

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050534	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/04/2008
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NAME OF PROVIDER OR SUPPLIER JOHN F. KENNEDY MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 47-111 MONROE STREET, INDIO, CA 92201 RIVERSIDE COUNTY
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	<p>The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.</p> <p>E000 Initial Comments</p> <p>The following reflects the findings of the California Department of Public Health during complaint investigations (Complaint #s CA00158976 and CA00158812).</p> <p>Representing the Department of Public Health: [REDACTED]</p> <p>Abbreviations used in this document:</p> <p>AHA - American Heart Association CEO - Chief Executive Officer CEN - Certified Emergency Nurse COO - Chief Operating Officer DQI - Director of Quality Improvement ED - Emergency Department H&P - History and Physical hr - Hour(s) HSC - Health and Safety Code ICU - Intensive Care Unit IV - Intravenous kg - Kilogram(s) lb - Pound(s) MD - Medical Doctor ml - Milliliter(s) MSN - Master of Science in Nursing NICU - Neonatal Intensive Care Unit O2 - Oxygen PALS - Pediatric Advanced Life Support</p>		<p>The plan of correction is prepared in compliance with federal regulations and is intended as JFK Medical Center's (the "hospital") credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.</p> <p>Organization Minutes: The confidential and privileged minutes are being retained at the facility for agency review and verification if required.</p> <p>Exhibits: All exhibits including revisions to Medical staff Bylaws, reviewed/revise or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request.</p> <p style="text-align: right;">09 SEP 29 15 SAN DIEGO COUNTY HEALTH DEPARTMENT</p>	
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Event ID:96D811 9/16/2009 4:47:12PM

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>C.O.O.</i>	(X8) DATE <i>9/25/09</i>
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	<p>Continued From page 1</p> <p>RN - Registered Nurse RT - Respiratory Therapist sat - Saturation VS - Vital Signs</p> <hr/> <p>A 012 1280.1 (a) HSC Section 1280</p> <p>If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars (\$25,000) per violation.</p> <p>A 014 1280.1 (c) HSC Section 1280</p> <p>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.</p> <p>T22 DIV5 CH1 ART3-70214 (a) (C) Nursing Staff Development</p> <p>(a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217 (m). The program shall include, but shall not be limited to, orientation and the</p>		<p><u>Tag: A014</u></p> <p>Policy & Procedures: Policy and procedure review and revision started in August 2008 to reflect current standards of care and nursing practice. Included in the review process were the Director of Emergency Department, DCQI, Interim Chief Nursing Officer and Interim Emergency Department Director. All new and revised Emergency Room policies and procedures were reviewed by the Director of the Emergency Department and approved by the Department of Emergency Services, the Medicine Executive Committee and the Governing Board in December 2008. The revised policies and procedures included:</p> <ul style="list-style-type: none"> Standards of Care in the Emergency Department to ensure the most current standards were in place and applicable to the patient population of JFK; 	<p>8/08</p> <p>12/08</p>
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	<p>Continued From page 2</p> <p>process of competency validation as described in subsection 70213 (c).</p> <p>(2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions:</p> <p>(C) Registered nurses shall not be assigned total responsibility for patient care, including the duties and responsibilities described in subsections 70215 (a) and 70217 (h) (3), until all the standards of competency for that unit have been validated.</p> <p>Based on interview and record review, the facility failed to ensure the ED nursing staff possessed the knowledge and skills required to meet the needs of Patient 1 who presented for emergency care. This failure caused the death of the two day old infant due to meningitis and septic shock, and the potential for injury and death for all patients seen in the ED.</p> <p>Findings:</p> <p>The record for Patient 1 was reviewed on August 4, 2008. Patient 1, a two day old male, presented to the ED on July 31, 2008, at 1:25 a.m., with his parents reporting fever and crying all day.</p> <p>The triage note indicated the baby (who weighed</p>		<ul style="list-style-type: none"> Assessment of the Emergency Department Patient to include frequency of assessment and reassessment based on the patient's symptoms and diagnosis; Emergency Department "Triage to Bed" defining placement of the patient following triage; Expectations of Care Delivery outlining nursing responsibilities and functions in the provision of patient care and services; Pediatric Emergencies to ensure the policy reflected national standards and guidelines, including guidelines for administration of medication and fluids; Pediatric Medication revised in conjunction with Pharmacy to include current medications and nursing responsibilities for monitoring pediatric patients. <p>The Director of the Laboratory developed and implemented a policy and procedure on critical lab values that included specific Emergency Room tests and values. The Interim Director of the Emergency Department and the Chief Nursing Officer developed the Results Reporting policy and procedure outlining the steps for staff in notifying physicians of the results of lab and diagnostic studies.</p> <p>The Chief Nursing Officer and the Director of Education adapted the textbook <u>Emergency Nursing Core Curriculum: 5th Edition, 2005 Jean Puell</u> in the development of the core curriculum for nursing in the Emergency Department.</p>	<p>12/08</p> <p>12/08</p> <p>12/08</p> <p>12/08</p> <p>12/08</p> <p>8/08</p>
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	<p>Continued From page 3</p> <p>3.3 kg [which equals 7.3 lbs]) had a temperature of 102.8 (normal 98.6), a heart rate of 212 beats/minute (normal 120 - 150), and a respiratory rate of 68 breaths/minute (normal 35 - 50). These were all signs of possible sepsis. There was no blood pressure or blood sugar measurement (a violation of standards of practice for this patient with these symptoms).</p> <p>The nurse's notes indicated the baby was taken immediately to an ED bed, and assigned to RN 1. The assessment at that time indicated the baby was dusky (a skin color indicating poor respiratory and circulatory status), and had a rapid respiratory rate with retractions (the areas between the ribs and in the neck being, "sucked" in, due to trouble breathing). These were more possible signs of sepsis. There was no blood pressure measurement. There was no measurement of blood sugar.</p> <p>The physician's H&P, dictated on July 31, 2008, at 9:19 a.m., further indicated the baby had not been feeding well, and had vomited on the night of arrival to the ED. The assessment done by the physician indicated the baby had fontanelles (soft spots on an infant's head) with increased turgor (bulging), was retracting when breathing, had a distended abdomen, and did not have, "normal responsiveness." These were all possible signs of sepsis and /or meningitis.</p> <p>Further entries in the record indicated:</p> <p>a. 1:35 a.m. (10 minutes after arrival), an IV was</p>		<p>The National Patient Safety Goal Team reviewed, revised, and approved the Hospital-wide Critical Tests and Critical Values/Results policy and procedure on November 20, 2008. The revised policy states that if the staff is unable to contact the physician or his/her designee within 30 minutes upon receipt of the critical value, the hospital Chain of Command policy will be followed.</p> <p>The Chief Nursing Officer, the Director of laboratory reviewed and revised the nursing Chain of Command policy to make it a hospital wide policy. The policy includes the chain of command for nursing leadership, physician leadership and resource persons within the hospital available for consultation. The revised policies were approved by the Medical Executive Committee and the Governing Board during their regularly scheduled meetings in January 2009.</p> <p>Training: A qualified, competent Emergency Room Registered Nurse from a sister hospital was assigned to the Emergency Department to act as a resource, provide education, monitor care and documentation until all JFK Emergency Department nursing staff completed a comprehensive eight hour education that was developed by the ED leadership staff from the sister hospital. This RN did not take patient assignments, but rather observed care and reviewed all documentation for compliance with policy and to educate nursing staff on quality, safe and appropriate care of the patient who presents to the ED.</p>	<p>11/20/08</p> <p>12/17/08</p> <p>1/6/09 1/15/09</p>	
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	<p>Continued From page 4</p> <p>started at a rate of 5 ml/hr. No fluid bolus [33 ml for dehydration to 198 ml for septic shock] was given. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior). There was no measurement of blood sugar;</p> <p>b. 1:55 a.m. (30 minutes after arrival), blood was drawn. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior). There was no measurement of blood sugar;</p> <p>c. 2:10 a.m. (45 minutes after arrival), a chest x-ray was done. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior). There was no measurement of blood sugar;</p> <p>d. 2:20 a.m. (55 minutes after arrival), a consent for a lumbar puncture (spinal tap due to suspected meningitis) was signed. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior). There was no measurement of blood sugar;</p> <p>e. 2:25 a.m. (one hour after arrival), blood was drawn. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior). There was no measurement of blood sugar;</p> <p>f. 2:30 a.m. (one hour, five minutes after arrival), the ED physician did a lumbar puncture. There was no reassessment of the condition of the baby (VS with</p>		<p>Five qualified, competent RN's in care of the Emergency Department patient, from the sister hospital, conducted classes and observed competencies developed for the JFK ED nursing staff beginning on the evening of August 8, 2008. The training classes were eight hours long including didactic training and hands on learning. This training included re-education on the revised policies and procedures in nursing assessment, reassessment, informed consent, medication administration and universal protocol..</p> <p>All nursing staff in the ED was trained on the nursing process focusing on the assessment and reassessment of patients, use of waived testing equipment, use of restraints and hands-on training for commonly used pieces of equipment. Re-education included the use of scenarios and questions in the following areas:</p> <ul style="list-style-type: none"> • Restraint and seclusion • Moderate and deep sedation • Procedure sedation/pediatric population • Age specific appropriate care • Arrhythmia recognition • Pain management • IV admixture • Blood transfusions • Emergency severity index • Infant tests • Pediatric tests • Critical drugs/Infusion tests <p>The Director of the Emergency Department educated all clinical staff in the ED on the hospital policy on Chain of Command and all new staff hired at the hospital will be required to take the course during the orientation period.</p>	<p>8/08</p> <p>8/08</p> <p>8/08</p>

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	<p>Continued From page 5</p> <p>02 sat, color, respiratory effort, behavior). There was no measurement of blood sugar;</p> <p>g. 3 a.m. (one hour, 35 minutes after arrival), temperature was 99.4, heart rate was 175, respiratory rate was 45 with an O2 sat of 99%. The baby was still crying. The nurse attempted to obtain urine using a catheter (a tube inserted into the bladder). There was no urine output (an indication of poor blood supply to the kidneys due to low blood pressure). The physician was notified. There was no indication the nurse requested or received new orders for care. There was no blood pressure measurement. There was no measurement of blood sugar. There was no indication of the baby's color or respiratory effort;</p> <p>h. 3:30 a.m. (two hours, five minutes after arrival), the nurse notified the ED physician of a, "critical," laboratory result, a blood sugar of 36 (normal 80 - 120). There was no indication a new order was requested or received. There was no indication any treatment was rendered. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior);</p> <p>i. 3:50 a.m., an antibiotic was given. Although immediate use of antibiotics was indicated, this first dose was given two hours and 25 minutes after the baby arrived in the ED. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior);</p> <p>j. 4 a.m., the baby was moved into an isolation room. There was no reassessment of the condition</p>		<p>The Director of the Emergency Department and qualified staff from the sister hospital measured the effectiveness of the training through the use of a written test given during the didactic session to identify additional learning needs that were addressed in the eight hour course.</p> <p>The effectiveness of the training was evaluated through the use of a web based education program and a written test 60 days after the completion of the first round of training. 100% of the staff (excluding staff on medical and maternity leave) passed with a score of 90% or better. Staff returning from medical or maternity leave will be required to complete the competencies and pass a written test with a score of 90% prior to working in the Emergency Department.</p> <p>This information has been incorporated into new Emergency Department RN orientation and re-orientation.</p> <p>The Chairman of the National Patient Safety Goal Team, who is a member of the Quality Management Department, created a critical test/value poster and distributed it to department directors/managers for posting in their respective departments. The Department Directors/Managers will educate all staff on the revised policy. Upon arrival of the new Emergency Department Director, the Interim Director for the ED, competent and qualified in emergency medicine, will remain in place for 90 days to mentor and train the new Director for a period of 90 days. The Interim Director will then assume the roles and responsibilities of the nurse educator for the ED and ICU, and will continue to be an expert resource for the new Director.</p>	<p>8/08</p> <p>11/08</p> <p>1/30/09</p> <p>12/18/08</p>
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	<p>Continued From page 6</p> <p>of the baby (VS with O2 sat, color, respiratory effort, behavior);</p> <p>k. 4:28 a.m. (3 hours after arrival in the ED), the regional NICU transport team was called to transfer the baby to an ICU level of care;</p> <p>l. 4:37 a.m. (one hour and seven minutes after the critical lab value was reported), glucose (sugar) was given IV. There was no reassessment of the condition of the baby (VS with O2 sat, color, respiratory effort, behavior);</p> <p>m. 4:40 a.m.(one hour, 40 minutes after the last set of vital signs), the baby was hypothermic (low temperature of 96.5), his heart rate was 163, and his respiratory rate was 33. There was no indication any attempt was made to warm the baby. A second attempt was made to obtain urine from a catheterization. There was no urine output. There was no assessment of the baby's respiratory effort, color or behavior. There was no blood pressure measurement; and</p> <p>n. 5:40 a.m., the baby was covered for warmth (one hour after being hypothermic). The nurse was unable to get a drop of blood to recheck the blood sugar (indicating poor circulation). An 18 ml fluid bolus was given (not the required 33 ml for dehydration up to the 198 ml for septic shock). There was no reassessment of the condition of the baby. There was no blood pressure measurement.</p> <p>The record indicated the baby's heart rate decreased to 30 beats per minute at 5:50 a.m., and</p>		<p>Monitoring:</p> <p>The Interim Director of the Emergency Department or qualified designee will audit 30 adult medical records and 30 pediatric medical records per month for documentation of assessment and reassessment including vital signs as defined in policy including frequency of vital signs and interpretation of cardiac rhythm strips.</p> <p>The Interim Director of the Emergency Department monitors staffing on a daily basis to ensure only qualified, competent staff are on duty.</p> <p>The Interim Director of qualified designee review the results of the audits with the Emergency Department staff as they are being done to rectify any issues immediately and to re-enforce the education provided to the staff. The monitoring will continue until four successive months of 100% compliance has been reached. Once the goals have been achieved, the data will be validated with an additional audit by the Director of Clinical Quality Improvement or qualified designee. Future medical record review will be conducted randomly on a quarterly basis by the Director of the ED or their designee.</p> <p>The Interim Director of the ED aggregates the data and reports the information to the Quality Council, the Medical Executive Committee and the Governing Board at their regularly scheduled meetings for review and action as required.</p>	11/08
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	<p>Continued From page 7</p> <p>resuscitation efforts were started. The NICU transport team arrived at 6 a.m., and assisted with resuscitation efforts. The first attempt at obtaining a blood pressure was done after the arrival of the transport team, and the blood pressure was 0/0 (unable to obtain any pressure).</p> <p>The resuscitation efforts were unsuccessful, and the baby died. The diagnoses made by the ED physician were Meningitis, Septic Shock, and Acute Hypoglycemia.</p> <p>Review of the record indicated RN 1 failed to:</p> <p>a. Provide ongoing assessment, resulting in the inability to identify the response to care rendered, or to determine deterioration in the baby's condition;</p> <p>b. Closely monitor serial vital signs (in accordance with accepted standards of practice, Sheehy's Emergency Nursing, Principles and Practice, 5th Edition), checking them at intervals of one hour and 35 minutes, one hour and 40 minutes, and one hour and 40 minutes, respectively (three sets of vital signs on a critical infant over a four hour and 50 minute period of time), resulting in the inability to identify trends and deterioration in the baby's condition;</p> <p>b. Check a blood pressure in an infant with multiple signs of poor perfusion, decreased blood pressure, and shock, resulting in the inability to determine the need for proper intervention;</p>		<p>The National Patient Safety Goal chairman revised the current critical test/audit sheet for nursing to include a monitor if the Chain of Command policy needed to be utilized in the event the physician did not call back within 30 minutes. The results of the audits are submitted to the Quality Management Department monthly and included in the hospital-wide National Patient Safety Goal data report. The report is presented to the Quality Council, Medical Executive Committee and the Governing Board for review and action as required.</p> <p>The Interim Director of Emergency Services or designee conducted chart reviews on 100% of patients who presented to the Emergency Room with an allergic reaction for the appropriate care.</p> <p>The chart review will occur for 90 days. If issues are identified, one on one counseling will occur with the employee. After 90 days, if compliance has not been reached a mandatory class will be conducted by the medical Director of Emergency Services and monitoring will continue until compliance has been sustained. The Interim Director of the Emergency Department will report results of the chart review to the Quality Council, the Medical Executive Committee and the Governing Board for review and action as required.</p> <p>Other Corrective Actions: The Chief Executive Officer and the Director of Human Resources approved a national recruitment effort to fill the opening left when the former Director of the Emergency Department resigned. The position has been filled by a qualified, competent Critical Care RN with leadership experience who began his role of the Director of ED/ICU in January 2009</p>	<p>12/08</p> <p>12/18/08</p> <p>1/09</p>

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	<p>Continued From page 8</p> <p>c. Provide prompt intervention for hypothermia, resulting in the inability to prevent further deterioration in the baby's condition;</p> <p>d. Identify the need to check the blood sugar early in the ED stay, resulting in the baby being in a "critical" hypoglycemic state for an unknown period of time;</p> <p>e. Communicate with the ED physician regarding the need for immediate antibiotics in a neonate with multiple signs of sepsis, resulting in a two hour and 25 minute delay in administering the first antibiotic;</p> <p>f. Recognize the absence of urine output could be related to poor blood flow to the kidneys due to low blood pressure, and obtain an order for fluids, resulting in continued absence of kidney function;</p> <p>g. Communicate with the physician regarding the appropriate fluid bolus for this baby according to his weight, resulting in a delay in administering fluids and infusion of an inadequate amount of fluid; and,</p> <p>h. Recognize and communicate with the physician the need for an ICU level of care early in the baby's ED stay, resulting in a delay of three hours to call a NICU transport team.</p> <p>During an interview with RT 1 on August 4, 2008, at 11:19 a.m., the RT stated he went to the ED on July 31, 2008, at 5:45 a.m., and saw a group of people around the baby. The RT stated the baby looked, "horrible," the baby was pale and mottled, and he could not believe the ED staff did not notice</p>		<p><u>Addendum:</u> An experienced, qualified, competent RN was hired as the clinical manager of the Emergency Department.</p> <p>The Interim Director for the Emergency Department is qualified and competent to provide direction to the Emergency Department until the new Director arrived in January 2009. The Interim Director will resume the role of the Clinical Nurse Educator for the ED/ICU.</p> <p>The Chairman of the National Patient safety Goal Team, who is a member of the Quality Management Department, created a critical test/value poster and distributed it to the Directors for posting in their units.</p> <p><u>Responsible Person(s):</u> Chief Nursing Officer Director Emergency Department Interim Director Emergency Department Director of Education Chief Executive Officer Director Human Resources Director of Laboratory</p> <p><u>Disciplinary Action:</u> Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures.</p> <p>Medical Staff members demonstrating non-compliance with corrective action will be referred for peer review in accordance with Medical Staff bylaws, as appropriate.</p>	<p>5/26/09</p> <p>12/08</p>

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	<p>Continued From page 9</p> <p>it earlier. The RT stated he wondered why the baby stayed so long in the ED without being transported to a NICU.</p> <p>During an interview with the Director of the ED on August 8, 2008, at 10:05 a.m., the Director stated, "That baby didn't have to die." The Director acknowledged the temperature of the baby dropped too low, and stated the staff should have monitored the baby more closely, and he should have received more fluid than he did.</p> <p>The employee file for RN 1 was reviewed on August 8, 2008. The file indicated RN 1 was hired by the facility on July 7, 2008 (three and a half weeks prior to being assigned to this critical baby). The file indicated RN 1 did not have PALS certification or validation of ED clinical competencies.</p> <p>The California Board of Registered Nursing defines standards of competent performance as consistently demonstrating the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process when acting as the patient's advocate. Acting as the advocate requires initiating action to improve health care or to change decisions or activities which are against the interests of the patient (CCR, Title 16, Chapter 14, Section 1443.5).</p> <p>The presence of septic shock (a profound, life threatening bacterial infection in the bloodstream) constitutes a medical emergency. Initial resuscitation is based on rapid administration of fluids while monitoring the patient's clinical</p>			

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	<p>Continued From page 11</p> <p>neonatal sepsis are associated with meningitis. Sepsis must be considered in any neonate presenting to an ED with a rectal temperature greater than 100.5. Presenting complaints that may indicate or be associated with a diagnosis of sepsis include fever, tachycardia, respiratory distress, irritability, full fontanelle, abdominal distension, vomiting, and feeding difficulties. Interventions in neonates need to be more aggressive than those of older children, as their ability to fight infection is significantly compromised due to their developmental status (Emergency Nursing World, Research Applied to Clinical Practice, Robert C. Knies, RN, MSN, CEN).</p> <p>According to Sheehy's Emergency Nursing, Principles and Practice, 5th Edition:</p> <p>a. The basis of all care delivered to patients in the ED is accurate and appropriate assessment;</p> <p>b. Ongoing assessment is necessary to identify a response to care rendered, or to determine deterioration in a patient's status;</p> <p>c. Vital signs are indicators of the patient's present condition, and serial values should be obtained if vital signs are to have any impact on identification of trends or developments in the clinical situation;</p> <p>d. The normal blood pressure for a newborn is 70/40, and a decreasing blood pressure is a serious sign warranting immediate intervention;</p> <p>e. Hypothermia (low body temperature) in infants</p>		

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	<p>Continued From page 12</p> <p>can lead to metabolic acidosis. (an acid state in the body), decreased respiratory rate, decreased heart rate, and cardiopulmonary arrest;</p> <p>f. Management of septic shock in the pediatric ED patient includes thermoregulation (keeping the temperature within normal limits) to decrease oxygen demand on the tissues, administration of IV fluids to replace volume lost due to dilation of the blood vessels, immediate use of IV antibiotics to treat the infection, careful monitoring of blood sugar due to limited stores of sugar in the liver putting the patient at risk for low blood sugar, and use of medications to increase cardiac output if needed;</p> <p>g. The pediatric patient with sepsis requires an ICU level of care;</p> <p>h. Meningitis is an acute inflammation of the meninges in the brain causing an increase in intracranial pressure (the pressure inside the brain);</p> <p>i. Common signs of increased intracranial pressure include irritability;</p> <p>j. Bulging fontanelles are a late sign of increased intracranial pressure related to meningitis; and</p> <p>k. In the late stages, meningitis requires aggressive intervention that includes admission to an ICU.</p> <p>The employee files for seven random additional ED nurses (including the ED Director) were reviewed on August 8, 2008. The files indicated there was no validation of ED clinical competencies for any of</p>			

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	<p>Continued From page 13</p> <p>these nurses.</p> <p>During an interview with the nurse educator on August 8, 2008, at 11:20 a.m., the educator stated the facility had general nursing competencies, and in addition all departments, except the ED, had department specific competencies. He stated all nursing areas, except the ED, had competencies that included the types of patients the unit cared for, the types of disease processes they took care of, the types of procedures they did, and the types of equipment they used. The educator stated he did not know why the department specific competencies were not done in the ED.</p> <p>During an interview with the ED Director on August 8, 2008, at 12:10 a.m., the Director stated she had only been doing "core" competencies for the ED nurses, which included general nursing practices. The ED Director stated she had not been validating department specific competencies for the ED nurses in the past, but she had recently developed a tool to do so. She stated the nurses were "working on" their competencies, but none of them had been completed.</p> <p>The CEO, COO, and DQI were notified Immediate Jeopardy was identified on August 8, 2008, at 12:38 p.m. The Immediate Jeopardy was identified due to the facility's failure to ensure competency of the nursing staff in the ED, resulting in the death of Patient 1, a two day old infant, and the potential for injury and death in all patients seen in the ED.</p> <p>The facility provided an immediate plan of correction</p>				

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	<p>Continued From page 14</p> <p>to address the immediate jeopardy on August 11, 2008, that included:</p> <p>a. Floating a RN from their local sister facility every shift who had documented competencies specific to the ED to serve as a clinical resource nurse and monitor the nursing care provided in the ED. This would occur until all ED nurses working in the facility had verification of competencies specific to the ED;</p> <p>b. Development of nursing competencies specific to the ED;</p> <p>c. An eight hour course including didactic training and hands on learning with the equipment used in the ED, with validation of competencies for 100% of the ED nursing staff by August 30, 2008;</p> <p>d. Employment of an ED nurse consultant to assess the effectiveness of the ED leadership and recommend changes;</p> <p>e. Employment of a clinical nurse educator for the ED and ICU; and,</p> <p>f. Formal training and assessment of competency of all future ED nurses, with no nurse being assigned to care for a patient without prior verification of competency.</p> <p>After implementation of the plan of correction was verified, the DQI and CEO were notified the Immediate Jeopardy was abated on August 11, 2008, at 12:40 p.m.</p>			

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