

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/14/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00250406, CA00226479 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 22362, HFEN</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.1(c): For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>The Department substantiated violations of the regulations.</p> <p>Abbreviations Used:</p> <p>@ at bpm beats per minute CLRN clinical lead RN C/S cesarian section decel decelerations DX diagnosis</p>			12/14/2011 5:00:43PM

Event ID:LID811

1/11/2012

5:00:43PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Chief Operating Officer

(X8) DATE

1/24/12

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	<p>Continued From page 1</p> <p>F fahrenheit FHR fetal heart rate FMS fetal monitoring strip FSE fetal scalp electrode IVFD invitro fetal death L liter L&D labor and delivery LDR labor and delivery room MD medical doctor min minute O2 oxygen OR operating room P&P policy and procedure PNE perinatal educator post op post operative R right rcvd received RN registered nurse sono sonogram</p> <p>A014 1280.1 (c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient.</p> <p>T22 DIV 6 CH 1 ART 6-70547 (a) (3). Perinatal Unit General Requirements. (a) A perinatal unit shall provide: (3) Care for mothers and infants needing emergency or immediate life support measures to sustain life up to 12 hours or to prevent major</p>				

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	<p>Continued From page 2</p> <p>disability. Based on interview, record review and facility document review, the facility failed to ensure the labor and delivery nurses provided emergency measures in order to sustain life. This resulted in a delay in recognizing an abnormal fetal heart pattern, implementing immediate interventions, to include notifying the mother's (Patient A's) physician of an abnormal fetal heart pattern, resulting in the subsequent death of Patient B, a full term infant.</p> <p>Findings:</p> <p>A review of Patient A's record was conducted on [REDACTED] 2010. The "Assessment, Labor & Recovery Flow Sheet" indicated Patient A was admitted to the facility on [REDACTED] 2010, at 1:30 a.m. At 1:35 a.m., the note indicated, "MD called on cell...FHR (fetal heart rate), 120's, difficult to trace (fetal heart tracing- a method of monitoring the fetal heartbeat and uterine contractions, R/T (related to) maternal size..."</p> <p>Further review of the "Assessment, Labor & Recovery Flow Sheet," dated [REDACTED] 2010, indicated:</p> <p>"...0203 (2:03 a.m.) FHR - 105-110 bpm (beats per minute) with weak sono (sonogram-use of sound waves to determine the heartrate) signal noted. pt. turned to L (left) side & searching for FHR... 0204 (2:04 a.m.)... FHR audible @ 105-110 bpm, difficult to trace FHR due to mother's obese abdomen... 0210 (2:10 a.m.) FHR audible at 105 with audible</p>		<p>Continued From page 2</p> <p>Response to:</p> <p>T22 Div 6 CH 1 ART 6-70547 (3)</p> <p>Actions taken:</p> <p>The hospital conducted a thorough investigation and initiated the following immediate and long term systemic actions:</p> <ol style="list-style-type: none"> 1. The Women's Services Director conducted a one-on-one case review and counseling with the primary nurse involved. A plan for remediation was developed to include education and proctoring. The nurse subsequently elected to resign her position at SWHCS. 2. The Women's Services leadership team (Managers/Director/Educator) initiated immediate staff education by a read and acknowledgment packet. The education included assessing fetal heart rate and assuring fetal well being and the Charge Nurse's role of enhanced oversight: - receiving report from the primary nurse; 	<p>5/10/10</p> <p>5/11/10</p>

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	<p>Continued From page 3</p> <p>decel (decelerations-decrease in the FHR,) noted... 0215 (2:15 a.m.)...explained to mother having difficult keeping FHR on monitor, but I can hear it @ 95-105 bpm. noted.... pt. turned to supine position with R tilt."</p> <p>The facility's policy and procedure titled, "Fetal & Uterine Monitoring Assessment, Interpretation, & Documentation," (Revised August, 2008,) indicated, "If the baseline FHR is less than 110 bpm, it is termed bradycardia (an abnormally slow fetal heart rate may contribute to a lack of blood flow to vital organs)."</p> <p>A review of the FMS dated [REDACTED] 2010, indicated at 2:07 a.m., "FHR audible @ 105-110," and at 2:17 a.m., "Audible FHR @ 105 bpm." There was no documentation found to indicate the physician was notified at 2:07 a.m., or at 2:17 a.m., of the slow heart rate of the fetus.</p> <p>A review of the, "Assessment, Labor & Recovery Flow Sheet," indicated, at 2:21 a.m., "holding sono & tracing FHR @ 85-105 bpm. 0224 (2:24 a.m.) O2 placed via mask at 10L/min...0225 (2:25 p.m.) (MD) notified of difficulty maintaining FHR tracing with sono..."</p> <p>The physician was not informed of the difficulties in obtaining a FHR, or a baseline FHR after [REDACTED] 2010, at 1:35 a.m., until 2:25 a.m., 50 minutes after the physician was notified that the patient was in the hospital and in labor.</p> <p>A review of the "Labor Admission Orders," dated</p>		<p>Continued From page 3</p> <p>- collaborating on the status of the patient's admission assessment; - focused attention given to assuring fetal well being. 100% staff acknowledgement of education was documented</p> <p>3. Women's policy "Fetal and Uterine Monitoring Assessment, Interpretation and Documentation" was immediately reviewed and revised. The revisions are consistent with AWHONN principals and practice guidelines. To assure fetal well being of all laboring patients, the primary nurse is to report the initial assessment to the Charge Nurse or designee. If fetal well being can not be confirmed with a continuous fetal heart rate tracing, additional measures to assess fetal status must be taken and the physician notified.</p> <p>4. The revised policy "Fetal and Uterine Monitoring Assessment, Interpretation and Documentation" was approved by the Department of OB/GYN, Medical Executive Committee (MEC) and the Board of Governors.</p> <p>5. Additionally, in October of 2011 the "Fetal and Uterine Monitoring Assessment, Interpretation and Documentation" policy was reviewed and revised to include the National Institute Child Health and Human Development (NICHD) updated terminology related to fetal heart rate interpretation to standardize the language among Healthcare providers. The policy was reviewed and approved by the Department of OB/GYN, MEC and the Board of Governors.</p>	<p>5/6/10</p> <p>5/6/10</p> <p>10/2011</p>

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	<p>Continued From page 4</p> <p>██████████ 2010, at 1:30 a.m., indicated, "FHR and uterine activity monitoring per policy."</p> <p>A review of the "Fetal & Uterine Monitoring Assessment, Interpretation, & Documentation," (Revised 8/08), indicated, for a patient in active labor, "Prior to using auscultation, (use of specialized equipment to audibly hear the FHR), obtain a 20-minute reassuring FHR tracing by CEFM (continuous electronic monitoring). After a reassuring FHR is documented the nurse may proceed using auscultation per order..."</p> <p>Further record review failed to show a 20 minute period of time where there was a reassuring FHR.</p> <p>An interview was conducted with RN B on ██████████ 2010, at 3:15 p.m. RN B stated, "I came to the patient's room at 1:55 a.m. I was the charge nurse that evening. (RN A) gave me an s-bar report (the hand off communication). I began the admission assessment and I realized that the FHR wasn't tracing and was on the low end of normal. I audibly heard the FHR between 105 and 110 when I completed the admission assessment, and I was still having difficulty getting it to trace. I did not attempt to get another machine nor did I call anyone at that time. The oxygen was put on (Patient A) at 2:24 a.m., the patient did not have oxygen on prior to that. I didn't put the oxygen on earlier because I didn't have an accurate assessment. I wasn't assured that the baby was O.K. I didn't have enough of a continuous tracing. I called the doctor at 2:25 a.m. Then I put on the FSE (document which reflects the baby's heartrate</p>		<p>Continued From page 4</p> <p>6. One-on-one discussions with each L&D nurse were conducted to reinforce the elements of assuring fetal well being, actions to initiate if there is difficulty in obtaining a continuous tracing (e.g. obesity) or if there is a non-reassuring tracing. 100% of staff acknowledgement of this information was documented. The "Fetal and Uterine Monitoring Assessment, Interpretation and Documentation" has been incorporated in the new hire orientation for L&D nurses.</p> <p>7. The Women Services leadership team (Managers/Director/Educator) completed a retrospective case/chart review in their multidisciplinary higher reliability unit meeting, including a case discussion. The opportunities for improvement were discussed at this meeting and included the elements of assuring fetal well being, actions to initiate if there is difficulty in obtaining a continuous tracing (e.g. obesity) or if there is a non-reassuring tracing.</p> <p>8. Additionally, The Women Services leadership team (Managers/Director/Educator) completed a retrospective chart review for each L&D RN monthly over a twelve month period to ensure compliance with the required elements involved in assuring fetal well being and took immediate corrective action as indicated.</p> <p>9. Monthly each L&D Nurse is required to conduct and successful complete a FHR strip review, entering their interpretation using NICHD language into an electronic learning module to ensure competencies.</p>	5/31/10	05/10	6/10	6//10 & ongoing

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	<p>Continued From page 5</p> <p>and the strength of the mothers contractions), the bag of waters (the fluid which surrounds and protects the baby in the uterus) was still intact."</p> <p>A review of the "Nursing Progress Notes Continuation Sheet," dated [REDACTED] 2010 at 2:25 a.m., indicated, "late entry... (MD,) notified to come to pts. bedside for evaluation." The notes at 2:38 a.m., indicated, "Called (physician) for STAT C-Section for Fetal Bradycardia."</p> <p>An interview was conducted with the CLRN on [REDACTED] 2010, at 10:15 a.m. After reviewing Patient A's FMS, dated [REDACTED] 2010, originating at 1:30 a.m., the CLRN stated, "The purpose of the FMS is to check fetal well being and to check if the baseline (the FHR during a 10 minute segment) is normal. A normal FHR baseline ranges from 110-160, this tracing indicates a signal loss, it is hard to establish a FHR, I would not feel comfortable saying what the rate was, I would call the MD."</p> <p>An interview was conducted with the PNE on [REDACTED] 2010, at 9:30 a.m., the PNE stated the physician should have been called when the FHR was difficult to establish.</p> <p>The facility policy and procedure titled, "Fetal & Uterine Monitoring Assessment, Interpretation, & Documentation," (revised August, 2008.) indicated, "If the baseline FHR is less than 110 bpm, it is termed bradycardia ..."</p> <p>A review of the facility document, "Position Title: Clinical RN, Labor and Delivery," was conducted.</p>		<p>Continued From page 5</p> <p>10. Biannually the L&D registered nursing staff is required to complete and successful obtain certification in advance fetal monitoring and interpretation by the AWHONN standards.</p> <p>Monitoring:</p> <p>The Women's Services Director and Managers are accountable to ensure the ongoing compliance with this policy. Monthly reviews are done; indicators include assuring fetal well being, recognition of non-reassessing patterns and prompt physician notification as warranted. Individual feedback is provided to the staff via one-on-one meetings as warranted. The outcome of the reviews are discussed at unit staff meetings and the OB high reliability meetings. Information forwards to the Patient Safety Council, the OB/GYN Department meeting, MEC and the Board. Upon achieving three consecutive months of compliance, the Patient Safety Council will determine what, if any, further action is necessary.</p> <p>Responsible Party: Women's Services Director.</p>	<p>Biannually and ongoing</p> <p>6/1/10 and ongoing</p>

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	<p>Continued From page 6</p> <p>The "Unit Specific Competencies: Labor And Delivery," indicated, "...Initiate appropriate nursing interventions for non-reassuring fetal heart rate patterns...per hospital policy and procedure."</p> <p>The facility policy and procedure titled, "Admission Assessment Of The Labor Patient," (revised August, 2008,) indicated, "...the provider (the physician) shall be informed of any real or potential complications including but not limited to: Non-reassuring fetal heart rate (FHR which can be associated with adverse neonatal outcomes related to a lack of oxygen)."</p> <p>The "Nursing Progress Notes Continuation Sheet," dated [REDACTED] 2010, at 2:43 a.m. indicated, "Transferred to OR via pt. bed in hand and knee position, draped by a blanket. Transferred to OR bed...Unable to assess baseline (FHR,) heavy artifact." The note at 2:55 a.m. indicated, "Incision by MD,"</p> <p>At 2:57 a.m., the notes indicated, "Respiratory present, Baby Delivered with no Respiratory effort, No Heart rate, Pale Colour, No muscle Tone noted, Resuscitation efforts started, 0300 (3 a.m.) Code White Called." At 3:33 a.m. the physician, "Ceased Resuscitation efforts" (stopped resuscitation).</p> <p>A review of the "Delivery Room Register," dated [REDACTED] 2010, indicated Patient A had a C/S for a, "Pre-op DX Fetal Bradycardia, Non-reassuring FHR....Post op DX IVFD (in vitro fetal death)."</p> <p>The facility policy and procedure titled, "Fetal &</p>			

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	<p>Continued From page 7</p> <p>Uterine Monitoring Assessment, Interpretation, & Documentation," indicated, "...non-reassuring patterns can be associated with adverse neonatal outcomes related to hypoxia (lack of oxygen) and because the clinician is unable to predict which fetuses may be affected, non-reassuring FHR patterns require careful evaluation and timely intervention."</p> <p>"If the FHR pattern is non-reassuring, interventions along with the maternal-fetal response to the interventions should be documented...The goals of intervention include maximizing both uteroplacental and umbilical blood flow and gas exchange, therefore interventions are implemented toward those ends and include but are not limited to: ...Administer oxygen by non-rebreather facemask at 10 liters per min...Primary care physician is to be notified of abnormal FHR patterns in a timely manner."</p> <p>An interview was conducted with Patient A's physician on [REDACTED] 2010, at 3:50 p.m. When questioned regarding situations in which he would expect a call from the labor and delivery nurse the physician stated he would expect a call when the patient has their initial evaluation upon arrival, then after a follow-up cervical exam and also if anything unusual occurs, such as an episode of bradycardia. The physician further stated, "The nurse called to notify me of (Patient A's) arrival, then called me one hour later."</p> <p>The physician stated, "I got to the hospital, I scrubbed in and delivered the baby, (he was) covered with thick meconium (baby feces) and</p>			

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	<p>Continued From page 8</p> <p>blood...there was a partial separation (of the placenta which supplies oxygen and nutrients to the fetus)."</p> <p>Review of the Coroner's Investigation Report, dated [REDACTED] 2010, was conducted. The cause of death for Patient B was "Placental Abruption, (premature separation of the placenta from the uterus)."</p> <p>The inability of the nurse to obtain and recognize an abnormal FHR pattern, a sign of fetal distress, resulted in a delay with notifying Patient A's physician, and a failure to provide emergency measures, which contributed to the death of Patient B, a full term, viable infant.</p> <p>The facility's failure to identify an abnormal fetal heart rate pattern and implement immediate interventions, to include notifying the patient's physician, in violation of Sections 70213(a) and 70547(a)(3) of Title 22 of the California Code of Regulations, was a deficiency that caused, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.</p> <p>The facility's failure to maintain and implement written policies and procedures to identify an abnormal fetal heart rate pattern and implement immediate interventions, to include notifying the mother's physician of an abnormal fetal heart rate pattern, in violation of Sections 70213(a) and 70547(a)(3) of Title 22 of the</p>			

Event ID: LID811

1/11/2012

5:00:43PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/14/2011
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 25600 MEDICAL CENTER DRIVE, MURRIETA, CA 92562 RIVERSIDE COUNTY		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Continued From page 9</p> <p>California Code of Regulations was a deficiency that caused, or was likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.</p> <p>[REDACTED]</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 1280.1(c).</p>			

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