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
	050009	A. BUILDING _____ B. WING _____	05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen of the Valley Medical Center	1000 Trancas St, Napa, CA 94558-2906 NAPA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00353131 - Substantiated Representing the Department of Public Health: Surveyor ID # 27294, 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 1280.3: 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. Penalty Number: 110011421 E 291 T22 DIV5 CH1 ART3 - 70215(a) (1) Planning & Implementing Patient Care (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. Findings:		Abbreviations: CNO -- Chief Nursing Officer CMO -- Chief Medical Officer COO -- Chief Operating Officer ED -- Emergency Department MSQC -- Medical Staff Quality Council MSEC -- Medical Staff Executive Committee CQC – Clinical Quality Council BOT – Board of Trustees ** This finding was corrected following a Federal Complaint Validation Survey. The Plan of Correction was accepted on 12/16/13. **Immediate and Follow Up Actions:** E 291 - T22 - 70215(a)(1)(2) Debriefing of all involved medical staff and nursing staff commenced on 4/22/13, including ED Physician, COO/CMO, CNO, ED Director, ED Manager, ED Educator, 2N Manager, PI representatives review these events. This focused review identified process changes, that once implemented will ensure nursing staff provides continuous cardio/pulmonary monitoring and respiratory support, as ordered, prior to and during transfer from the ED to the medical unit and/or when a patient is transferred to another patient care area. ** Immediate action plans were implemented. Actions include: 1. *A new hospital-wide policy titled, "Intra-facility Transport of Monitored Patients", was developed to ensure safe transport for	12/31/13 12/31/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Stanton RN, Vice President Patient Care/CNO — TITLE — (X6) DATE: 8/6/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 5

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. Plan of Correction Received & accepted

Mary Fidler, RN Manager of Regulatory Compliance
1/19/16 @ 2:10 pm. B. Nelson, RN, HFEN

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	See- E 292 E 292 T22 DIV5 CH1 ART3 - 70215 (a) (2) Planning & Implementing Patient Care (a) A registered nurse shall directly provide: (2) The planning, supervision, implementation, and evaluation of the nursing care provided to each patient. The implementation of nursing care may be delegated by the registered nurse responsible for the patient to other licensed nursing staff, or may be assigned to unlicensed staff, subject to any limitations of their licensure, certification, level of validated competency, and/or regulation. Based on staff interview, and clinical record review, the hospital failed to ensure nursing staff provided continuous cardio/pulmonary monitoring (monitoring of heart and breathing activity), and respiratory support (breathing) prior to and during transfer from the emergency room to the medical unit for one patient (Patient 100). These failures may have delayed recognition of Patient 100's deteriorating medical status in which the patient died. These failures were violations of Section 70215(a)(1)(2) of Title 22 of the California Code of Regulations and were deficiencies that caused or were likely to cause serious injury or death to the patient and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a). Findings: Patient 100, a 59 year old male was admitted to		patients requiring cardiopulmonary monitoring and respiratory support immediately prior to and during transfer to an in-patient unit. Staff must adhere to hospital policies and procedures. This policy includes the following statements: a. Purpose: patients being transported should receive the same or equivalent physiological monitoring during transport as they are receiving as part of their hospital care. b. Pre-transport communication and coordination: • The RN's between the sending and receiving departments will coordinate care, transportation, and notify ancillary services, if applicable, (i.e. respiratory therapy) as to the timing of the transport, equipment, and/or support needed. • The responsible RN will provide a Situation Background Assessment Recommendation (SBAR) report to the RN assuming care prior to and following the transport. c. Equipment and monitoring: • The patient being transported shall receive appropriate physiologic monitoring during transport, testing and procedure per level of care. • Airway support: -- Airway management equipment and resuscitation bag of proper size and fit for the patient, if indicated by respiratory status, should accompany the patient. • Ventilatory support: - Supplemental oxygen should be continued; or, readily available for the patient not currently on supplemental oxygen therapy. - Prior to transport, ensure oxygen tank	

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	the Emergency Department on 04/22/13 at 10:45 a.m., with severe shortness of breath and an oxygen saturation level of 78%. Patient 100's diagnoses included fluid overload (excess of fluid in the lungs) due to End Stage Kidney Disease, hypoxemia (decrease of oxygen concentration in the blood stream) heart disease, and a high potassium level of 7.0 (normal potassium levels range between 3.5 to 5.1 mmol/L. Elevated potassium levels, (Hyperkalemia), can cause life threatening heart arrhythmia's (abnormal heart rhythm) at any time if not urgently treated. During an interview on 07/18/13 at 10 a.m., Licensed Staff F stated that Patient 100 was placed on BiPap, (Bi-level Positive Airway Pressure - a non-invasive means of providing ventilation) to assist with his breathing and was also on telemetry (heart monitoring) per physician orders. She stated his oxygen saturation level was good at 96% -100% on the BiPap although he still complained of shortness of breath. Licensed Staff F stated she was aware of Patient 100's high potassium level. She stated Patient 100 was to be admitted to 2 North, the telemetry unit and dialysis (a procedure that uses a dialysis machine to filter out waste products from the blood, when kidney failure is present) had been ordered. When asked about the transfer to 2 North, she stated Respiratory Therapist B took Patient 100 off the BiPap for about 10 minutes prior to transfer to see how Patient 100 would do since the hospital did not have a portable BiPap. She stated he did ok, and his oxygen saturation was 100%, but he continued to complain of shortness of breath. She stated Physician C		has sufficient oxygen amount to transport patient. - Patient receiving positive airway pressure or mechanical ventilation must be supported by a device capable of delivering the same minute ventilation, pressure, fractional concentration of oxygen (FIO2), and Positive End Expiratory Pressure (PEEP) that the patient is receiving. • Circulatory support: - Ensure sufficient supply of intravenous fluid accompanies the patient when applicable - Ensure sufficient supply of continuous infusion medications regulated by an infusion pump that the patient is currently requiring/receiving. - Cardiac monitoring should be continued using a portable monitor • Transporting the patient - Patients with Step Down Unit (SDU) and Intensive Care (ICU) designation should have a minimum of two people to accompany the patient, one of who shall be an Advanced Cardiac Life Support (ACLS) certified. - All intubated and mechanically ventilated patients must be accompanied by a respiratory therapist, anesthesiologist, or attending physician. - If there is a question regarding the patient's instability for transport, the patient's attending physician or their physician designee must evaluate the patient prior to transport. - Nurses caring for the patient should remain with the patient until	

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	gave a verbal order to discontinue prior to transfer telemetry. Licensed Nurse F stated it was not unusual to discontinue the telemetry prior to transfer. Licensed Staff F stated she asked Physician C if there was anything else and he said no; just get him upstairs for dialysis. The emergency record for Patient 100, dated 04/22/13, indicated the following physicians orders written 04/22/13 at 10:52 a.m. for cardiac monitoring (telemetry), pulse oximetry, (noninvasive electronic monitoring of percentage of oxygen carried in the blood), and oxygen 1-6L (flow rate) per nasal cannula (plastic tubing for oxygen administration through the nose), to keep oxygen saturation over 92%. At 11:19 a.m. on 04/22/13., the physician ordered Bi-Pap, (noninvasive support of respirations), for Patient 100. During an interview on 07/18/13 at 10 a.m., Licensed Staff F stated Patient 100 did not have continuous oximetry monitoring during the transfer. She stated that both Physician C and Physician D were aware that Patient 100 was still short of breath and his low blood pressure of 86/61 at 12:37 p.m., 20 minutes prior to transfer. Patient 100 was transferred on 04/22/13 at 1 p.m. Licensed Staff F stated during the transfer Patient 100 was still complaining of being short of breath. She stated he looked no different than he had in the Emergency Department. She stated they arrived on the unit and as they went to transfer Patient 100 to the bed he became unresponsive, was not breathing and had no pulse. A code blue (heart and respiratory resuscitation) was initiated but Patient 100 died.		appropriately trained personnel can accept patient transfer of care. d. This policy was developed and approved by applicable nursing staff, Medical Staff, CMO/COO, and CNO during 11/2013. MSQC approval was obtained on 11/2013; MSEC, CQC, and BOT approval was finalized on 12/2013. 2. To ensure safe transport for patients requiring cardiopulmonary monitoring and respiratory support immediately prior to and during transfer to an in-patient unit the following was implemented: a. One Portable BiPap was purchased in October 2013. Six additional BiPap machines were purchased in November 2013. b. Respiratory Therapy staff completed mandatory education and competency validation for new Portable BiPap (Battery powered V60) equipment on 10/2/13 through 10/4/13. c. Equipment was placed into service on 10/7/13. 3. Applicable staff were debriefed regarding this event and underwent mandatory verbal and written training regarding scope of practice and assessment /reassessment of patients. To ensure services are only provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies, procedures and State laws; and to ensure safe transport for patients requiring cardiopulmonary monitoring and respiratory support immediately prior to and during	10/31/13 11/30/13

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	Physician E's Critical Care note dated 04/22/13, indicated that Patient 100 told his wife during the transfer he felt worse than he did in the emergency department, and that he was very short of breath, and just felt bad. The medical record for Patient 100 did not contain documentation for Patient 100 having a trial off BiPap; no written physician orders to discontinue the BiPap and no written order for the heart monitoring (telemetry) and oximetry to be discontinued were found. These failures to ensure nursing staff provided continuous cardio/pulmonary monitoring (monitoring of heart and breathing activity), and respiratory support (breathing) prior to and during transfer from the emergency room to the medical unit for Patient 100 may have resulted in delayed recognition of Patient 100's deteriorating medical status in which the patient died. These were violations of Section 70215(a)(1)(2) of Title 22 of the California Code of Regulations and deficiencies that caused or were likely to cause serious injury or death to the patient and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a).		transfer to an in-patient unit, mandatory education for applicable nursing staff and RT was completed in November 2013. Education topics included the following: a. Requirements for transport of a patient on BiPap. b. Requirement for a physician order whenever a patient is trialed off BiPap. c. Requirement for a physician order whenever a patient is discontinued from BiPap. d. Need to monitor telemetry and oximetry during transport, when ordered. e. Medical Record Documentation requirements – documentation of transport will include personnel included in transport, method of transport and equipment used during transport (i.e. monitor, ventilator, O2, IV pump, etc.). f. To ensure physician orders are not missed, once the admitting / attending physician assumes care the patient, the ED nurse will call or speak Face-to-Face to the admitting / attending physician. At a minimum, the conversation will include discussions regarding the plan of care, the patient's immediate needs, and clarification of Stat Orders needed to be completed prior to transfer to the in-patient unit. g. Key considerations before transporting a patient from the ED to an in-patient unit include at least the following: • Communication with the attending physician • Patient stability for transport • Completion of Stat orders • Completion of ED or Stat ordered tests • Appropriate level of care – clarify when any doubt • SBAR handoff report has been given	

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			to the receiving RN o Transport monitor, pulse oximeter when needed o Appropriate support staff available and are assisting with transport (RT, Tech, etc.)	
			4. Mandatory education titled "Medical Treatment of Hyperkalemia" commenced for ED nursing staff on 10/15/13 including education about administration of Calcium Gluconate, Insulin, Sodium bicarbonate, Albuterol, and treatment to remove potassium from the patient's body through dialysis. Education was completed on 11/21/13 with100% documented compliance.	11/21/13
			5. Mandatory education titled, "Medication Management In ED" commenced for ED nursing staff on 7/1/13 and was completed on 8/29/13 with 100% documented compliance. Education topics included: a. Requirement to verify physician orders with a printed order or the open EMAR. b. RN responsibility for documentation and practice.	9/1/13
			6. Mandatory education titled, "Attending Physician Contact & Reporting Procedure" commenced for ED nursing staff on 10/15/13. The purpose of this education was to reinforce factors necessary when admitting ED patients to the medical center in a safe and timely manner, to assure essential and appropriate information is communicated amongst caregivers, and to maintain a safe continuum of care. Education was completed on 11/21/13 with 100% documented compliance.	12/1/13

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			7. Staff must adhere to the hospital's Emergency Services policies and procedures including the policy titled, "Reporting Procedure for Admitted Patients". This policy was revised to include the following statements. a. The Emergency Department Nurse will have either a phone or face-to-face conversation with the admitting physician for all patients that have orders for admission or observation. The conversation will cover the elements of the following: (1) Plan of Care, (2) Immediate Needs, & (3) Stat or Now orders that will need to be completed prior to transport to the floor. b. These policy revisions were approved by the ED Medical Director, ED Director, ED Manager, and CNO by 10/2013; Policy was approved by Medical Staff Quality Committee on 11/20/13. Medical Staff Executive Committee, Clinical Quality Council, and BOT approval was completed in 12/2013. 8. Completion of mandatory staff education is monitored and tracked via department specific reports and/or via HealthStream (the hospital's electronic Learning Center system). Elements of the above mandatory education have been added to the annual competency requirements for ED nursing staff and have been included in new hire orientation for all new staff working in the ED. Monitoring Process: 1. Monthly random audits of ED patient's medical records occurred 2/1/13 through 10/31/13 to review "Medical record documentation noting that the ED Nurse completed either a phone or face-to-face	12/31/13 9/17/15

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			conversation with the admitting physician for all patients that have orders for admission or observation; thereby, requiring transport to a nursing unit. The number of records audited were Feb=30/30, Mar=59/59; Apr=48/48; May=81/81; June=109/109; July=65/65; Aug=87/87; Sept=123/123; Oct=128/128 resulting in 100% compliance. Audit Indicators: Medical Record Documentation is complete noting the ED RN completed either a phone conversation or a face-to-face conversation with the admitting physician for all patients that have orders for admission or observation. Medical Record documentation of the phone or face-to-face conversation with the admitting physician included: a. The Plan of Care b. Immediate needs c. Stat or now orders that will need to be completed prior to transport to the floor 2. Transporting of patients will be audited to ensure compliance with the "Intra-Facility Transport of Monitored Patients" policy. Audit to include Patients requiring transport from the ED to the Step Down Unit and ICU. Audits will include patient transports for each shift. Audits will be monthly to include a minimum of 35 transports. This audit will commence on 08/17/15. Following four (4) continuous months of compliance, this audit may be reduced to quarterly monitoring until sustainable corrections are assured.	

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			Audit indicators: a. Transporting of patients with Step Down Unit and ICU designation have a minimum of two people to accompany the patient, one of who shall be Advanced Cardiac Life Support (ACLS) certified. b. The patient received appropriate physiologic monitoring during transport per level of care c. SBAR handoff report is completed prior to transport Responsible Person(s): ED Director or designee Actions for the above Plan of Correction were evaluated for effectiveness. Audit data and analysis was reported to involved staff, Patient Safety Council, Administration, Nursing Leadership, MSQC, MSEC, CQC and BOT for tracking and integration into the hospital's quality assurance program.	

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