticipated length of hospitalization will be approximately 1-2 days. This was explained to the patient upon initial assessment and evaluation. Anticipated discharge date will be [redacted]2013. However if the patient does well he could potentially be discharged tomorrow [redacted]13). The Hospitalist physician's admission orders for Patient A dated [redacted]13 at 7:45 p.m. showed as follows: 1. Admit to Med(ical)-Surg(ical) Unit		5. As part of the monitoring process, results will be reported to the Core Stroke Team. **Responsible Parties:** Chief Nursing Executive Clinical Practice Support Nurse Managers Nursing Staff Stroke Coordinator	Monthly

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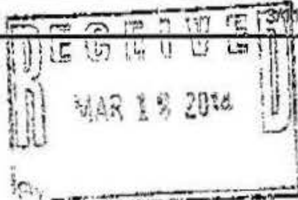

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2. Diagnosis: Aspiration with hypoxia
3. Vitals routine
4. Activity: OOB (out of bed) with assistance to chair only.
5. Nursing: Per routine
6. Diet: Cardiac prudent
7. O2 (oxygen) via NC (nasal cannula) at 2 liters; continuous
8. ST (Speech Therapist) evaluation (Screen and Swallowing) Re: R/O (rule out) Aspiration.

There was no documentation noted during review of the nursing progress notes dated [redacted]13 at 9:45 p.m. through [redacted]13 at 11:00 p.m., which indicated nursing contacted the ED physician and/or the Hospitalist physician for clarification of orders if Patient A should be fed or continued NPO, nor was there documentation the ST screen and swallow evaluation had been scheduled as ordered. In addition, there was no documentation in the nursing progress notes that a nursing swallow screen had been performed.

Review of the facility's policy and procedure titled, "Swallow Screen by Nursing, Bedside," dated 12/2003; revised 11/05 indicated the following:

Purpose: To provide a process for identification, assessment, and referral for treatment of patients with difficulty swallowing (dysphagia).

Policy:

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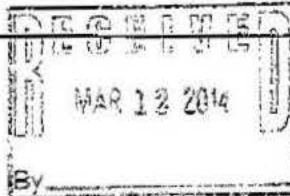
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1. Registered nurses can perform a bedside swallowing screen with or without physician order.

2. The physician will be notified of signs and symptoms of swallowing difficulties (dysphagia).

3. Based on patient assessment, the nurse will make the appropriate referrals, (e.g. registered dietician (RD) and swallowing evaluation by Speech Therapist (ST) or Occupational Therapist (OT).

Practice:

Bedside swallow screen may be performed by RN based on physician's order or based on patient's diagnosis. Certain clinical situation may also warrant bedside nursing swallowing screen...

Bedside Swallow Screen without physician's order:

1. RN assesses for signs and symptoms of difficulty swallowing. They may include:
a. Patient report of food sticking in throat.
b. Difficulty chewing.
c. Pocketing of food (food remaining in the cheeks after a meal).
d. Food remaining in the oral cavity.
e. Change in vocal quality (e.g. wet voice).
f. Symptoms of aspiration -
1. Wet, gurgly voice

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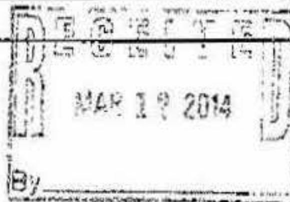

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2. Choking/coughing during or after eating
i. prior history of dysphagia

2. The RN reports findings to the physician and obtains order for swallowing evaluation and modification of diet and/or nutritional evaluation by the RD (registered dietician).

During an interview on 9/20/13 at 1:30 p.m., with the ED RN 1 (registered nurse 1), assigned to care for Patient A, RN 1 stated a swallow screen would "automatically" be done in the ED before giving a patient with swallowing problems anything by mouth, but she did not remember if she had done a swallow screen for Patient A. Review of RN 1's continuous Nursing Progress Notes dated [redacted]13 starting at 1:45 p.m. which listed the chief complaint as SOB (shortness of breath, possible aspiration), ending at 4:18 p.m. with Patient A's discharge from the ED at 4:18 pm, failed show documentation that a bedside swallow screen had been performed.

The Hospitalist physician was interviewed on 10/2/13 at 11:56 a.m., and stated that he expected the nurse to do a swallow screen, first, and when safe and without problems to allow Patient A to eat. In addition, the Hospitalist physician stated that Patient A "was at risk" and that he should have been contacted for clarification of his orders for a swallowing evaluation to be done by the speech therapist.

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	The ED Nurse Manager 1 was interviewed on 10/2/13 at 1:17 p.m., and stated the practice in the ED was to do a swallow screen before giving any medications by mouth. During an interview with the ED CN (charge nurse) 1, on 10/2/13 at 1:30 p.m., she stated when a stroke patient, with swallowing difficulty is admitted to the ED, the policy and procedure is that a nurse should complete a bedside swallow screen. CN 1 further stated that patients identified with swallowing concerns should be kept NPO (nothing by mouth), until the swallow screen was completed and the physician notified of the result of the evaluation. Review of Patient A's medical record indicated RN 2 admitted Patient A to the medical-surgical Stroke Unit on [redacted]13 at 8 p.m. RN 2's admission assessment notes listed Patient A's diagnoses as stroke, right sided body weakness, mild confusion, "mildly disorientated, and slurred speech. Patient A's Medical-Surgical Telemetry System Review/Plan of Care identified the following problem: "100% supervision, aspiration precaution [supervision during oral intake of food, liquids and medications]." There were no nursing interventions listed in Patient A's nursing care plan for the problem of aspiration precaution. During a telephone interview on 10/8/13 at 2:34 p.m. with RN 2, he identified himself as a travel nurse (temporary agency staff contracted by the hospital to provide nursing			

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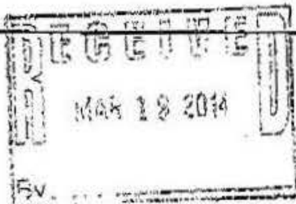

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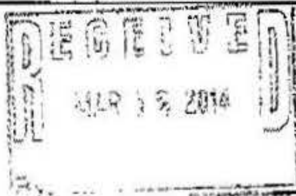
services). RN 2 stated he did not do a bedside swallow screen of Patient A and did not remember if he had reported not doing so to the on-coming nurse (RN) 3 during the change of shift report. RN 2 stated the Hospitalist physician had ordered a "regular diet" for Patient A but that he did not contact MD 2 for clarification of the diet order.

Stroke Unit RN 3, assigned to care for Patient A on [redacted]13 during the day shift, was interviewed by telephone on 10/4/13 at 8:06 a.m. and stated that she did not "recall" if she did a bedside swallow screen on Patient A. A review of Patient A's nursing notes dated [redacted]13 failed to show documentation of a bedside swallow screen by RN 3.

Certified nurse assistant (CNA) 1 was interviewed on 9/20/13 at 2:10 p.m., and stated on the morning of [redacted]13, she asked RN 3 if Patient A could eat and RN 3 said Patient A could have a soft diet but required "100 % supervision while eating." CNA 1 described 100% supervision as, "I have to feed the patient."

CNA 1 stated that she remembered Patient A's breakfast consisted of scrambled eggs, a sausage meat patty, cranberry juice and a cup of coffee, which she fed Patient A and that he ate "quite a bit." CNA 1 stated she had to stop feeding Patient A because she saw a "bump" on the side of his cheek and Patient A began "coughing and spitting" up the food that she



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	was feeding him. CNA 1 stated she did not call for help; instead she stayed in Patient A's room for about 15-20 minutes while "suctioning" inside his mouth with a "Yankaur" suction tube. (Yankaur: is an oral tool; typically a firm plastic suction tip with a large opening surrounded by a bulbous head. This tool is used to suction mouth secretions in order to prevent aspiration, i.e., food going into the lungs.) CNA 1 stated she reported to RN 3 that she had to stop feeding Patient A because he was "coughing" to which RN 3 replied, "OK." CNA 1 stated she did not see RN 3 go to Patient A's room to assess his condition after reporting Patient A's coughing incident that occurred while being fed. The Stroke Unit Nurse Manager 2 was interviewed on 10/2/13 at 9 a.m., regarding CNA 1's suctioning a patient. Nurse Manager 2 stated the scope of practice for CNAs did not include oral suctioning of a patient. "CNA's can only check and make sure that a suction machine was set up and ready in the patient's room, "they were not supposed to suction patients." During a telephone interview on 9/20/13 at 1:50 p.m., CNA 2 stated that she did not recall RN 3 telling the staff during morning report that Patient A had passed the swallowing screen but remembered RN 3 reported Patient A had a "swallowing problem," and needed 100 % supervision, while being fed.			

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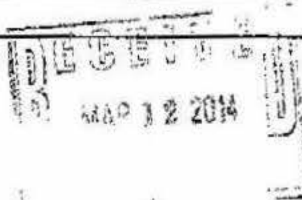
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CNA 2 stated that she cannot recall the time she found Patient A, but remembers it was between "breakfast and lunch time" on [redacted]13 while she was doing her routine patient check when she found Patient A in his room, unresponsive and that his color was "not right." CNA 2 stated she tried to wake Patient A and when he did not respond, she called for help and a code blue was called. (Code blue: emergency call throughout the hospital for patient assistance; usually for a cardiac arrest or respiratory distress).

Review of the code blue Resuscitation Record dated [redacted]13, recorded as 9:47 a.m., indicated the CPR (cardio-pulmonary resuscitation) started at 9:31 a.m., and the pre-arrest diagnosis was listed as hypoxia s/p (status/post) choking on food/aspiration. The code is recorded as lasting 18 minutes and Patient A was transferred to the ICU (Intensive Care Unit) unresponsive.

The Critical Care Physician Consultant, who responded to the code on [redacted]13, documented the following information in the code blue note:

Procedure: Endotracheal intubation (endotracheal tube; tube inserted through the mouth into the windpipe [trachea].

Indication for procedure: Apnea (temporary cessation of breathing) and cardiac arrest.

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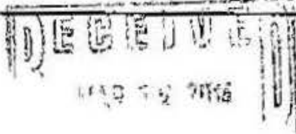

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050305	A. BUILDING ______ B. WING ______	12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Bates Summit Medical Center-Alta Bates Campus	**2450 Ashby Ave, Berkeley, CA 94705-2067 ALAMEDA COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

"Patient was found in cardiac arrest...He was given oxygen via Ambu bag [hand held device used to provide ventilation to patients who are not breathing] and upon laryngoscopy [procedure used to obtain a view of the throat to facilitate tracheal intubation], significant amounts of food material as well as liquid was in the oropharynx [back of the throat]. This was suctioned clear...and an ET [endotracheal tube] inserted via a laryngoscope [device used to facilitate insertion of an ET tube] was placed."

Review of the Critical Care Physician Consultant progress note dated [redacted]13 indicated that Patient A was in his "usual state of health when he presented with difficulty swallowing and witnessed choking. He was cyanotic [bluish or purplish discoloration of the skin due to deficient oxygenation of the blood] upon arrival at the hospital. This morning he was being helped with breakfast, reportedly around 9-10 a.m. by the staff, and did not do very well... At 9:30 a.m. he was found unresponsive and a code blue was called. When I arrived he was asystolic [no blood pressure] and pulseless [no pulse] and chest compression were taking place... I then intubated the patient [tube inserted through the mouth into the windpipe to establish a patent airway]... Currently he [Patient A] is unresponsive..."

A Neurology Physician (physician specializing

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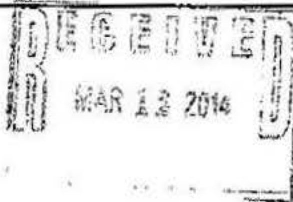

MAR. 14. 2014 3:59PM RISK MGT PATIENT REL NO. 716 P. 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050305	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 12/12/2013
NAME OF PROVIDER OR SUPPLIER: Alta Bates Summit Medical Center-Alta Bates Campus		STREET ADDRESS, CITY, STATE, ZIP CODE: 2450 Ashby Ave, Berkeley, CA 94705-2067 ALAMEDA COUNTY	

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	in diseases of nervous system) assessment note dated [redacted]13, indicated that Patient A "had cerebral anoxia [brain was deprived of oxygen] and had significant central nervous system injury", and that Patient A's "prognosis for making a recovery is poor." Patient A expired in the Intensive Care Unit on [redacted]13 at 3:50 p.m., with a diagnosis of anoxic brain injury with coma. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).			

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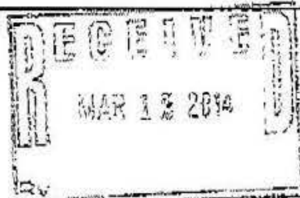

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