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
	052031	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARLOW RESPIRATORY HOSPITAL	2000 Stadium Way, Los Angeles, CA 90026-2606 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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

The following reflects the findings of the Department of Public Health during an inspection visit:

Complaint Intake Number: CA00298992
~~No complaints found~~ - Substantiated Amended 8/2/13

Representing the Department of Public Health:
Surveyor ID # 27811, 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.

HEALTH FACILITIES
INSPECTION DIVISION
ADMINISTRATION
2013 JUN 24 PM 4:01
RECEIVED

TITLE22 DIV5 CH1 ART3- 70213 (a) Nursing Services Policies and Procedures

(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.

Based on record review and interview, the facility failed to implement its policy and procedure on physician notification of arrhythmias (abnormal heart rhythm). Patient 1, who was monitored via telemetry, had arrhythmias that were not reported to the patient's physician. Patient 1 became

On December 14, 2011 all of the staffs on duty at the time of the event were met with to discuss the issues identified. The meeting included the Chief Nursing Officer, the Medical Director, the Clinical Director and the Director of Respiratory Care. During the meeting the policy regarding the requirement to notify physicians of any critical test results including any potentially lethal arrhythmias identified during telemetry monitoring of the patient was reviewed.

Event ID:85GM11 6/7/2013 8:25:55AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Mary R Delmin TITLE COO/CNO (X6) DATE 6/20/13

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 6

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.

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unresponsive and had no pulse. Cardiopulmonary resuscitation measures were instituted but were unsuccessful.

Findings:

On August 3, 2012, an unannounced visit was made at the facility to conduct a complaint investigation regarding Patient 1's death.

A review of the Patient Registration Form indicated Patient 1 was admitted to the facility on [redacted] 2011, with diagnoses that included respiratory failure and ventricular fibrillation (a condition in which there is uncoordinated contraction of the cardiac muscle of the ventricles in the heart making them quiver rather than contract properly)

A review of a History and Physical examination dated [redacted] 2011, indicated the patient was admitted with the chief complaint of respiratory failure.

The Admission Orders dated [redacted] 2011, indicated the patient was to be monitored via cardiac telemetry (heart rhythm monitoring).

A Physical Assessment conducted by a registered nurse on [redacted] 2011 at 8 a.m., indicated Patient 1 was alert, confused and was oriented to person and event. According to the assessment, the patient had a sinus tachycardia rhythm (a heart rhythm with elevated rate of impulses).

After this event an assessment of possible causes lead the hospital to eliminate the LVN positions at the Valley Presbyterian Hospital satellite. Eliminating the LVN positions allowed for streamlined communications and better accountability by the RN for the total care of patients. Additional RN staffs were hired and the LVN positions were eliminated as of February 1, 2012.

After the unannounced visit by CDPH on August 3, 2012 plans were immediately developed to give staff additional education to prevent an occurrence like this happening in the future. Mandatory 2/8 hour day educational sessions were developed entitled "Recognizing and Managing Clinical Deteriorations." All RNs and Unit Clerk/Monitor Techs were required to attend. The agenda included:
Staff response to an emergency, a review of Arrhythmias, acute coronary syndrome, heart failure, sepsis bundles, and diabetes management, to name a few of the topics (A copy of the course outline is attached.)
Throughout the didactic education the requirement to notify physicians of any critical occurrences with their patients was emphasized. The education was well received by staff and a

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A review of a telemetry strip (recording of heart rhythm) dated [redacted] 2011 at 6:41 a.m., indicated the patient had a sinus tachycardia rhythm. At 8:53 a.m., the patient had approximately 6 periventricular contractions (PVC).

According to Lexi-comp (a clinical database), PVCs are extra beats that happen before a normal heartbeat. PVCs are caused by a problem with the heart's electrical system, in which the ventricles send abnormal electrical signals. These signals cause the extra beats.

A review of a telemetry strip dated [redacted] 2011 at 2:23 p.m., indicated Patient 1 had two short runs of PVCs. At 2:24 p.m., the patient had two runs of PVCs. At 2:25 p.m., Patient 1 had four PVCs followed by a three beat run of ventricular tachycardia and followed by four other PVCs. The patient also had short run of VTACH and PVCs at 2:25:38 p.m. and 2:25:47 p.m.

According to Lexi-comp, ventricular tachycardia (VTACH) is a condition that causes the heart to beat much faster than normal. When the heart beats too fast, it cannot pump blood as well. This can lead to dizziness, fainting, or death if the VTACH is sustained.

On [redacted] 2011 at 2:28 p.m., according to the telemetry strip, Patient 1 had approximately four PVCs followed by an 11 beat run of VTACH.

A review of the medical record revealed no documented evidence that Patient 1 was either

pre-test and post-test were conducted to assess staffs' comprehension of the content. Actual case studies were used in conveying the concepts necessary to successfully rescue patients.

All RNs and Monitor Techs are required to go through basic EKG training and the Monitor Techs are required to have advanced EKG training given at skills day (sign in sheets and course outlines attached.)

After the event a new Clinical Director was hired to provide better structure and accountability at the staff level monitoring clinical practice on a daily basis. In addition a new position of Clinical Nursing Supervisor was added working Monday through Friday providing additional support to improve staffs' critical thinking and clinical decision making.

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assessed or that the patient's physician was notified for the abnormal heart rhythms that Patient 1 experienced on [redacted]2011, at 2:26 p.m. and 2:28 p.m.

On August 3, 2012, during an interview at 11:43 a.m., the clinical leader (RN 1) reviewed the medical record and could not produce evidence that Patient 1's physician was notified of the PVCs and runs of VTACH. According to RN 1, when a patient experiences runs of VTACH, the patient should be assessed and the patient's physician should be notified.

A review of the telemetry strip dated [redacted] 2011 and timed at 2:48 p.m., revealed Patient 1 had a sustained VTACH that, according to the telemetry time stamps, lasted approximately 9 seconds. At 2:50 p.m., the patient had a sustained VTACH and, according to the written note on the strip, the rapid response team was notified.

On August 3, 2012, during an interview at 11:45 a.m., the registered nurse (RN 2) caring for Patient 1 stated, the monitor technician (person tasked with monitoring the patients' heart rhythm) told RN 2 that the patient had dysrhythmias (abnormal heart rhythm) at 2:48 p.m. RN 2 stated she entered the room and found the patient "scratching on his chest" and "became unresponsive." According to RN 2, she was not told of any arrhythmias or runs of VTACH prior to the incident where she went into the patient's room.

A review of a Nurse's Progress Note dated

Events are reviewed daily and when necessary a determination meeting is held to see if a root cause analysis is warranted. All codes and RRTs are evaluated for appropriateness of care The codes, RRT's and event findings are analyzed and determination outcomes are reported to the Medical Staff Quality Committee. Teamwork and communication training and education were done at the 8 hour education days for staffs. The effect of the education and actual patient care practice is being monitored through event report analysis and follow up. Education and training will continue to focus on sudden change of condition and necessity to communicate those changes to the individuals responsible for the care of the patient. This will be done annually at skills day using case studies.

The Clinical Director at VPH is responsible for ensuring there is permanent correction of the deficiency.

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[redacted]2011 at 2:60 p.m., indicated "Vfib [ventricular fibrillation] noted in the monitor." RN 2 responded to the room and the patient "became unresponsive and no pulse felt; CPR was started; code blue was called."

A review of an Emergency Department Consultation Critical Care/Code Blue report, dictated on [redacted] 2011, indicated the physician responded to a code blue where the patient was receiving CPR. At the first rhythm and pulse check, the rhythm was PEA (pulseless electrical activity) and there was no pulse. Medications were administered and defibrillator shocks were given. The patient received a total of 20 minutes of CPR and never regaining pulses. The patient did not show a sign of life or respirations and the patient was pronounced dead at 3:18 p.m.

On March 14, 2013, during a telephone interview at 9:40 a.m., MD 1 stated he should have been notified immediately of a patient's abnormal heart rhythm to begin interventions such as a STAT EKG.

A review of the facility's policy and procedure titled, "Critical Tests and Critical Values" dated January 2010, stipulated that critical tests results would be immediately communicated to the appropriate provider in a timely manner in order to provide subsequent patient treatment decisions. Moreover, the policy stipulated that PVCs and ventricular tachycardia were considered critical values and the physician would be notified.

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The facility's failure to follow its policy and procedure regarding notification of the physician about the patient's arrhythmias (abnormal heart rhythm), is a deficiency that has 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.

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).