



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>South Coast Global Medical Center</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 S Bristol St, Santa Ana, CA 92704-6201 ORANGE COUNTY</b>		
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	<p>Title 22, § 70215(a)(1)(2),(b), and (c) Planning and Implementing Patient Care.</p> <p>(a) A registered nurse shall directly provide:</p> <p>(1) Ongoing patient assessments as defined in the Business and Professional Code, Section 2725(b)(4). Such assessments shall be performed, and the finding documented in the patient's medical records, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area.</p> <p>(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.</p> <p>(b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission.</p> <p>(c) The nursing plan for the patient's care shall be discussed with and developed as a result of coordination with the patient, the patient's</p>		<p>Policies and procedures are based on current standards of nursing practice and are consistent with the nursing process including assessment, nursing diagnosis, planning, intervention, evaluation, and patient advocacy.</p> <p><u>Training and In-service</u></p> <p>Training and Education on new policies and procedures and any updates or revisions on existing ones provided by the nursing unit directors or their designee.</p> <p><u>Monitoring</u></p> <p>A Monthly random audit of 30 medical records to assess patient assessment, intake and output, and bowel movement documentation will be conducted Any patient identified with change of condition will be audited for reassessment follow up actions on a monthly basis by nursing unit directors or designees.</p> <p><u>Title 22 §70215 (a)(1)(2), (b), (c)</u></p> <p><u>Initial Nursing Assessment</u></p> <p><u>Policy and Procedure Review</u></p> <p>The Initial Nursing Assessment Policy and Procedure has been reviewed and revised by the nursing directors and the</p>	<p>4/26/2014</p> <p>4/1/2014</p> <p>3/27/2014</p>

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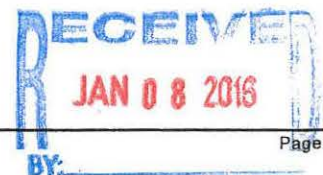
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	<p>family, or other representatives, when appropriate and staff of other disciplines involved in the care of the patient.</p> <p>Business and Professions Code § 2725(b)(4) states: observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standard procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on interview and medical record review, the hospital failed to ensure the nursing staff provided necessary nursing services to prevent and treat Patient 1's medical condition related to fecal impaction (a solid, immobile bulk of human feces that develops in the rectum, as a result of constipation, opioid medications, decreased activity, and certain mental illnesses, that can lead to bowel perforation and infection) and address the patient's refusal of multiple medical and nursing interventions during the patient's two hospitalizations from 1/4 to 1/9/14, and from 1/11 to 1/13/14, including the following:</p>		<p>CNO/COO to ensure the appropriateness of the policy and to include psychosocial assessment and psychosocial referral.</p> <p><u>Training and In-service</u></p> <p>Hospital RNs will receive education on the requirements of the nursing assessment and documentation from their nursing unit director or designees.</p> <p><u>Monitoring</u></p> <p>All current hospital patients' assessments will be checked by the nursing unit directors or designees to make sure that nursing assessment match the hospital policy. Any patient assessment which deviates from the policy will be corrected immediately by the nursing unit director or their designees to reflect the guideline requirements.</p> <p>A monthly random audit of 30 medical records to assess patient assessment which will be conducted and will include: timeliness, patient's physical, psychological, spiritual, cultural concerns, social status and identification of patient's needs: nutritional, functional and educational. The audit will be conducted by nursing unit director or designees to ensure monitoring and safe patient care, the</p>	<p>3/30/2014</p> <p>3/27/2014</p> <p>4/26/2014</p> <p>4/1/2014</p>

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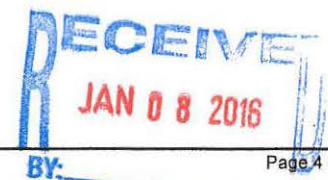
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	<p>- During Patient 1's first admission to the hospital from 1/4 to 1/9/14, for a diagnosis of fecal impaction, the nursing staff failed to provide ongoing assessments of the patient's signs and symptoms of illness and reactions to treatment, appropriate care planning, and necessary standard nursing interventions. The nursing staff failed to notify the physician and the conservator of Patient 1's refusal of treatment and changes in the patient's condition, and failed to advocate for Patient 1 in obtaining the orders for medical interventions necessary to treat Patient 1's lack of effective bowel movements, symptoms related to fecal impaction, and mental illness. The nursing staff failed to ensure Patient 1 was evaluated by a physician and was stable for discharge before discharging the patient from the hospital on 1/9/14.</p> <p>- During Patient 1's second admission to the hospital for fecal impaction from 1/11 to 1/13/14, the nursing staff failed to develop an appropriate care plan, again failed to notify the physician of Patient 1's refusal of treatment and changes in condition, and failed to advocate for Patient 1 by obtaining the orders for medical interventions necessary to treat Patient 1's lack of effective bowel movements, abdominal pain, and other symptoms related to fecal impaction and mental illness. The nursing staff also failed to notify Patient 1's conservator of her declining condition and refusal of treatment.</p>		<p>results will be forwarded to Quality Council/Patient Safety Committee, Medical Executive Committee and the Governing Board as often as they meet.</p> <p><u>Patient Advocacy</u></p> <p><u>Policy and Procedure Review</u></p> <p>A new policy has been developed to address the clinical advocacy by the nursing directors and the CNO/COO to reflect the patient advocacy and professional responsibility toward patient safety.</p> <p><u>Training and In-service</u></p> <p>Hospital RNs received education on the Patient Advocacy Policy and Procedure and Chain of Command Policy and Procedure from nursing unit directors or designees.</p> <p><u>Monitoring</u></p> <p>Nursing directors or designees will meet on a daily basis to solicit input to identify those who are at risk or need advocacy such as patients with psychosocial issues, care and treatment issues, discharge/transfer concerns and/or any case which may require additional support.</p> <p>All current hospital patients in house will be screened and will be evaluated for</p>	<p>3/27/2014</p> <p>4/26/2014</p> <p>4/26/2014</p> <p>4/26/2014</p>

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	<p>As a result, on 1/13/14, Patient 1 was found with a ruptured bowel and peritonitis (inflammation of the membrane covering the entire abdominal wall caused by bacterial or irritating substances, introduced into the abdominal cavity by a penetrating wound or perforation of an organ). Patient 1 had a cardiac arrest followed by an emergency surgery. Intra-operatively, Patient 1 was found with a perforated colon and peritonitis. Post-operatively, Patient 1 remained critically ill and developed an ischemic bowel (injury to the bowel due to insufficient blood supply) with multi-organ system failure. Patient 1 expired on 1/13/14 at 2108 hours.</p> <p>Findings:</p> <p>According to the Current Medicine Group LLC ISSN 1522-8017, Current Gastroenterology Reports 2008, 10:449-501 "Management and Prevention of Fecal Impaction," fecal impactions occur in both sexes and at any age, but are included particularly in patients with certain psychiatric disorders that predispose to obstipation (severe constipation caused by intestinal obstruction). Clinical manifestations include fecal incontinence (involuntary bowel excretions), abdominal pain and distention, anorexia (lack of appetite), intestinal obstruction, and perforation. The management consists of enemas (fluid introduced into the rectum, typically to expel the rectal contents), osmotic laxatives (which increase fluid in the</p>		<p>any psychosocial issues or additional needs by the nursing unit directors or designees and the appropriate actions will be taken to ensure safe patient care.</p> <p>For any patient who meets the identified criteria the chain of command will be activated immediately to advocate and support the patient and their families.</p> <p>A concurrent audit on patients who meet the identified criteria will be conducted by nursing unit directors or designees to ensure appropriate actions to protect patient/families, and the results will be forwarded to Quality Council/Patient Safety Committee, the Medical Executive Committee and the Governing Board.</p> <p>When necessary, the Bioethics Committee will be consulted when there is a conflict between the staff, licensed practitioner and the patient and/or family member(s). The committee consists of 2 physicians, lay representatives, social workers, a representative of the clergy, ethicists, an attorney, the administration (or designee) and representative(s) from the Governing Board. Consultation with the concerned parties is to facilitate communications and aid conflict resolution.</p>	<p>4/26/2014</p> <p>4/26/2014</p> <p>4/26/2014</p>

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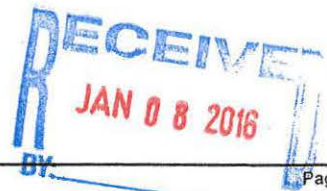
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	<p>intestines) such as polyethylene glycol, disimpaction (manual removal of feces), colon evacuation, and a maintenance bowel program to prevent recurrent impactions.</p> <p>According to Medical-Surgical Nursing, Concepts &amp; Clinical Practice, USA, Mosby, 2012, nursing should monitor all hospitalized patients for constipation. The need for communication among the nursing staff about the patient's bowel function is especially important; bowel movements (BM) must be carefully recorded as to time, amount, and consistency for the nurse to make appropriate judgments about the need for laxatives and enemas.</p> <p>Review of the hospital's policy and procedure (P&amp;P) titled "Nursing Assessments and Reassessment," revised 2/11, showed the registered nurse (RN) should reassess the patient every shift, when there is a significant change in condition or diagnosis, and prior to discharge to evaluate the patient's progress regarding the plan of care. This assessment would provide a database for the RN to plan, coordinate, delegate, and supervise the care of the patient. The minimum reassessment time frame for the medical surgical unit is every shift plus any changes in condition.</p> <p>Review of the hospital's P&amp;P titled "Refusal of Medical Treatment," revised 5/13/11, showed staff should provide the following interventions when a patient refuses medical treatment:</p>		<p><u>Patient Reassessment and change of condition</u></p> <p><u>Policy and Procedure Review</u></p> <p>All current hospital patients will be reviewed by the nursing unit directors or designees to make sure that nursing reassessment is matching the hospital policy.</p> <p>All patients with change of condition will receive the following actions:</p> <ol style="list-style-type: none"> <li>1. Physician notification</li> <li>2. Rapid response activated if the patient's condition is deteriorating.</li> <li>3. Document the time of MD notification, action taken, and patient's response to treatment and patient reassessment</li> <li>4. Focus reassessment in regard to the patient's need.</li> <li>5. Care plan update</li> <li>6. If MD did not respond to the call within 30 minutes, call again and activate Chain of Command Policy and Procedure and notify the unit director.</li> <li>7. All Physician notifications will be documented on the Electronic Medical Record (EMR) under Physician Notification tab/or progress note for tracking and follow up.</li> </ol>	<p>3/30/2014</p> <p>4/26/2014</p>

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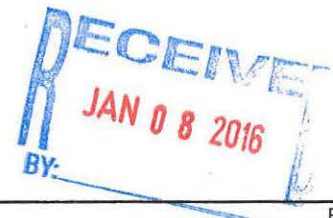
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	<p>-The RN should contact the physician immediately when a patient refuses drugs, blood or other medical treatment.</p> <p>-The physician should explain to the patient the reason for ordering the treatment and the possible ill effects if the patient refuses it, the physician should document what she/he discusses with the patient in the medical records.</p> <p>-The hospital's physician/RN should have the patient sign a "Refusal to Permit Medical Treatment" form, complete a hospital Risk Identification Report (RIR), and notify the Department Manager or Administrative Supervisor.</p> <p>Review of the hospital's P&amp;P titled "Physician Communication," revised 5/13/11, showed the RN in charge of the care of the patient should notify the physician in a timely manner of any alterations in the patient's mental, emotional, and physical condition and alert the physician to any abnormal laboratory or radiology results.</p> <p>Review of Patient 1's Conservatorship documents, showed the Public Guardian was appointed conservator of the person and estate of Conservatee (Patient 1) with the powers specified in the Probate Code sections 2400 et seq., effective 12/23/13 to 12/23/14. The conservator would also have the power to detain the conservatee in the facility providing intensive treatment, and to require the conservatee to receive treatment related</p>		<p><u>Training and In-service</u></p> <p>Hospital RNs received education on Patient Reassessment and Change of Condition Policy and Procedures from nursing unit directors or designees.</p> <p><u>Monitoring</u></p> <p>Any patient identified with change of condition will be audited for reassessment follow up actions on a monthly basis. The audit will be conducted by nursing unit directors or designees to ensure monitoring and safe patient care and results will be forwarded to the Quality Council/Patient Safety Committee, the Medical Executive Committee and the Governing Board.</p> <p><u>Bowel Movement and Intake and Output</u></p> <p><u>Policy and Procedure Review</u></p> <p>A new Policy and Procedure for Bowel Movement Management was developed by the Director of Medical/Surgical addresses the patient's normal bowel pattern. This policy and procedure has been approved by the appropriate medical staff committees.</p>	<p>4/26/2014</p> <p>4/26/2014</p> <p>3/14/2014</p>

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	<p>specifically to remedying or preventing the recurrence of the conservatee's being gravely disabled, including administration of psychotropic medications. The court found that the conservatee lacked the capacity to give or withhold informed consent for such treatment.</p> <p>On 1/28/14, medical record review for Patient 1 was initiated. Documentation showed Patient 1 was diagnosed with schizoaffective disorder (a psychotic disorder marked by severely impaired thinking, emotions and behaviors) and was under conservatorship (appointed guardian) for being gravely disabled (unable to provide for her basic physical needs). The patient resided in a Therapeutic Residential Center (TRC, a live-in health care facility providing medication and therapy for substance abuse, mental illness, or other behavioral problems) and had a history of refusing treatment for constipation and chronic constipation.</p> <p>Patient 1 was brought to the hospital's Emergency Department (ED) via an ambulance from the TRC on 1/1/14 at 1928 hours, with a chief complaint of moderate abdominal pain for three days, accompanied by nausea and loss of appetite. An Acute Abdominal Series (AAS, x-rays to diagnose problems in the large intestine) dated 1/1/14 at 2003 hours, showed an extremely large amount of stool was identified throughout the entire large intestine. The ED physician documented Patient 1 was</p>		<p>All current patients have been assessed for normal bowel pattern by the primary nurses on an ongoing basis.</p> <ol style="list-style-type: none"> <li>1. This policy has been implemented on patients who have abnormal bowel pattern treatment and documented accordingly by the primary nurse and is occurring on an ongoing basis.</li> <li>2. All bowel movements will be recorded in a timely manner in the daily assessments under the GI section to include the following: bowel sounds, specific location, frequency, constancy of patient complaint (Abdominal pain), patient refusal to eat or drink, and any other symptom on an ongoing basis.</li> <li>3. Nurses will communicate the patient's bowel movement on shift to shift report using SBAR.</li> <li>4. All intake and output will be documented accurately by the primary nurse on ongoing basis.</li> <li>5. Any significant changes in bowel movement or intake and output will be reported to the primary physician on an ongoing basis.</li> <li>6. If the patient refuses medical</li> </ol>	3/27/2014

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	<p>positive for constipation and had "improved." Patient 1 was discharged back to the TRC on the same day, 1/1/14.</p> <p>On 1/4/14, Patient 1 was brought back to the ED with a chief complaint of severe and persistent abdominal pain, accompanied by loss of appetite and abdominal tenderness (pain).</p> <p>The report from an Acute Abdominal Series x-rays dated 1/4/14 at 2144 hours, showed Patient 1 had severe fecal impaction with a dilated colon. The report also showed the colon was so packed with feces and the possibility of free air (possible internal organ perforation) was difficult to exclude. The ED physician reviewed the AAS and documented his clinical impression included abdominal pain, fecal impaction, and constipation. The physician documented Patient 1's condition was unchanged and the plan was to admit the patient to the hospital.</p> <p>The Surgical Consultation report dictated on 1/5/14, showed the consultation was conducted on 1/4/14. The surgeon documented Patient 1 complained of abdominal pain and constipation and wanted to have a surgery for the constipation; however, the surgeon explained to the patient that at that point, the surgeon encouraged diet modifications.</p> <p>Review of the nursing Admission Assessment Report dated 1/5/14, showed Patient 1's</p>		<p>treatment for fecal impaction, the primary nurse will activate the patient refusal of medical treatment policy</p> <p><u>Training and In-service</u></p> <p>Hospital RNs will receive education on Bowel Movement Policy and Procedures from nursing unit directors or designees</p> <p><u>Monitoring</u></p> <p>A monthly random audit of 30 medical records to assess the intake and output, and bowel movement documentation will be conducted by nursing unit directors or designees to ensure monitoring and safe patient care. The results will be forwarded to Quality Council, the Medical Executive Committee and the Governing Board.</p> <p><u>Discharge</u></p> <p><u>Policy and Procedure Review</u></p> <p>Discharge and Transfer of Inpatient Policy and Procedure has been reviewed and revised by nursing unit directors to reflect the following:</p> <ol style="list-style-type: none"> <li>1. Review the discharge order</li> <li>2. Provide the patient with discharge instructions</li> </ol>	<p>4/26/2014</p> <p>4/26/2014</p> <p>3/27/2014</p>

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	<p>abdomen was distended, bowel sounds were active (sounds made by the movement of the intestines as they push food through), and the patient was cooperative with care.</p> <p>The History and Physical examination dated 1/5/14, showed Patient 1 had increased constipation for the last week and was found to have a fecal impaction. Physician 1 documented a surgical consultation was done for Patient 1; however, the patient already had two BMs in the morning.</p> <p>Review of the nursing care plan for Patient 1's problem of fecal impaction dated 1/5/14, showed the patient's goal was for her bowel elimination to return to normal. The care plan approaches included to educate the patient regarding causes of constipation, have a dietary consult, and administer the medications as ordered. However, the care plan failed to identify measurable outcomes for the patient, such as a reduction in severity or duration of abdominal pain, for determining the success of the care provided, and the possible need for additional care planning. In addition, the care plan did not address Patient 1's mental illness and refusal of treatment.</p> <p>Review of Patient 1's physician's orders showed an order dated 1/5/14 at 1229 hours, to administer a Fleet enema (a lubricant laxative that works by relieving constipation or fecal impaction) 135 milliliter (ml) rectally once and repeat once.</p>		<ol style="list-style-type: none"> <li>3. All patients will be evaluated within the last 24 hours prior to discharge by a licensed practitioner</li> <li>4. The nursing assessment should reflect that the clinical condition of the patient is progressing and safe to be discharged</li> <li>5. Primary RN will communicate to the licensed practitioner if the patient is not safe to be discharged</li> <li>6. All communication will be documented</li> </ol> <p><u>Training and In-Service</u></p> <p>Hospital RNs will receive education on discharge criteria and the appropriate actions and the education will be conducted nursing unit directors or designees.</p> <p><u>Monitoring</u></p> <p>On ongoing basis, all discharged patients will be evaluated by primary nurses and based on the previous criteria.</p> <p>A monthly random audit of 30 medical records will be conducted to review patient discharge criteria. The audit will be conducted by nursing unit directors or designees to ensure monitoring and</p>	<p>4/26/2014</p> <p>4/26/2014</p> <p>4/26/2014</p>

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	<p>Review of the Medication Administration History Report dated 1/5/14 at 1508 hours, showed the ordered Fleet enema was not given as it was refused by the patient. There was no documentation to show the RN had notified the physician or conservator or provided other interventions to address the patient's refusal of medical treatment.</p> <p>Review of the Daily Focus Assessment Report and Progress Notes Report showed the nursing staff documented on 1/5/14 at 0848 hours and again at 2000 hours, Patient 1's abdomen was firm (a normal abdomen should be soft and non-distended).</p> <p>Review of the Social Services notes dated 1/6/14 at 1130 hours, showed the patient had delusions and poor insight. The Social Service staff documented review of the patient's records from the TRC showed the patient was inconsistent with treatment compliance. The note indicated the patient had a conservator who "requested updates as pertinent."</p> <p>On 1/6/14, the physician ordered Golytely (polyethylene glycol, a laxative) 240 ml orally every 10 minutes until fecal effluent was clear; not to exceed a total volume of 4000 ml.</p> <p>On 1/6/14 at 1940 hours, the nursing staff documented Patient 1 complained of pain and pressure in the rectum at a level of 4/10 (a numeric pain scale of 0-10 with 0 = no pain and</p>		<p>safe patient care, the results will be forwarded to Quality Council/Patient Safety Committee, the Medical Executive Committee and the Governing Board</p> <p><u>Business and Professions Code 2725 (b)(4)</u></p> <p><u>Policy and Procedure Review</u></p> <p>The patient rights and responsibilities for Refusal of Medical Treatment have been reviewed by the nursing directors and the CNO/COO on to make sure the appropriateness of the policy. The policy deemed to be in congruence with Title 22.</p> <p>The hospital works to provide safe treatment as permitted by the law, however, some of the patients need more support to make appropriate decisions regarding their treatment under total free will, for this reason the following actions will be taken to ensure safe patient care:</p> <ol style="list-style-type: none"> <li>1. Patients who continuously refuse treatment will sign a refusal document specifying what the medical treatment is;</li> <li>2. Patients who continuously refuse treatment by a licensed practitioner will require a reason for refusal and actions taken including, but not limited</li> </ol>	<p>4/26/2014</p> <p>4/26/2014</p>

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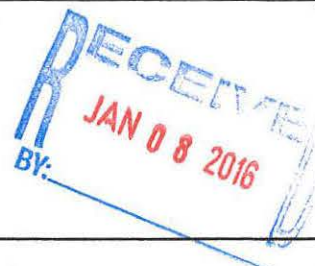
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	<p>10 = worst pain); the patient's bowel sounds were active and her abdomen was distended.</p> <p>Review of the Nursing Progress Notes Report showed documentation of attempts to administer Golytely to Patient 1 as follows:</p> <p>* On 1/6/14 at 1300 hours, Patient 1 taking sips of Golytely.</p> <p>* On 1/7/14 at 0945 hours, Patient 1 did not drink all the Golytely and did not pass any stool; the patient continued to refuse to drink Golytely.</p> <p>* On 1/7/14 at 1738 hours, Patient 1 had no BM on that day and refused to finish the Golytely.</p> <p>* On 1/8/14 at 0822 hours, the patient was confused.</p> <p>* On 1/9/14 at 0800 hours, the patient was encouraged to drink Golytely but refused.</p> <p>However, there was no documentation to show the nursing staff had notified the physician or conservator of Patient 1's refusal to take Golytely as ordered, or that the patient was asked to sign the "Refusal to Permit Medical Treatment" form. Furthermore, there was no documentation to show that a Risk Identification Report (RIR) was completed, or the Department Manager or Administrative Supervisor was notified as per the hospital's P&amp;P on "Refusal of Medical Treatment."</p>		<p>to: discussion with patient and/or family regarding the risk of refusal of treatment, and provide the patient and/or family with alternative treatments available;</p> <p>3. The licensed practitioner will be notified and the nurse can advocate for psychiatric evaluation on patients who continuously refuse treatment;</p> <p>4. The social worker will be involved immediately to do a psychosocial screening and to identify patient abilities to make appropriate medical decisions;</p> <p>5. The nurse has the right to advocate for the patient and activate the chain of command when the existing problem has not been resolved.</p> <p><u>Training and In-service</u></p> <p>Hospital RNs received education on how to handle patients with special needs such as refusing treatment. The education will be conducted by the nursing unit directors or designees.</p>	4/26/2014

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	<p>Review of the output records show on 1/5/14, Patient 1 had one BM; however, there was no documentation to show the bowel characteristics as to the accurate amount and consistency of the stools passed. Patient 1 had no BMs on 1/6 and 1/7/14.</p> <p>Review of the CT scan (computed tomography scan is an imaging procedure using special x-ray equipment to create a series of detailed pictures) of Patient 1's abdomen and pelvis with oral contrast report dated 1/6/14, showed evidence of severe fecal impaction. A significant amount of stool was seen throughout the entire patient's colon (large intestine).</p> <p>Review of the Medication Administration History Report showed the nursing staff documented on 1/7/14 at 2326 hours, Patient 1 again refused the rectal enema.</p> <p>Review of the Daily Focus Assessment Report dated 1/7/14 at 1930 hours, showed Patient 1 was constipated and her abdomen was firm and distended with active bowel sounds. Patient 1 complained of a severe abdominal pain of 8/10 at 2324 hours and was medicated with one tablet of Norco 5-325 milligrams (mg). Norco is a narcotic pain medication with side effects of constipation due to decreasing gastrointestinal motility.</p> <p>On 1/8/14, the nursing staff documented</p>		<p><u>Monitoring</u></p> <p>Any patient identified refusing treatment will be audited for appropriateness of the actions taken on a monthly basis. The audit will be conducted by nursing unit directors or designees to ensure monitoring and safe patient care, the results will be forwarded to Quality Council/Patient Safety Committee, the Medical Executive Committee and the Governing Board.</p>	4/26/2014

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	<p>Patient 1 had one large and three small BMs; however, there was no assessment of the consistency of the BMs documented. At 0346 hours, the patient's abdominal pain was assessed at the level of 8/10 on the pain scale and the patient was medicated with one tablet of Norco 5-325 mg. At 0752 hours, Patient 1's abdomen was documented as firm, distended, and tender with active bowel sounds. At 0815 hours, the patient complained of severe pain in the rectum at the level of 8/10 on the pain scale and the patient was medicated with Norco 5-325 mg.</p> <p>Despite evidence on examination and CT scan result of severe fecal impaction requiring treatment, there was no documentation to show the RNs had notified the physician or conservator of the patient's refusal of treatments or provided other interventions to address the patient's refusal of medical treatment as per the hospital's P&amp;P.</p> <p>Review of the Physician's Progress Note dated 1/8/14, did not show the physician was aware of the patient's refusal of treatment, and instead the documentation showed the physician documented Patient 1 received Golytely, accompanied by Fleet enemas. The physician documented Patient 1 proceeded to have a large BM. Further documentation showed the physician's plan was to discharge Patient 1 back to the TRC if the constipation had resolved.</p>				

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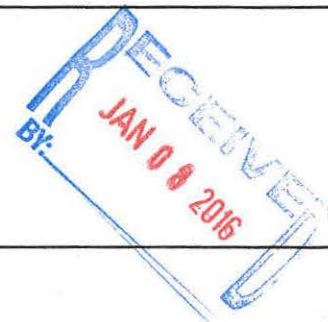
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	<p>Review of physician's orders dated 1/8/14, showed an order for Patient 1 to have a Kidney, Ureters and Bladder (KUB) x-ray stat (immediately) status post bowel movement. Review of the report of the KUB performed on 1/8/14 at 1024 hours, showed there was a decrease in the amount of stool throughout the colon; a significant amount of stool remained in the recto sigmoid colon (terminal portion of the sigmoid colon by the rectum); and gaseous distention of the colon in the abdomen.</p> <p>On 1/8/14 at 1950 hours, the nursing staff documented Patient 1 complained of a severe pain at the level of 7/10 on the pain scale in the lower back; the patient was medicated with one tablet of Norco 5-325 mg.</p> <p>On 1/9/14 at 0115 hours, the nursing staff documented the patient was rocking, restless and complained of severe pain in her lower back at the level of 7/10 on the pain scale; the patient was medicated with one tablet of Norco 5-325 mg.</p> <p>On 1/9/14 at 0800 hours, the nursing staff documented the patient was encouraged to drink Golytely, but she continued to refuse.</p> <p>On 1/9/14 at 0939 hours, RN 1 documented Patient 1's abdomen was firm and distended with active bowel sounds; the patient complained of severe pain to her lower back.</p> <p>On 1/9/14 at 1110 hours, the patient again</p>			

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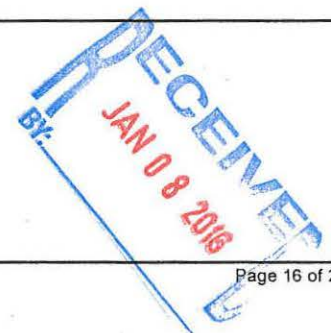
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	<p>complained of severe pain on her lower back at the level of 9/10 on the pain scale; the patient was medicated with one tablet of Norco 5-325 mg.</p> <p>However, there was no documentation to show the RNs had notified the physician regarding the lack of improvement of Patient 1's recurrent abdominal pain and distention and the patient's new complaints of pain located at the rectum and lower back.</p> <p>On 1/9/14, medical record review showed the nursing staff documented the patient had four small and five incontinent BMs. There was no documentation to show the characteristics of the stools passed. There was inadequate information documented to indicate whether the fecal impaction was improving as a result of the treatments.</p> <p>Review of the nursing Admission Assessment Report dated 1/5/14, showed Patient 1 was taking olanzapine (an antipsychotic medication) at bedtime daily prior to admission and the History and Physical examination showed the plan was to continue the olanzapine. However, according to the Medication Administration Record, no antipsychotics were ordered or given to Patient 1 in the hospital. In addition, there was no documented evidence of a psychiatric evaluation performed in the hospital.</p> <p>The Daily Focus Assessment Report dated</p>			

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	<p>1/5/14 at 0848 hours, recorded Patient 1's level of consciousness as "alert," "oriented," and with "clear" speech. The patient's mood was documented as "cooperative" on 1/5, 1/6, and again on 1/7/14 at 0932 hours, despite the patient's refusal of the medications. On 1/7/14 at 1930 hours and on 1/8/14 at 0752 hours, the patient was noted as "oriented, alert, appropriate" but "uncooperative" with "oppositional/defiant behaviors."</p> <p>On 1/8/14 at 1950 hours, the patient's mood was described as "anxious/worried, angry," and also, "oriented, alert, appropriate." However, on 1/9/14 at 0939 hours, the patient's condition was described as "confused speech, disoriented," "shouts angrily, curses, uses foul language," and "restless/agitated, impulsive."</p> <p>On 1/9/14 at 1812 hours, 31 hours after the last documented physician assessment, the nursing staff documented Patient 1 was picked up to return to the TRC.</p> <p>There was no documented evidence to show the nursing staff had informed the physician or conservator of the patient's deteriorating mental status as indicated by uncooperativeness, disorientation, and agitated behavior. There was no documented evidence to show the nursing staff had advocated for the patient to obtain mental health treatments.</p> <p>There was no documented evidence to show</p>			

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	<p>the nursing staff had evaluated the patient's response to the nursing interventions to address recurrent pain, abdominal distention, irregular defecation pattern, and episodes of refusing medical treatments to determine whether further interventions were required prior to discharge. There was no documentation to show the nursing staff had advocated for the patient to prevent the discharge when the patient continued to have abdominal distension, intermittent severe pain, and deteriorating mental status; and to request a physician to come to evaluate the patient.</p> <p>During an interview with RN 1 on 1/28/14 at 1400 hours, he stated he received orders from Physician 1 over the telephone to discharge Patient 1. However, there was no documentation to show RN 1 had notified the physician about Patient 1's firm and distended abdomen, severe intermittent lower back, abdominal, and rectal pain, and deteriorating mental status. RN 1 confirmed Physician 1 did not come to the hospital and physically examine Patient 1 prior to discharge on 1/9/14.</p> <p>During an interview with Physician 1 on 1/29/14 at 0845 hours, the physician stated Patient 1 had chronic constipation due to the use of psychotropic medications. The physician stated he discussed with the patient the risk of refusing the medications to treat fecal impaction. The physician stated according to the nurses, the patient was taking Golytely and had multiple BMs.</p>			

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	<p>The physician stated the KUB x-ray report performed on 1/8/14, showed a decrease in the amount of stool in the colon. The physician stated Patient 1 had "improved, we did all we could do, and she was good to go."</p> <p>However, there was no documentation in the medical record to show the physician had discussed the potential complications of refusal of medical treatments with the patient. When the physician was asked if he had contacted Patient 1's conservator in order to inform him about the seriousness of the patient's condition, the physician stated, "No, I didn't speak with the Conservator."</p> <p>Review of documentation from the TRC showed Patient 1 complained of stomach/abdominal pain at the level of 8/10 on the pain scale upon readmission to the TRC on 1/9/14 at 1830 hours. While at the TRC on 1/10 and 1/11/14, Patient 1 was assessed with a distended abdomen with hypoactive (decreased) bowel sounds.</p> <p>On 1/11/14, the patient was brought back to the hospital's ED from the TRC. The Emergency Physician Record dated 1/11/14, showed the patient had worsening abdominal pain, distention, and a fever of 100.7 degrees Fahrenheit (F) (normal body temperature range: 96.8 - 99.5 degrees F). The ED physician documented Patient 1's white blood cell count (WBC) was elevated to 14,500</p>			

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	<p>(normal WBC range: 4,800 - 10,800 and high WBC count usually indicates infection), and the patient would be admitted to the hospital.</p> <p>The CT scan of the abdomen and pelvis reported on 1/11/14 at 2050 hours, showed Critical Findings Results (results outside the normal range and may represent life-threatening situations) of severe constipation with a significant amount of stool throughout the colon with significant impaction in the recto sigmoid, which had dilated up to approximately 14 centimeter (cm) in diameter (normal size is up to 6 cm in diameter).</p> <p>The Progress Notes Report dated 1/11/14 at 2010 hours, showed the ED nurse documented Patient 1 returned from the CT scan at 2035 hours. The CT image was reviewed by the ED physician and the ED physician advised the patient to have a manual fecal disimpaction, but the patient refused. At 2113 hours, Patient 1 again refused the manual fecal disimpaction and Fleet enemas. However, there was no documentation to show the conservator was notified of the patient's condition and refusal of treatments.</p> <p>Patient 1 was readmitted to the hospital on 1/11/14 at 2247 hours, and medications including Fleet enemas were again ordered.</p> <p>Review of the Progress Notes Report dated 1/12/14 at 0323 hours, showed the RN documented the patient refused medications,</p>			

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	<p>including a Fleet enema.</p> <p>On 1/12/14 at 0800 hours, the RN documented Patient 1 was confused, very hostile, and uncooperative with staff, and again refused an enema.</p> <p>On 1/12/14 at 1600 hours, the RN documented the patient refused to have vital signs assessed. However, there was no documentation to show the physician or conservator was informed of the patient's refusal of treatments or assessments.</p> <p>Documentation in the Daily Focus Assessment Report dated 1/12/14 at 0800 hours, showed the patient was assessed as "confusion and danger of self-harm," "uncooperative," and "disoriented." However, there was no documented evidence of any mental health evaluations to determine further necessary mental health interventions to address Patient 1's non-compliance.</p> <p>On 1/12/14 at 0431 hours, the RN documented Patient 1 had a large BM described as "small balls followed by loose stools."</p> <p>Review of the Intake/Output form dated 1/12/14 at 0609 hours, showed Patient 1 had one incontinent BM and at 1730 hours, Patient 1 had fiye BMs. There was no documentation of the amount and consistency of any of the stools passed. There was no documented evidence to show the nursing staff had accurately monitored and documented the</p>			

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NAME OF PROVIDER OR SUPPLIER <b>South Coast Global Medical Center</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 S Bristol St, Santa Ana, CA 92704-6201 ORANGE COUNTY</b>		
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	<p>patient's defecation patterns and progress of fecal impaction to form the basis for determining if further interventions were needed.</p> <p>Review of the Daily Focus Assessment Report and Progress Notes Report dated 1/12/14, showed Patient 1 became incontinent of bowel and bladder (involuntary excretions).</p> <p>No vital signs assessment was recorded at 1600 hours. At 2000 hours, the patient's blood pressure was 98/56 mmHg [millimeter(s) of mercury] (normal blood pressure range: 100-139/60-89 mmHg) and the heart rate was 128 bpm [beat per minute] (normal heart rate range: 60-100 bpm).</p> <p>Although the 2000 hours vital signs were significantly abnormal, no further vital signs checks were documented until 0030 hours on 1/13/14, and there was no evidence the physician was notified of the abnormal heart rate and blood pressure taken at 2000 hours.</p> <p>On 1/13/14 at 0030 hours, Patient 1's blood pressure was 102/58 mmHg and the heart rate increased to 138 bpm. However, there was no documented evidence the physician was notified of the patient's abnormal and increasing heart rate at 0030 hours.</p> <p>Medical record review failed to show documented evidence the RNs reassessed Patient 1's vital signs after the significant</p>			

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	<p>change in condition regarding a possible ruptured bowel. There were no further vital signs documented on 1/13/14 from 0030 hours to 0641 hours. At 0641 hours, the patient's blood pressure decreased from 102/58 to 84/54 mmHg, the heart rate increased from 138 to 150 bpm, the temperature was slightly decreased from 98 to 96 degree F, and the oxygen saturation (measurement of level of oxygen in the blood) decreased from 96 to 94% (normal oxygen saturation range: 95-100%).</p> <p>On 1/13/14 at 0147 hours, Physician 2 was notified the patient's abdomen was more distended and of an increase in agitation; a CT scan order was obtained. Patient 1 left to have the CT scan at 0330 hours. At 0358 hours, documentation showed the patient was breathing hard; oxygen was applied at two liters per minute via a nasal cannula.</p> <p>On 1/13/14 at 0020 and 0315 hours, the nursing staff documented Patient 1 complained of severe abdominal pain at the level of 8/10 on the pain scale. The patient was medicated at 0318 hours with Dilaudid (a narcotic medication used to relieve moderate/severe pain) 1 mg/ml intravenously.</p> <p>The Preliminary Teleradiology (transmission of radiological patient images) Report dated 1/13/14 at 0406 hours, for the CT of abdominal and pelvis showed there was persistent massive dilation of the colon and rectum with a</p>			

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	<p>large amount of fecal material in the rectum and distal colon, concerning for fecal impaction and distal obstruction (blockage of the furthest part of the bowel). The radiologist documented the findings were discussed with Physician 2 at 0419 hours.</p> <p>The transcribed CT of Abdomen and Pelvis report dated 1/13/14 at 1019 hours, showed interval development of a small amount of free fluid, and free air within the abdomen and pelvis; the possibility of ruptured bowel with peritonitis could not be excluded.</p> <p>Medical record showed on 1/13/14, an anesthesiologist signed a pre-operative evaluation for Patient 1 at 0630 hours; a surgical procedure started at 0703 hours on 1/13/14.</p> <p>Review of a Critical Care Consult dictated on 1/13/14 at 0815 hours, showed the patient was extremely unstable and was taken to the operating room immediately. After the anesthesia induction and intubation, the patient had a cardiac arrest. The patient was revived and her abdomen was opened. Fecal material was found all over the abdomen. The physician documented Patient 1 was transferred to the Intensive Care Unit (ICU, a special unit in the hospital to provide intensive care medicine) where she developed septic shock with multi-organ failure secondary to the perforated bowel with peritonitis. The prognosis was poor due to ischemic (without</p>			

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	<p>adequate blood supply) bowel.</p> <p>Further medical record review showed Patient 1 had a second cardiac arrest on 1/13/14 at 2018 hours and expired at 2108 hours.</p> <p>During an interview with Surgeon 1 on 1/29/14 at 0900 hours, he stated when he saw and examined Patient 1 on 1/12/14, her abdomen was distended and the stomach area was "big" and non-tender. Surgeon 1 stated the patient was having incontinent, spontaneous BMs. Surgeon 1 stated he did not think Patient 1 was developing sepsis or an intestinal perforation because she did not have a fever and her labs and vital signs were normal.</p> <p>Medical record review failed to show documentation the hospital staff had contacted Patient 1's conservator regarding the patient's refusal of medical treatments from the second hospital admission on 1/11/14 until 1/13/14 at 0516 hours, when the patient required an emergent surgery.</p> <p>During an interview with Patient 1's conservator on 2/6/14 at 0800 hours, the conservator was asked if the hospital had notified/informed him the seriousness of the patient's condition anytime between 1/11 and 1/13/14. The conservator stated, "No."</p> <p>Review of the Progress Notes Report showed on 1/13/14 at 0516 hours, the RN documented she attempted to contact the patient's</p>			

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	<p>conservator but was unable. At 1400 hours, the hospital notified the conservator of the patient's admission to ICU.</p> <p>Review of the Patient 1's Certificate of Death, completed by a physician, showed the immediate cause of death was cardiac arrest. The other significant conditions contributing to the patient's death were listed as septic shock, bowel perforation-spontaneous, and fecal impaction with severe constipation.</p> <p>On 3/26/14 at 1530 hours, the above findings were confirmed at the time of the exit conference with the Director of Clinical Process Improvement, Quality Management Department RN, and Director of Medical Surgical and Senior Services.</p> <p>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 1280.3(g).</p>			

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